



Commonwealth of Virginia
Department of Medical
Assistance Services

2024–25 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) 2024–25 (Contract Year 4). 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 of, access to, and timeliness of care for these members.

The 2024–25 Child Welfare Focus Study assesses healthcare utilization during measurement year (MY) 2024 (i.e., January 1–December 31, 2024) 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 Child Welfare Focus Study, 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, 2024, 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, 2024, 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, 2024, and identified by DMAS as enrolled in Medicaid under the aid category “070” for former foster care members.

For the healthcare utilization analysis, the eligible populations were limited to members enrolled in Medicaid managed care with any MCO or a combination of MCOs during the measurement year, with enrollment gaps totaling no more than 45 days. 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. HSAG assessed performance on select 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) and state custom utilization measures by comparing the rates for the study populations to the rates for 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
- Primary and dental care for members who aged out of the foster care program
- Behavioral healthcare for members who were newly enrolled in foster care, members who were newly enrolled in adoption assistance, and members who aged out of the foster care program

These members were continuously enrolled in Medicaid managed care 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 2024.

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 22 measures, representing 34 study indicators, across six domains, as displayed in Table 1-1.

Table 1-1—Healthcare Utilization Measure Indicators

Measure and Indicators
Primary Care
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)

Measure and Indicators
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing (APM) [^]
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP) [^]
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—One-Month Follow-Up, Two-Month Follow-Up, Three-Month Follow-Up, Six-Month Follow-Up, and Nine-Month Follow-Up (ADD) [^]
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD-AD) [*]
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)
Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD) [*]
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 measures were not calculated for the former foster care members, as the measures are not applicable to members 19 to 26 years of age.

^{*} Indicates these measures were only calculated for the former foster care members, as the measures are only applicable to members 18 years of age and older.

[†] Indicates these measures 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 measurement 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 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 Within 1 Year for New Adoption Assistance Members—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 CMS Adult and Child Core Set Technical Specifications and Resource Manual for Federal Fiscal Year (FFY) 2025 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, sex, 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	<i>p</i>
Primary Care			
Child and Adolescent Well-Care Visits	67.4%	58.1%	<0.001*
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits	63.3%	66.7%	0.56
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	82.6%	76.5%	0.18
Oral Health			
Annual Dental Visit	79.6%	63.2%	<0.001*
Preventive Dental Services	73.7%	56.4%	<0.001*
Oral Evaluation, Dental Services	73.3%	55.7%	<0.001*
Topical Fluoride for Children—Dental or Oral Health Services	39.4%	25.4%	<0.001*
Behavioral Health			
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up	57.2%	57.3%	0.99
Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up	73.8%	89.7%	0.09
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing	37.6%	32.7%	0.37
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	83.0%	74.3%	0.27
Follow-Up Care for Children Prescribed ADHD Medication—One-Month Follow-Up	79.0%	66.9%	0.03*
Follow-Up Care for Children Prescribed ADHD Medication—Two-Month Follow-Up	92.7%	82.7%	0.01*
Follow-Up Care for Children Prescribed ADHD Medication—Three-Month Follow-Up	94.4%	89.5%	0.15
Follow-Up Care for Children Prescribed ADHD Medication—Six-Month Follow-Up	97.6%	96.2%	0.72
Follow-Up Care for Children Prescribed ADHD Medication—Nine-Month Follow-Up	98.4%	97.7%	1.00

Measure	Children in Foster Care Rate	Controls Rate	p
Substance Use			
Initiation and Engagement of SUD Treatment—Initiation of SUD Treatment	50.0%	35.3%	0.18
Initiation and Engagement of SUD Treatment—Engagement of SUD Treatment	18.0%	2.9%	0.04*
Respiratory Health			
Asthma Medication Ratio	71.0%	76.7%	0.55
Service Utilization			
Ambulatory Care Visits	91.6%	90.7%	0.23
ED Visits	28.7%	37.2%	<0.001*
Inpatient Visits	7.1%	4.4%	<0.001*
Behavioral Health Encounters—Total	74.3%	59.6%	<0.001*
Behavioral Health Encounters—ARTS	3.7%	2.1%	<0.001*
Behavioral Health Encounters—CMH Services	34.9%	20.1%	<0.001*
Behavioral Health Encounters—RTC Services	11.7%	5.1%	<0.001*
Behavioral Health Encounters—Therapeutic Services	6.1%	1.8%	<0.001*
Behavioral Health Encounters—Traditional Services	71.9%	57.6%	<0.001*
Overall Service Utilization	93.8%	93.5%	0.67

* 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 had rates of healthcare utilization higher than or equal to controls for 24 study indicators, 15 of which were statistically significant. Of note, the rate for children in foster care was significantly lower than the rate for controls for the *ED Visits* study indicator. The children in foster care eligible population included 7,463 children enrolled in Medicaid during MY 2024. Among the eligible population, 3,071 children (41.1 percent) were continuously enrolled with any MCO or combination of MCOs during the measurement year. Finally, 2,948 of the continuously enrolled children in foster care (96.0 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 2.4 percentage points fewer children 2 years of age or younger, 2.0 percentage points more children 6 to 10 years of age, 3.4 percentage points more members enrolled with Sentara, and 2.8 percentage points more members in the Acute population.

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	51.8%	52.1%	0.72
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits	50.0%	74.3%	0.56
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	85.7%	78.1%	0.38
Oral Health			
Annual Dental Visit	62.6%	61.5%	0.17
Preventive Dental Services	58.1%	56.5%	0.05
Oral Evaluation, Dental Services	56.9%	55.6%	0.11
Topical Fluoride for Children—Dental or Oral Health Services	26.8%	24.5%	0.002*
Behavioral Health			
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up	61.1%	57.8%	0.57
Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up	79.3%	85.1%	0.41
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing	34.5%	38.3%	0.34
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	63.2%	70.9%	0.30
Follow-Up Care for Children Prescribed ADHD Medication—One-Month Follow-Up	51.6%	55.8%	0.30
Follow-Up Care for Children Prescribed ADHD Medication—Two-Month Follow-Up	75.8%	75.8%	0.99
Follow-Up Care for Children Prescribed ADHD Medication—Three-Month Follow-Up	82.8%	83.2%	0.90
Follow-Up Care for Children Prescribed ADHD Medication—Six-Month Follow-Up	91.9%	92.0%	0.96
Follow-Up Care for Children Prescribed ADHD Medication—Nine-Month Follow-Up	94.7%	95.0%	0.89
Substance Use			
Initiation and Engagement of SUD Treatment—Initiation of SUD Treatment	50.0%	43.6%	0.50
Initiation and Engagement of SUD Treatment—Engagement of SUD Treatment	5.4%	16.4%	0.07
Respiratory Health			
Asthma Medication Ratio	79.3%	81.7%	0.68
Service Utilization			
Ambulatory Care Visits	84.2%	85.1%	0.11

Measure	Children Receiving Adoption Assistance Rate	Controls Rate	p
ED Visits	19.3%	29.9%	<0.001*
Inpatient Visits	3.6%	2.8%	0.004*
Behavioral Health Encounters—Total	57.0%	49.9%	<0.001*
Behavioral Health Encounters—ARTS	1.7%	1.5%	0.28
Behavioral Health Encounters—CMH Services	14.7%	14.6%	0.90
Behavioral Health Encounters—RTC Services	5.0%	3.6%	<0.001*
Behavioral Health Encounters—Therapeutic Services	1.4%	1.5%	0.67
Behavioral Health Encounters—Traditional Services	56.1%	48.1%	<0.001*
Overall Service Utilization	87.0%	88.5%	0.01*

* 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 had rates of healthcare utilization higher than or equal to controls for 14 study indicators, five of which were statistically significant. Of note, the rates for children receiving adoption assistance were significantly lower than the rates for the controls for the *ED Visits* and *Overall Service Utilization* study indicators. The children receiving adoption assistance eligible population included 8,654 children enrolled in Medicaid during MY 2024. Among the eligible population, 6,998 children (80.9 percent) were continuously enrolled with any MCO or combination of MCOs during the measurement year. Finally, 6,973 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, except that there were 2.1 percentage points more children 2 years of age and younger and 2.2 percentage points fewer children enrolled with Sentara.

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	21.9%	21.6%	0.92

Measure	Former Foster Care Members Rate	Controls Rate	p
Oral Health			
Annual Dental Visit	39.6%	36.8%	0.58
Preventive Dental Services	31.1%	27.9%	0.50
Oral Evaluation, Dental Services	32.9%	30.1%	0.56
Topical Fluoride for Children—Dental or Oral Health Services	8.2%	8.5%	0.91
Behavioral Health			
Antidepressant Medication Management—Effective Acute Phase Treatment	33.8%	42.6%	0.31
Antidepressant Medication Management—Effective Continuation Phase Treatment	10.8%	23.0%	0.07
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up	39.7%	44.8%	0.64
Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up	56.0%	44.4%	0.70
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	65.7%	53.3%	0.19
Substance Use			
Follow-Up After ED Visit for Substance Use—30-Day Follow-Up	25.0%	30.0%	1.00
Initiation and Engagement of SUD Treatment—Initiation of SUD Treatment	51.3%	70.1%	0.01*
Initiation and Engagement of SUD Treatment—Engagement of SUD Treatment	20.2%	35.1%	0.02*
Use of Pharmacotherapy for Opioid Use Disorder	72.5%	78.6%	0.50
Respiratory Health			
Asthma Medication Ratio	83.3%	37.5%	0.14
Service Utilization			
Ambulatory Care Visits	59.9%	63.7%	0.04*
ED Visits	45.1%	38.0%	<0.001*
Inpatient Visits	7.9%	8.8%	0.41
Behavioral Health Encounters—Total	36.3%	32.5%	0.04*
Behavioral Health Encounters—ARTS	9.3%	6.4%	0.01*
Behavioral Health Encounters—CMH Services	9.7%	5.8%	<0.001*
Behavioral Health Encounters—RTC Services	5.1%	2.9%	0.004*
Behavioral Health Encounters—Therapeutic Services	2.1%	1.0%	0.02*
Behavioral Health Encounters—Traditional Services	34.7%	31.6%	0.09
Overall Service Utilization	74.3%	73.2%	0.51

* 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 25 study indicators, former foster care members had higher rates of healthcare utilization than controls for 15 study indicators, six of which were statistically significant. Of note, the former foster care rate was significantly lower than the rate for controls for the *Initiation and Engagement of SUD Treatment—Initiation of SUD Treatment, Initiation and Engagement of SUD Treatment—Engagement of SUD Treatment, and Ambulatory Care Visits* study indicators. The former foster care members eligible population included 2,455 members enrolled in Medicaid during MY 2024. Among the eligible population, 1,368 members (55.7 percent) were continuously enrolled with any MCO or combination of MCOs during the measurement year. Finally, 1,365 of the continuously enrolled former foster care members (99.8 percent) were matched to a control member and included in the final study population for comparison to controls. The demographic makeup of the study population closely mirrored the demographic makeup of the former foster care eligible population, except that there were 4.2 percentage points more members 19 to 22 years of age and 2.8 percentage points more male members.

Timely Access to Care Findings

Table 1-6 contains the timely access to care study indicator results for children newly enrolled in foster care, 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	2,058	1,729	84.0%
Timely Access to Care for New Foster Care Members—Timely Access to Dental Care for New Foster Care Members	2,058	923	44.8%
Timely Access to Care for New Foster Care Members—Timely Access to Primary Care or Dental Care for New Foster Care Members	2,058	1,839	89.4%
Timely Access to Care for New Foster Care Members—Timely Access to Primary Care and Dental Care for New Foster Care Members	2,058	813	39.5%
Timely Access to Behavioral Health Care Within 60 Days for New Foster Care Members—Timely Access to Behavioral Health Care for New Foster Members	1,811	863	47.7%
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	629	503	80.0%
Timely Access to Behavioral Health Care Within 1 Year for New Foster Care Members—Timely Access to Behavioral Health Care for New Foster Members	1,355	987	72.8%
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	493	470	95.3%
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	992	481	48.5%

Measure	Denominator	Numerator	Rate
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	383	281	73.4%
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	114	75	65.8%
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	114	46	40.4%
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	114	82	71.9%
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	114	39	34.2%
Timely Access to Behavioral Health Care for Members Who Aged Out of Foster Care—Timely Access to Behavioral Health Care for Members Who Aged Out of Foster Care	114	47	41.2%
Timely Access to Behavioral Health Care for Members Who Aged Out of Foster Care—Timely Access to Behavioral Health Care for Members Who Aged Out of Foster Care With a Behavioral Health Diagnosis	81	40	49.4%

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) (84.0 percent and 65.8 percent, respectively), while less than half of these members had a timely visit with a dental provider (44.8 percent and 40.4 percent, respectively). Most members who had a dental provider visit also had a PCP visit. Among those with a behavioral health diagnosis, 95.3 percent of new foster care members and 73.4 percent of new adoption assistance members had a visit with a mental health provider (MHP) within one year of enrollment. However, only 49.4 percent of members who aged out of foster care with a behavioral health diagnosis had an MHP visit within the measurement year. Of note, 80.0 percent of children newly enrolled in foster care with a behavioral health diagnosis had an MHP visit within 60 days of enrollment.

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 with High Rate Disparity	Percent of Study Indicators with High Rate Disparity	Count of Study Indicators with Low Rate Disparity	Percent of Study Indicators with Low Rate Disparity
Age Category				
Healthcare Utilization: Children in Foster Care	16	69.6%	15	65.2%
Healthcare Utilization: Children Receiving Adoption Assistance	15	60.0%	15	60.0%
Healthcare Utilization: Former Foster Care Members	1	4.2%	1	4.2%
Timely Access to Care	7	70.0%	7	70.0%
Sex				
Healthcare Utilization: Children in Foster Care	5	20.8%	5	20.8%
Healthcare Utilization: Children Receiving Adoption Assistance	7	30.4%	7	30.4%
Healthcare Utilization: Former Foster Care Members	7	30.4%	7	30.4%
Timely Access to Care	4	25.0%	4	25.0%
Race				
Healthcare Utilization: Children in Foster Care	2	8.7%	1	4.3%
Healthcare Utilization: Children Receiving Adoption Assistance	8	34.8%	9	39.1%
Healthcare Utilization: Former Foster Care Members	4	17.4%	3	13.0%
Timely Access to Care	5	31.3%	5	31.3%
Region				
Healthcare Utilization: Children in Foster Care	16	66.7%	17	70.8%
Healthcare Utilization: Children Receiving Adoption Assistance	16	66.7%	12	50.0%
Healthcare Utilization: Former Foster Care Members	10	41.7%	8	33.3%
Timely Access to Care	8	50.0%	11	68.8%
MCO				
Healthcare Utilization: Children in Foster Care	10	41.7%	9	37.5%
Healthcare Utilization: Children Receiving Adoption Assistance	14	58.3%	13	54.2%
Healthcare Utilization: Former Foster Care Members	4	16.7%	5	20.8%
Timely Access to Care	5	31.3%	4	25.0%

For the healthcare utilization study indicators, the health disparities analysis identified few disparities by race for children in foster care and former foster care members, but several racial disparities for children receiving adoption assistance. There were many disparities identified by MCO for children in foster care and children receiving adoption assistance; however, findings varied across study indicators. Additionally, for children in foster care and children receiving adoption assistance, a majority of study indicators had disparities based on age category and region. For example, children 2 years of age and younger were less likely to have a dental 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 had disparities based on age 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 control groups 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 control groups. Covariate balance between the stratification-limited study populations and the stratification-limited control groups 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 2024–25 study, all characteristics for which rates were stratified were exact-matched except for member sex, and HSAG found that most covariates were balanced within the overall 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, rather than to assess the frequency of service utilization. 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 control groups 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 populations and control groups.

- MY 2022 and MY 2023 findings may be impacted by the coronavirus disease 2019 (COVID-19) public health emergency (PHE), which expired on May 11, 2023.¹ Therefore, HSAG recommends exercising caution when interpreting these findings, where applicable.
- Each reporting year, the code sets used in the measure specifications to identify services are updated to reflect codes that were billable during the measurement year. Therefore, some rate differences between measurement years may be attributable to changes in code sets and billing practices rather than changes in utilization.

Conclusions and Recommendations

The 2024–25 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 an overview of DMAS’ quality improvement efforts, the conclusions from this year’s study, and recommendations for DMAS’ consideration.

DMAS’ Quality Improvement Efforts

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. Additionally, DMAS has taken actions in response to HSAG’s recommendations from the prior year’s focus study. As context for the current study’s conclusions and recommendations, the following section provides an overview of these quality improvement efforts.

Initiatives and Policy Changes

Cardinal Care Managed Care Procurement and Foster Care Specialty Plan

Cardinal Care Managed Care (CCMC) was launched in January 2023 to enhance Virginia’s Medicaid managed care system. Through the initiative, Virginia consolidated the two previous managed care programs (Medallion 4.0 and Commonwealth Coordinated Care Plus [CCC Plus]) into CCMC, defined transformation goals for the program, and reprocured the contracted managed care health plans to improve the delivery system and better serve members.

The managed care procurement, which began in 2023 with a Request for Proposals, included an addendum for one selected MCO to serve as the single statewide Foster Care Specialty Plan (FCSP) for all members in foster care, adoption assistance, and former foster care Medicaid eligibility groups. DMAS recognizes the unique needs of children and young adults impacted by the child welfare system. The need for timely access to a comprehensive and coordinated array of services is key to improving outcomes. The FCSP Contract Addendum was created with additional requirements for outreach and

¹ U.S. Department of Health and Human Services. Covid-19 Public Health Emergency. Available at: <https://www.hhs.gov/coronavirus/covid-19-public-health-emergency/index.html>. Accessed on Oct 9, 2025.

care management, as well as staffing requirements to include expertise in trauma-informed care and the Virginia child welfare system.

DMAS issued a Notice of Award for the new CCMC health plans on December 30, 2024, with Anthem HealthKeepers Plus selected to serve as the single statewide FCSP and awarded the FCSP Contract Addendum. DMAS has worked with Anthem HealthKeepers, the Department of Social Services, and other stakeholders to plan for the implementation of the new FCSP beginning July 1, 2025, for all youth in foster care, receiving adoption assistance, and members under 26 years of age who were in foster care until their discharge at 18 years of age or older.

The FCSP will be a single point of accountability for the State; will mitigate access and continuity of care issues; and includes an innovative, trauma-informed care management model to address the unique needs of members and initiatives in Virginia. DMAS anticipates that the implementation of Anthem HealthKeepers' FCSP, to serve all members included in this Child Welfare Focus Study, will lead to an improvement in overall utilization, timeliness of healthcare, and health disparities among these members.

Safe and Sound Task Force

Under the leadership of Virginia's Governor, the Safe and Sound Task Force continued through SFY 2024–25. The objective of the task force is to work collaboratively across state and local agencies serving youth in foster care to address the barriers related to safe and appropriate placements. Through this work, the Task Force has identified that access to appropriate and timely medical and behavioral health services is a priority for ensuring safe and appropriate placements for these children.

The core priorities identified by the Task Force 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. The Task Force will continue beyond the current administration and is now hosted by the Virginia Department of Social Services (VDSS) 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 health care services as well as timely access to and utilization of services for child welfare members. DMAS utilizes conclusions and recommendations from the Child Welfare Focus Study to inform its participation and input in the work of the Task Force.

Safe Kids, Strong Families

In May 2025, Virginia's Governor launched a child welfare redesign initiative focused on increasing support for families of youth in foster and kinship care, reducing reliance on congregate (or residential) care, and improving access to services that support youth and families impacted by the child welfare system. The first few months of these efforts began with a study to address systemic challenges faced by youth and families involved in the child welfare system. DMAS has been involved since the launch of this initiative, attending roundtable discussions; design sessions; and serving on the Safe Kids, Strong Families Steering Committee.

DMAS is committed to continuing to work with partners and stakeholders toward improving access to necessary healthcare services for Medicaid members involved in the child welfare system. Additionally, DMAS anticipates that efforts toward these improvements over the next year will result in higher rates

of appropriate and timely health care utilization for individuals in foster care, receiving adoption assistance, and those formerly in foster care through age 26.

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 health care 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 reentry and stabilization when transitioning from a crisis. DMAS is an integral partner and stakeholder within this plan.

In support of the Governor's Right Help, Right Now Behavioral Health Transformation Plan, DMAS in collaboration with other state agencies and stakeholders has completed the first of a two-year initiative to redesign Medicaid legacy community mental health rehabilitative services (CMHRS) for youth. The 2024–2026 biennium budget provided DMAS with the authority to replace its CMHRS and case management services. Additionally, a new bill (Senate Bill 403) adds two new professions and scopes of practice for Behavioral Health Technicians and Behavioral Health Technician Assistants. This new scope of practice (to be developed by the Department of Health Professions) will be integrated into the newly designed Medicaid behavioral health services.

During SFY 2024–25, DMAS completed a variety of objectives toward implementing new behavioral health Medicaid services by June 2026. DMAS worked collaboratively with stakeholders and researched evidence-based services in order to develop service requirements and definitions, fee-for-service (FFS) rates and utilization, cost, and budget impact estimations for the redesigned services. In July 2025, DMAS began operationalizing these new services through licensure and regulatory changes, preparing providers and MCOs to transition to new services, and planning for implementation and go-live by June 2026.

DMAS' goal in implementing these new services 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, including identified disparities and areas of improvement in this year's Child Welfare Focus Study related to behavioral health services, DMAS will continue to work collaboratively with its partners to move Right Help, Right Now forward.

Input on Prior Focus Study Recommendations

Focus Study Measures and Analyses

The 2023–24 Child Welfare Focus Study continued to monitor healthcare utilization among children in foster care. For the fourth year, children receiving adoption assistance and former foster care members were also included as child welfare populations in this study. SFY 2023–24 was the third year analyzing measures related to health disparities and timely access to care for children in foster care, children receiving adoption assistance, and former foster care members. This includes 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.

Based on HSAG's prior focus study recommendations, DMAS has requested that the 2024–25 Child Welfare Focus Study, as well as all future studies, continue to include these additional analyses. This will allow DMAS to continue to monitor impacts of the COVID-19 PHE, to verify or establish new appropriate baseline rates post-pandemic, and to identify areas for improvement and monitor impacts of program changes. 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.

Quality Improvement Recommendations

HSAG provided DMAS with several recommendations related to quality improvement in the areas of healthcare utilization, timeliness of care, and healthcare disparities among children in foster care, children receiving adoption assistance, and former foster care members. This year, DMAS has utilized a variety of methods to collaborate with members and/or their guardians, providers, and other stakeholders, as well as to initiate and continue quality improvement strategies to address HSAG's recommendations.

Community Partnerships and Focus Groups

DMAS continues to facilitate regular virtual statewide Foster Care Partnership meetings with child welfare stakeholders from across the state. These stakeholders included those from the Virginia Department of Social Services, local departments of social services (LDSS), the Virginia Commission on Youth, Licensed Child Placing Agencies (LCPAs), Medicaid contracted 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 are developed based on cross-sector discussions around current needs of youth in foster care, factoring in results and recommendations of the 2023–24 Child Welfare Focus Study.

In addition to utilizing the Foster Care Partnership to solicit feedback in planning for the implementation of the new FCSP, stakeholders involved also share challenges, barriers, and best practices around accessing timely and appropriate services. Each year, the Foster Care Partnership hosts an annual review of the Child Welfare Focus Study results, conclusions, and recommendations for discussion and brainstorming. HSAG shared the 2023–24 outcomes during a Foster Care Partnership meeting on May 28, 2025, with over 450 attendees statewide. Areas of interest during that discussion included follow-up measures for SUD.

As previously discussed, as part of the Governor's Right Help, Right Now initiative, DMAS is re-designing Medicaid legacy CMHRS for youth. DMAS hosted workgroups throughout SFY 2024-25 with internal and external stakeholders to begin work on this project. Year 1 of the project concentrated on policy, rate development, and stakeholder engagement with the assistance of the DMAS contractor Mercer. The group also focused on workforce development to reduce disparities in access to services regionally. This provided an opportunity to share input based on Child Welfare Focus Study recommendations and to get feedback from impacted members and stakeholders related to behavioral health-specific measures and disparities.

Member Outreach

DMAS has continued to engage in frequent member and stakeholder outreach. DMAS sends 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. These newsletters now reach over 900 members, guardians, providers, community-based agencies, state agencies, and others statewide interested in keeping up to date with child welfare initiatives.

DMAS and Anthem HealthKeepers worked to create a variety of outreach materials to share information about Medicaid services for youth in foster care, adoption assistance, and former foster care as part of the CCMC procurement and planning for the transition to Anthem HealthKeepers Plus FCSP. These communications included flyers tailored to each FCSP eligibility group; FCSP assignment letters; FCSP welcome packets with thorough coverage and health plan information; and website updates to include resources such as webinar slides, webinar recording, and contact information for support.

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 presentations at the annual Children’s Services Act Conference, the VDSS Permanency Conference, DMAS’ BabySteps Bimonthly meeting, the Virginia League of Social Services Executives Board Meetings, Children’s Welfare Advisory Committee, and the Governor’s Safe & Sound Task Force 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.

Managed Care Oversight Efforts

As previously discussed, as of October 2023 DMAS is operating under one unified health program called Cardinal Care. Cardinal Care is a single brand encompassing all health coverage programs for Virginia’s two million Medicaid members. At the time of this report, there were five MCOs contracted with DMAS serving members in foster care, members in adoption assistance, and former foster care.

DMAS continues to improve efforts to track and analyze a variety of data sources to evaluate Virginia’s foster care Medicaid programs. DMAS MCOs continue to report on a variety of measures monthly, including those related to care coordination and member outreach, service utilization, and efforts to assist members who age out of the child welfare system with transition planning. DMAS continues to utilize a dashboard for easier analysis and tracking of utilization and member outreach over time and by MCO. These monthly reports also allow MCOs to report barriers to member outreach and engagement so that DMAS can assist and address efficient outreach and communication. The data from these

monthly reports are tied to both Cardinal Care contract compliance and program oversight, presenting DMAS with an opportunity to utilize various data sources, including those in the Child Welfare Focus Study, to better understand the status of Medicaid programs serving youth in foster care.

DMAS will monitor the impact of members' transition into the FCSP on all study indicators relative to historic rates as well as controls and national benchmarks. As part of the new FCSP, which began on July 1, 2025, DMAS has implemented additional reporting requirements in a supplemental FCSP Technical Manual. New reporting requirements are related to additional contract requirements in the FCSP Addendum for youth in foster care, to include documentation of care management outreach, level of care management received, triggering events requiring updated assessments or care plans, and support provided to members during transitions of care. DMAS plans to add additional measures to reporting requirements from Anthem HealthKeepers in future years based on outcomes and recommendations from future Child Welfare Focus Studies.

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.² While these children are in foster care, the State has custody and therefore primary responsibility for ensuring children receive the appropriate healthcare services. For example, a foster child's service worker must ensure the child meets a schedule of well-child visits and dental examinations based on nationally recognized guidelines.³ 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 2023, and MY 2024. During MY 2024, children in foster care had higher rates than controls for two of three indicators in the Primary Care domain, all indicators in the Oral Health domain, nine of 11 indicators in the Behavioral Health domain, and nine of 10 indicators in the Service Utilization domain. Rate differences between children in foster care and controls across study indicators persisted even after matching on many demographic and health characteristics.

During MY 2024, children in foster care had lower rates compared to controls for four study indicators, of which one was statistically significant: *ED Visits*. The lower rate for the *ED Visits* indicator may reflect better management of health conditions for children in foster care compared to controls. Additionally, the rate for the *Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up* indicator for children in foster care was 15.9 percentage points lower than controls during MY 2024; however, this rate difference was mostly driven by a large improvement in the rate for controls from MY 2023 to MY 2024.

The Virginia Foster Care Affinity Group worked on improving timely initial MCO outreach to foster care members to support service initiation efforts through December 2023 and predicted that these efforts may help improve rates of SUD treatment initiation and engagement. Findings show that while historically the rates of SUD treatment initiation and engagement for children in foster care has been lower than controls, the rates for children in foster care were higher than controls during MY 2023 and MY 2024. Additionally, the MY 2024 rates for children in foster care exceeded the national Medicaid

² Virginia Department of Social Services. Foster Care (FC). Available at: <https://www.dss.virginia.gov/family/fc/index.cgi>. Accessed on: Nov 17, 2025.

³ 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/09_2024/section_12_identifying_services_to_be_provided.pdf. Accessed on: Oct 2, 2025.

66.67th percentile for the *Initiation and Engagement of SUD Treatment—Initiation of SUD Treatment* indicator and exceeded the national Medicaid 50th percentile for the *Initiation and Engagement of SUD Treatment—Engagement of SUD Treatment* indicator. Therefore, DMAS has achieved meaningful improvement in the rates for these indicators over MY 2023 and MY 2024.

Among children in foster care, 21 study indicator rates increased, while eight study indicator rates decreased from MY 2023 to MY 2024. Therefore, healthcare utilization is generally improving for children in foster care. Of note, all indicator rates in the Oral Health domain increased. The largest increase from MY 2023 to MY 2024 was for the *Initiation and Engagement of SUD Treatment—Initiation of SUD Treatment* indicator (by 16.1 percentage points). The MCOs documented quality improvement efforts related to this indicator in their Quality Assessment and Performance Improvement (QAPI) Program Evaluation for MY 2023. Three MCOs (i.e., HealthKeepers, Molina, and Sentara) demonstrated substantial improvements in initiation of SUD treatment for children in foster care during MY 2024, though denominators are small and therefore subject to greater year-to-year variability. The largest decline from MY 2023 to MY 2024 was for the *Asthma Medication Ratio* indicator (by 6.1 percentage points). Of note, the measure specifications for the *Asthma Medication Ratio* study indicator changed substantially in MY 2024, and the national Medicaid 50th percentile benchmarks for children also decreased from MY 2023 to MY 2024; therefore, the decrease in the rate for this study indicator is in alignment with national trends.

Several stratifications within the children in foster care population demonstrated significant health disparities, particularly for dental services and behavioral health services. While a majority of measures demonstrated age-based disparities, some of these rate differences are associated with expected differences in healthcare utilization (e.g., members 2 years of age and younger are less likely to utilize behavioral health services). However, members 2 years of age and younger and members 14 years of age and older had significantly lower rates for most study indicators in the Oral Health domain, indicating opportunity for improvement. Additionally, members 12 years of age and older had significantly lower rates of well-care visits. Regional disparities were the most commonly identified disparities for children in foster care, occurring in over 70 percent of indicators. Of note, members in the Charlottesville/Western and Roanoke/Alleghany regions had significantly lower rates for all study indicators in the Oral Health domain, and members in the Northern & Winchester region had significantly lower rates for most of the *Behavioral Health Encounters* indicators. Members in the Southwest region had many indicators with significantly higher rates, including two Oral Health domain indicators. Aetna, Molina, and United had a high percentage of study indicators with significantly lower rates, particularly the *Behavioral Health Encounters* indicators and indicators in the Oral Health domain.

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

- To ensure high rates for the *Initiation and Engagement of SUD Treatment* indicator are sustained, HSAG recommends that DMAS continue to monitor whether indicator rates for children in foster care exceed controls and national benchmarks, particularly during and after the transition to the FCSP administered by HealthKeepers on July 1, 2025. The rate for initiation of SUD treatment for HealthKeepers was lower than the rate for All Eligible Members during MY 2024, though it still exceeded the rate for controls and the national Medicaid 50th percentile. HealthKeepers' rate for engagement in SUD treatment was higher than the rate for All Eligible Members. However, the denominators for HealthKeepers for these study indicators were very small and are therefore subject to greater year-to-year variability. Evaluating these study indicators with a larger HealthKeepers population following the transition will be more indicative of its performance. In the

QAPI Program Evaluations for MY 2023, some MCOs identified lack of in-network providers as a barrier to SUD treatment. DMAS should ensure that HealthKeepers has a sufficient network of SUD treatment providers in all regions, particularly those who were working with children in foster care previously enrolled with other MCOs.

- To address the disparities identified for children in foster care, DMAS may consider focusing quality improvement efforts toward the age and region groups with significantly lower rates, given that all children in foster care have transitioned to a single MCO. For the disparities identified by region, DMAS may consider evaluating whether provider availability and appointment availability align with these findings. Alternatively, DMAS may consider utilizing either stratified surveys or targeted surveys to collect information about the barriers for these groups and identify opportunities for improvement. Under the stratified survey approach, DMAS would conduct a survey on a representative sample of stakeholders (e.g., foster parents) for the entire study population and calculate results stratified by characteristics for which disparities were identified (e.g., region). Under the targeted survey approach, DMAS or HealthKeepers would sample stakeholders for affected members only (e.g., members in need of the service of interest who reside in a region with a significantly lower rate). These surveys could evaluate members' experience of care, including access to care, coverage transparency, and prior authorizations. Alternatively, DMAS could consider utilizing regional focus groups to gather information on these topics.
- Children in foster care transitioned to the statewide FCSP administered by HealthKeepers effective July 2025. Among the 15 indicators presented in the Primary Care, Oral Health, Behavioral Health, Substance Use, and Respiratory Health domains, the rate for children in foster care enrolled with HealthKeepers exceeded the rate for all eligible controls for 12 indicators during MY 2024. High rates on these measures indicate high performance. However, DMAS may still consider monitoring the impact of the transition to the FCSP using surveys or administrative data analyses. For example, a survey could be distributed to foster parents or providers that work with children in foster care. This survey could evaluate topics such as whether the member was able to keep their provider, whether services that were previously covered remained covered, and whether there were disruptions in payment for services and medications. Alternatively, administrative data could be used to assess healthcare utilization for children in foster care enrolled with the FCSP compared to controls and compared to members who opt out into FFS. Administrative data could also be used to calculate measures specific to the FCSP, such as utilization of value-added benefits and the percentage of members for which the FCSP met certain contractual requirements. Additionally, while quality improvement efforts in the existing QAPI programs typically focus on the broader Medicaid population, the transition to a single FCSP presents an opportunity to implement interventions specific to the foster care population consistently across the population. Surveys and administrative data analyses may help inform opportunities for these interventions.
- While the current study design provides insight into utilization of healthcare services, it does not assess health outcomes or member experiences among children in foster care. DMAS may consider implementing a survey evaluating members' experience with the FCSP, including quality of care, access to care, health-related quality of life, coverage transparency, usefulness of the value-added benefits, prior authorizations, and communication with the FCSP. Additionally, DMAS could consider an analysis evaluating the prevalence of pertinent outcomes among members enrolled with the FCSP, such as obesity, type 2 diabetes, teen pregnancy, suicide, and mortality, as well as evaluating causes of ED visits and inpatient visits.

Healthcare Utilization: Children Receiving Adoption Assistance

Children in the adoption assistance program are children with special needs who have been adopted from foster care. The Adoption Assistance program provides medical and financial assistance for the benefit of these children to help facilitate adoption placements and ensure permanency for children with special needs.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.⁵ The adoptive parents may also choose to enroll the adoption assistance child in private insurance instead of Medicaid. 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 2023, and MY 2024. During MY 2024, children receiving adoption assistance had higher rates than controls for one of three indicators in the Primary Care domain, all indicators in the Oral Health domain, two of 11 indicators in the Behavioral Health domain, and six of 10 indicators in the Service Utilization domain. Rate differences between children receiving adoption assistance and controls across study indicators persisted even after matching on many demographic and health characteristics.

During MY 2024, children receiving adoption assistance had lower rates compared to controls for 15 study indicators, of which two differences were statistically significant: the *ED Visits* study indicator (by 10.6 percentage points) and the *Overall Service Utilization* indicator (by 1.5 percentage points). However, the lower rate of ED visits may reflect better management of health conditions for children receiving adoption assistance compared to controls, and the lower rate of overall service utilization is attributable to the lower rate of ED visits. Of note, while not statistically significant, the rates for the *Initiation and Engagement of SUD Treatment—Engagement of SUD Treatment* and *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics* study indicators for children receiving adoption assistance were 11.0 and 7.7 percentage points lower than controls during MY 2024, respectively. For eight study indicators, the rates for children receiving adoption assistance were less than 3.0 percentage points lower than the controls.

Among children receiving adoption assistance, 25 study indicator rates increased, while four study indicator rates decreased from MY 2023 to MY 2024. Of note, rates for all study indicators in the Oral Health domain increased. The largest rate decreases from MY 2023 to MY 2024 were for the *Asthma Medication Ratio* study indicator (by 4.8 percentage points) and the *Initiation and Engagement of SUD Treatment—Engagement of SUD Treatment* study indicator (by 4.4 percentage points). Of note, the measure specifications for the *Asthma Medication Ratio* study indicator changed substantially in MY 2024, and the national Medicaid 50th percentile benchmarks for children also decreased from MY 2023 to MY 2024; therefore, the decrease in the rate for this study indicator is in alignment with national trends.

⁴ 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/09_2024/section_12_identifying_services_to_be_provided.pdf. Accessed on: Oct 2, 2025.

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/02-01-2022/Section_2_Adoption_Assistance.pdf. Accessed on: Oct 9, 2025.

Since children receiving adoption assistance comprise the largest child welfare population, 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, a large number of disparities were identified in the Oral Health domain and for the *Behavioral Health Encounters* indicators. Within the Oral Health domain, members enrolled with HealthKeepers and members in the Southwest region tended to have significantly higher rates of utilization. Conversely, members 14 years of age and older, White members, and members enrolled with either Aetna or Molina had significantly lower rates. Within the *Behavioral Health Encounters* indicators, male members; Black or African American members; members in the Charlottesville/Western, Roanoke/Alleghany, and Tidewater regions; and members enrolled with HealthKeepers or Sentara had significantly higher rates, while White members; members in the Northern & Winchester and Southwest regions; and members enrolled with Aetna, Molina, or United had significantly lower rates. Additionally, members in the Northern & Winchester region and members enrolled with Aetna or Molina had significantly lower rates for well-care visits and ambulatory care visits.

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

- The SFY 2024–25 study found that children receiving adoption assistance had lower rates than controls for nine of 11 Behavioral Health domain study indicators. Additionally, the rates for children receiving adoption assistance who were enrolled with HealthKeepers were lower than the rates for All Eligible Members and controls for several of these indicators. To address these low rates, DMAS should consider working with the FCSP administered by HealthKeepers to evaluate why rates are low and improve utilization where appropriate. HealthKeepers could collect information from case managers and adoptive parents for members with a triggering event (i.e., members who are denominator-positive for these indicators but numerator-negative for the expected healthcare services) to better understand the rates. Additionally, if DMAS elects to survey the child welfare populations regarding their experience of care, DMAS may consider including questions about members' experience with behavioral health services specifically.
- Similar to the recommendations for children in foster care, to address disparities identified by region, DMAS may consider evaluating whether provider availability and appointment availability align with the regional disparities identified for children receiving adoption assistance. DMAS may also consider utilizing either stratified surveys or targeted surveys to collect information about the barriers for these groups and identify opportunities for improvement. Finally, case managers may also be able to provide additional insight on differences in barriers across regions now that most case managers for the children receiving adoption assistance population will be concentrated under the single FCSP.
- Effective July 2025, children receiving adoption assistance are now enrolled in the FCSP statewide program administered by HealthKeepers, though these members can opt out into a different MCO upon request.⁶ Among the 15 indicators presented in the Primary Care, Oral Health, Behavioral Health, Substance Use, and Respiratory Health domains, the rate for children receiving adoption assistance enrolled with HealthKeepers exceeded the rate for all eligible controls for 10 indicators during MY 2024. High rates on these measures indicate high performance. Of note, HealthKeepers had a statistically significantly higher rate for 36 percent of study indicators for children receiving adoption assistance, including all indicators in the Oral Health domain and several *Behavioral*

⁶ Virginia Department of Social Services. Virginia Medicaid Announces Intent to Award Managed Care Contracts. Available at: <https://dmas.virginia.gov/media/ntehanym/dmas-press-release-february-29-2024.pdf>. Accessed on Oct 9, 2025.

Health Encounters indicators. Similar to the recommendations for children in foster care, HSAG recommends monitoring the impact of the transition to the FCSP using surveys or administrative data analyses. For the administrative data analyses, DMAS could compare the performance of the FCSP to the performance of other MCOs, if the denominator for children receiving adoption assistance who opted out is sufficiently large. Additionally, DMAS may consider evaluating the utilization of members who transitioned into the FCSP over time to determine whether there were disruptions in care. HSAG also recommends that DMAS collect information on why members choose to opt out of the FCSP, as it may inform opportunities for improvement in the FCSP. For example, the Medicare Part C and Medicare Part D Star Rating programs utilize a disenrollment reasons survey to evaluate contracted health plans, which assesses the percentage of members who indicated that they disenrolled from the plan due to a particular issue.⁷ These issues include getting the plan to provide and pay for needed care, problems with coverage of doctors and hospitals, problems with prescription drug benefits and coverage, and problems getting information and help from the plan. DMAS could consider modeling its approach after these disenrollment surveys.

- While the current study design provides insight into utilization of healthcare services, it does not assess health outcomes or member experiences among children receiving adoption assistance. Similar to the recommendations for children in foster care, DMAS may consider implementing a survey evaluating members' experience with the FCSP, including quality of care, access to care, health-related quality of life, coverage transparency, usefulness of the value-added benefits, prior authorizations, and communication with the FCSP. Additionally, DMAS could consider an analysis evaluating the prevalence of pertinent outcomes among members enrolled with the FCSP, such as obesity, type 2 diabetes, teen pregnancy, suicide, and mortality, as well as evaluating causes of ED visits and inpatient visits.

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.⁸ This study demonstrated that former foster care members have higher rates of appropriate healthcare utilization than comparable controls for a slight majority of study indicators in MY 2022, MY 2023, and MY 2024. During MY 2024, former foster care members had higher rates than controls for the one indicator in the Primary Care domain, three of four indicators in the Oral Health domain, two of nine indicators in the Behavioral Health Domain, the one indicator in the Respiratory Health domain, and eight of 10 indicators in the Service Utilization domain.

⁷ Centers for Medicare & Medicaid Services. Medicare 2025 Part C & D Star Ratings Technical Notes. Available at: <https://www.cms.gov/files/document/2025-star-ratings-technical-notes.pdf>. Accessed on: Oct 23, 2025.

⁸ Virginia Department of Social Services. Child and Family Services Manual: Achieving Permanency for Older Youth: Working with Youth 14-17. Available at: https://www.dss.virginia.gov/files/division/dfs/fc/intro_page/guidance_manuals/fc/07_2022/Section_13_achieving_permanency_for_older_youth.pdf. Accessed on: Oct 23, 2025.

Rate differences between former foster care members and controls across study indicators persisted even after matching on many demographic and health characteristics.

During MY 2024, former foster care members had lower rates compared to controls for 10 study indicators. The study indicators *Initiation and Engagement of SUD Treatment—Initiation of SUD Treatment*, *Initiation and Engagement of SUD Treatment—Engagement of SUD Treatment*, and *Ambulatory Care Visits* were the only indicators with rates statistically significantly lower than the rates for controls. The largest rate difference was for the *Initiation and Engagement of SUD Treatment—Initiation of SUD Treatment* indicator (by 18.8 percentage points). Additionally, the former foster care members' rate for *ED Visits* was statistically significantly higher than controls during MY 2024, MY 2023, and MY 2022, which may reflect worse management of health conditions for former foster care members compared to controls.

Among former foster care members, 12 study indicator rates increased, while 13 study indicator rates decreased from MY 2023 to MY 2024. Of note, the largest rate increases from MY 2023 to MY 2024 were for the *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up*, *Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up*, and *Use of Pharmacotherapy for Opioid Use Disorder* study indicators (by 13.9, 7.4, and 7.3 percentage points, respectively). The largest decline from MY 2023 to MY 2024 was for the *Asthma Medication Ratio* indicator (by 16.7 percentage points). However, the denominator for this indicator has historically been small and is therefore subject to greater year-to-year variability. There were also large declines for the *Oral Evaluation*, *Dental Services* and *Preventive Dental Services* study indicators (by 6.8 and 6.1 percentage points, respectively); however, the MY 2024 rates for both study indicators were still substantially higher than the MY 2022 rates.

For former foster care members, male members had a high percentage of study indicators with disparities during MY 2024, for which rates were significantly lower than female members. These indicators included five of the study indicators in the Service Utilization domain and well-care visits. Additionally, members in the Roanoke/Alleghany region had significantly lower rates for three of four study indicators in the Oral Health domain during MY 2024, while members in the Central region had significantly higher rates for three of four study indicators in the Oral Health domain.

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

- To address the low rates for Behavioral Health domain indicators and the high rate of ED visits, DMAS may consider strengthening case management for former foster care members to monitor behavioral health needs and emphasize preventive services to reduce preventable ED visits. Case managers may also be able to advise the FCSP and DMAS on common barriers to behavioral and preventive healthcare, causes of delays, and member choice for this population to provide guidance on how to address these utilization patterns. For example, the FCSP offers transportation to medical appointments and virtual urgent care access via a free cell phone as value-added benefits. Case managers may be able to advise on whether members reporting transportation challenges have been able to utilize the transportation benefit and whether members seeking care in the ED had an opportunity to utilize the urgent care benefit. Additionally, the MY 2024 rates for former foster care members enrolled with HealthKeepers were lower than All Eligible Members and lower than controls for six of nine and five of nine indicators in the Behavioral Health domain, respectively. While the denominators for these indicators tended to be small, and none of these rate differences were statistically significant, performance in this area should be monitored following the transition to

the FCSP. DMAS may consider working with the FCSP to evaluate and, if needed, address any regional network adequacy issues for behavioral health providers contracted with the FCSP.

- To address the disparities identified for former foster care members, DMAS may consider focusing quality improvement efforts toward male members. Quality improvement efforts could include conducting focus groups with, administering surveys to, or enhancing individual member outreach to male members to understand challenges associated with utilization of these services and implement targeted interventions for the greatest impacts.
- Effective July 2025, former foster care members are now enrolled in the FCSP statewide program administered by HealthKeepers, though these members can opt out into a different MCO upon request.⁹ Among the 15 indicators in the Primary Care, Oral Health, Behavioral Health, Substance Use, and Respiratory Health domains, the rate for former foster care members enrolled with HealthKeepers exceeded the rate for all eligible controls for nine indicators during MY 2024. High rates on these measures indicate high performance. Similar to the recommendations for children receiving adoption assistance, HSAG recommends that DMAS monitor the impact of the transition to the FCSP on healthcare utilization for former foster care members through surveys or administrative data analyses. Additionally, surveys may be particularly informative for former foster care members, given that all age groups in this study population can complete the survey directly.
- While the current study design provides insight into utilization of healthcare services, it does not assess health outcomes or member experiences among former foster care members. HSAG recommends assessing chronic conditions disproportionately impacting former foster care members. For example, a future focus study could assess rates of outcomes such as mortality or utilize a cascade of care measure evaluating the treatment progression of former foster care members diagnosed with an outcome, such as SUD, from initial diagnosis to remission. Additionally, capturing member experience could provide additional insight into the quality of care and ease of access to care for former foster care members, as well as their health-related quality of life. Therefore, DMAS may consider utilizing custom surveys of former foster care members to capture this information.

Timely Access to Care

SFY 2024–25 is the fourth year to include analyses for timely access to care in this study. VDSS guidelines require that children in foster care receive a medical examination no later than 30 days after initial placement in foster care.¹⁰ 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.¹¹ These guidelines are independent of Medicaid and MCO enrollment; therefore, a child may not be enrolled in Medicaid or an MCO for the entirety of this 60-day window. DMAS' CCMC 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

⁹ Virginia Department of Social Services. Virginia Medicaid Announces Intent to Award Managed Care Contracts. Available at: <https://dmas.virginia.gov/media/ntehanym/dmas-press-release-february-29-2024.pdf>. Accessed on Oct 9, 2025.

¹⁰ 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/09_2024/section_12_identifying_services_to_be_provided.pdf. Accessed on: Oct 9, 2025.

¹¹ Ibid.

prior to enrollment.¹² However, it is important to note that this time frame may be exceeded by the time the child is enrolled with an MCO. MCOs may also encounter challenges obtaining information from the child's social worker or foster care parent for recently placed children in foster care. The SFY 2024–25 study found that most new 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, only 44.8 percent of new foster care members received timely access to dental care, and this rate declined slightly from MY 2023 to MY 2024.

Study indicators also assessed timely access to primary and dental care for members who aged out of foster care. Findings demonstrate that most members who aged out of foster care in the year prior to the MY had a visit with a PCP during MY 2024; however, this rate declined substantially from MY 2023 to MY 2024. Similar to new foster care members, 40.4 percent of members who aged out of foster care had a visit with a dental provider during MY 2024.

Several study indicators assessed timely access to behavioral healthcare for new foster care members, new adoption assistance members, and members who aged out of foster care. The SFY 2024–25 study found that most 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, nearly all 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, most members with a behavioral health diagnosis had a visit with an MHP within a year after enrollment, and this rate increased from MY 2023 to MY 2024 (by 3.4 percentage points). These findings are consistent with prior measurement years. Lastly, most members who aged out of foster care had a behavioral health diagnosis, and 49.4 percent of these members had a visit with an MHP during MY 2024. This rate declined from MY 2023 to MY 2024 (by 5.4 percentage points) yet remained notably higher than the MY 2022 rate.

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 but more likely to have a visit with a dental provider. Only 20.0 percent of children 2 years of age or younger received a timely visit with a dental provider, despite that dental examinations are required for children in foster care beginning at age six months or when the child develops teeth, whichever is later. The American Dental Association (ADA) also recommends that all children have a dental visit between their first tooth and their first birthday.¹³ Among all new foster care members, older members were more likely to have an MHP visit for both the 60-day and one-year time frames; however, this trend was mostly explained by older members being more likely to have a behavioral health diagnosis. Female members who aged out of foster care were significantly more likely to have a visit with a PCP than male members. Members newly enrolled in foster care in the Northern & Winchester region were significantly less likely to have a PCP 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.

¹² Commonwealth of Virginia, Department of Medical Assistance Services. Cardinal Care Managed Care Contract, October 1, 2023 – June 30, 2024. Available at: <https://www.dmas.virginia.gov/media/d0dixoar/fy24-cardinal-contract-mid-year-amendment.pdf>. Accessed on: Oct 9, 2025.

¹³ Mark AM. Key points for your child's teeth. *The Journal of the American Dental Association*. 2022; 153: 94. Available at: [https://jada.ada.org/article/S0002-8177\(21\)00657-7/fulltext](https://jada.ada.org/article/S0002-8177(21)00657-7/fulltext). Accessed on: Oct 16, 2025.

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

- The study indicator findings identified 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 transition to the single FCSP in MY 2025 presents an opportunity to improve timely MCO assignment, which may also improve timely processing of key information from the child's social worker or foster care parent. Additionally, efforts to improve these processes can now be applied more consistently across each population under the single FCSP. Among the 16 timely access study indicators, the rates for members enrolled with HealthKeepers were significantly higher for two study indicators (i.e., access to dental care among new foster care members and access to primary care and dental care for new foster care members) and were not significantly lower for any indicators compared to the rate for members enrolled with other MCOs during MY 2024. DMAS may consider monitoring whether timely access to care, or any of the key drivers of timely access, improve after the transition to the FCSP. DMAS may consider working with the FCSP to implement lessons learned from previous pilot studies and test new processes to support timely access. Given that routine dental services are carved out to the VA Medicaid dental benefit manager, DentaQuest, DMAS may consider working with DentaQuest as well to ensure timely access to dental services for these populations.
- To address disparities identified for timely access to care, DMAS may consider focusing quality improvement efforts for timely access to care toward male members who aged out of foster care and younger new foster care members. DMAS may also consider working with the FCSP to educate foster parents on the expected dental visit schedule for children 2 years of age and younger and that oral inspections performed by PCPs are not a substitute for complete dental evaluations performed by dentists.
- In addition to programmatic challenges to timely access to care, other factors impacting timely access to care may include provider availability and appointment availability. These factors could be evaluated either through network adequacy analyses limited to the child welfare populations or surveying foster parents and members who aged out of foster care on their perceived access to care. HealthKeepers has stated that it will endeavor to identify out-of-network providers seen by child welfare population members and will contract with those determined to meet quality standards. DMAS may consider monitoring and quantifying HealthKeepers' progress toward expanding its network to include these providers. For example, DMAS could assess how many providers seen by the child welfare populations in the year prior to the transition are in HealthKeepers' network. DMAS may also consider assessing this progress by provider type and region, as network adequacy challenges are often related to these factors.

2. Overview and Methodology

Overview

Beginning in contract year 2015–16, DMAS contracted with HSAG to conduct, as an optional external quality review (EQR) task under CMS Medicaid guidelines,¹⁴ 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 members in child welfare programs (i.e., children in foster care, children receiving adoption assistance, and former foster care members) who receive Medicaid benefits. For instance, DMAS is currently redesigning community mental health rehabilitative services for youth under the Governor’s Right Help Right Now plan. Additionally, DMAS hosts community partnership meetings with stakeholders, such as Medicaid MCOs, from across Virginia to improve transition planning and increase appropriate utilization of services among members in child welfare programs.

In contract year 2024–25, HSAG conducted the Child Welfare Focus Study to determine the extent to which members in child welfare programs 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 2024 (i.e., January 1, 2024–December 31, 2024). Since contract year 2021–22, HSAG has also evaluated timely access to care for members who transitioned into or out of the foster care program. The American Academy for Pediatrics (AAP) recognizes a number of barriers in providing adequate and timely health services to children in foster care.^{15,16} 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,¹⁷ 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.¹⁸

Additionally, DMAS requested that HSAG evaluate disparities in healthcare utilization and timely access to care based on demographic factors (i.e., age, sex, race, region, and MCO). Federal regulations require state Medicaid agencies to incorporate a plan to identify, evaluate, and reduce

¹⁴ 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: Nov 18, 2025.

¹⁵ American Academy of Pediatrics. Physical Health Needs of Children in Foster Care. July 2021. Available at: <https://www.aap.org/en/patient-care/foster-care/physical-health-needs-of-children-in-foster-care/>. Accessed on: Nov 18, 2025.

¹⁶ American Academy of Pediatrics. Mental and Behavioral Health Needs of Children in Foster Care. July 2021. Available at: <https://www.aap.org/en/patient-care/foster-care/mental-and-behavioral-health-needs-of-children-in-foster-care/>. Accessed on: Nov 18, 2025.

¹⁷ 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.

¹⁸ 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.

health disparities as part of their managed care state quality strategy.¹⁹ 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.²⁰ The 2024–25 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 2024 findings to MY 2022 and MY 2023 findings, where applicable. Since the COVID-19 PHE was ongoing during MY 2022 and MY 2023, 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 2024 (i.e., January 1, 2024–December 31, 2024). 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, 2025, as well as demographic, eligibility, and enrollment data, from DMAS in July 2025, resulting in a six-month data runout from the end of MY 2024 to data extraction. 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, 2024, 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, 2024, and identified by DMAS as enrolled in Medicaid under the aid category “072” for children in the adoption assistance program.
- **Former Foster Care Members**—All members enrolled in Medicaid 19 to 26 years of age as of January 1, 2024, and identified by DMAS as enrolled in Medicaid under the aid category “070” for young adults formerly in foster care.

¹⁹ Centers for Medicare and Medicaid Services. CMS External Quality Review (EQR) Protocols. Available at: <http://www.medicaid.gov/sites/default/files/2023-03/2023-eqr-protocols.pdf>. Accessed on: Nov 18, 2025.

²⁰ Commonwealth of Virginia, Department of Medical Assistance Services. 2023–2025 Quality Strategy. Available at: <https://www.dmas.virginia.gov/media/ernmrksw/2023-2025-quality-strategy.pdf>. Accessed on: Nov 18, 2025.

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 Medicaid managed care with any MCO or combination of MCOs during the measurement year.²¹ Continuous enrollment was defined as no more than 45 days without enrollment in managed care under the child welfare program’s aid category during the measurement year. 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 also met 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 managed care 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) and Clinical Classifications Software Refined (CCSR),²² 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 13 population-specific health characteristics. Matching characteristics differed between the study populations, since HSAG only included characteristics that differed meaningfully from controls for each study population. Additionally, HSAG removed characteristics from the final propensity score model that were insignificant during initial propensity score modeling using all characteristics, based on the Wald Chi-square test. Members residing in an unknown managed care geographic region were removed before propensity score calculations because this category was too small for reliable balancing.

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

- Sex: Male, Female (Former Foster Care Members only)
- Medicaid Population: Acute, Managed Long-Term Services and Supports (MLTSS), More Than One Medicaid Population

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

²¹ HSAG considered Acute and MLTSS enrollment prior to October 1, 2023, and Cardinal Care Managed Care enrollment after October 1, 2023, as managed care enrollment.

²² Agency for Healthcare Research and Quality. Tools Archive for Clinical Classifications Software Refined. Available at: https://www.hcup-us.ahrq.gov/toolssoftware/ccsr/ccsr_archive.jsp#ccsr. Accessed on: Nov 18, 2025.

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

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)²³
- Continuously Enrolled MCO: Aetna Better Health of Virginia (Aetna); HealthKeepers, Inc. (HealthKeepers); Molina Complete Care of Virginia, LLC (Molina)²⁴; Sentara Health Plan (Sentara);²⁵ UnitedHealthcare of the Mid-Atlantic, Inc. (United); and More Than One MCO²⁶

²³ Age categories were calculated using the member's age at the beginning of the measurement year (i.e., January 1, 2024).

²⁴ Effective July 1, 2025, Molina is no longer contracted with Virginia Medicaid. Therefore, while the MY 2022, MY 2023, and MY 2024 findings include results for members enrolled with Molina, HSAG does not discuss recommendations specific to Molina.

²⁵ Given that VA Premier and Optima merged under one MCO (i.e., Sentara) in July 2023, HSAG included members with enrollment in Optima or VA Premier under Sentara for MY 2023. Additionally, HSAG recalculated MY 2022 rates stratified by MCO to combine Optima and VA Premier (i.e., displayed under Sentara) for comparison to the Sentara rate in MY 2023 and MY 2024.

²⁶ 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.

- Region: Central, Charlottesville/Western, Northern & Winchester, Roanoke/Alleghany, Southwest, Tidewater, and Unknown^{27,28}
- Race category: White, Black or African American, and Other²⁹

HSAG exact-matched on age, continuously enrolled MCO, region, and race since findings are stratified by these characteristics. Additionally, age is tied to health risk, likelihood of diagnosis, and healthcare utilization, and age determined which healthcare claims were used in the health characteristic assessment. Region is tied to health risk and provider availability. For the race category, HSAG found that other characteristics were not sufficiently balanced within racial groups without exact matching. The study also stratified study indicator rates by sex; however, HSAG continued to include sex in the propensity score model instead of exact matching, since HSAG found that other characteristics were sufficiently balanced within sex 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.³⁰ 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.

For alignment with other quality initiatives, most healthcare utilization measures were based on CMS’ Adult and Child Core Set Technical Specifications and Resource Manual for FFY 2025 Reporting or custom measure specifications. The healthcare utilization analysis assessed 22 measures, representing 34 study indicators, across six domains as displayed in Table 2-1.

Table 2-1—Healthcare Utilization Measure Indicators

Measure and Indicators
Primary Care
Child and Adolescent Well-Care Visits (WCV)

²⁷ Regional attribution was based on the demographic file and the October 1, 2023–June 30, 2024 Cardinal Care Managed Care Contract provided by DMAS and reflects the managed care regions.

²⁸ Commonwealth of Virginia Department of Medical Assistance Services. Cardinal Care Managed Care Contract: Oct 1, 2023–Jun 30, 2024. Attachment G. 554–555. Available at: <https://www.dmas.virginia.gov/media/d0djxoar/fy24-cardinal-contract-mid-year-amendment.pdf>. Accessed on: Nov 18, 2025.

²⁹ 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.

³⁰ 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: Nov 18, 2025.

Measure and Indicators
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) ³¹
Preventive Dental Services (PDENT-CH) ³²
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)^
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD-AD)*
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)
Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD)*
Respiratory Health
Asthma Medication Ratio (AMR)
Service Utilization
Ambulatory Care Visits

³¹ The *Annual Dental Visit* measure was calculated in accordance with the specifications outlined by the Partnership for Quality Measurement (PQM) consensus-based entity (CBE) ID #1388. Additionally, since Medicaid members may receive dental services from a nondental provider (e.g., a Federally Qualified Health Center), HSAG modified the specifications beginning in MY 2023 to allow visits with any provider authorized to provide dental services but restricted visits to those with a Current Dental Terminology (CDT) code to ensure only visits for dental services were counted.

³² Since CMS retired the *Preventive Dental Services* measure in the FFY 2022 Core Set technical specifications, the Child Welfare Focus Study continued to use the FFY 2021 Core Set technical specifications for this measure.

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

[^] Indicates these measures were not calculated for former foster care members as the measures are not applicable to members 19 to 26 years of age.

^{*} Indicates these measures were only calculated for former foster care members as the measures are only applicable to members 18 years of age and older.

[†] Indicates these measures 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 2024 study indicator rates to NCQA’s Quality Compass^{® 33} national Medicaid health maintenance organization (HMO) percentiles or CMS’ FFY 2024 Adult and Child Core Set national medians³⁴ (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 since 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.

³³ The source for certain health plan measure rates and benchmark (averages and percentiles) data (“the Data”) is Quality Compass[®] 2025 and is used with the permission of the National Committee for Quality Assurance (NCQA). Any analysis, interpretation, or conclusion based on the Data is solely that of the authors, and NCQA specifically disclaims responsibility for any such analysis, interpretation or conclusion. Quality Compass is a registered trademark of NCQA. The Data comprises audited performance rates and associated benchmarks for Healthcare Effectiveness Data and Information Set measures (HEDIS[®]) and HEDIS Consumer Assessment of Healthcare Providers and Systems (CAHPS[®]) survey measure results. HEDIS measures and specifications were developed by and are owned by NCQA. HEDIS measures and specifications are not clinical guidelines and do not establish standards of medical care. NCQA makes no representations, warranties, or endorsement about the quality of any organization or clinician who uses or reports performance measures, or any data or rates calculated using HEDIS measures and specifications, and NCQA has no liability to anyone who relies on such measures or specifications. NCQA holds a copyright in Quality Compass and the Data, or NCQA has obtained the necessary rights in the Data, and may rescind or alter the Data at any time. The Data may not be modified by anyone other than NCQA. Anyone desiring to use or reproduce the Data without modification for an internal, noncommercial purpose may do so without obtaining approval from NCQA. All other uses, including a commercial use and/or external reproduction, distribution, or publication, must be approved by NCQA and are subject to a license at the discretion of NCQA. ©2025 National Committee for Quality Assurance, all rights reserved. CAHPS is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

³⁴ Centers for Medicare & Medicaid Services. 2024 Child and Adult Health Care Quality Measures Quality. Available at: <https://data.medicare.gov/dataset/a5023394-ab10-465b-bb4a-7de5ac98d90c>. Accessed on: Nov 18, 2025.

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 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 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 Within 1 Year for New Adoption Assistance Members—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 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 2022, MY 2023, and MY 2024. For each demographic

characteristic (i.e., age category, sex, race, region, and continuously enrolled MCO,³⁵ where applicable³⁶), 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 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 finding indicates no health disparity was identified when the stratification was compared to the reference group.

³⁵ Given that VA Premier and Optima merged under one MCO (i.e., Sentara) in July 2023, HSAG included members with enrollment in Optima or VA Premier under Sentara for MY 2023. Additionally, HSAG recalculated MY 2022 rates and health disparities p -values to combine Optima and VA Premier (i.e., displayed under Sentara) for comparison to the Sentara stratification in MY 2023 and MY 2024.

³⁶ 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); therefore, a health disparities analysis cannot be performed for that demographic characteristic.

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 7,463 and 2,948 children in the foster care eligibles population and foster care study population, respectively. The eligible population consisted of children in foster care younger than 18 years of age as of January 1, 2024, receiving healthcare coverage from DMAS at any time during MY 2024. Table 3-1 displays the distribution of the children in foster care eligible population by age category, sex, race, region, MCO, and Medicaid population.

Table 3-1—Distribution of Children in Foster Care (n=7,463)

Category	Number	Percent
Age Category		
≤ 2 years	1,510	20.2%
3 to 5 years	1,186	15.9%
6 to 10 years	1,676	22.5%
11 to 13 years	1,023	13.7%
≥ 14 years	2,068	27.7%
Sex		
Male	3,830	51.3%
Female	3,633	48.7%
Race		
Black or African American	2,536	34.0%
White	4,685	62.8%
Other	242	3.2%
Region		
Central	1,646	22.1%
Charlottesville/Western	1,407	18.9%
Northern & Winchester	980	13.1%
Roanoke & Alleghany	1,132	15.2%
Southwest	971	13.0%
Tidewater	1,305	17.5%
Unknown	22	0.3%
Latest MCO in the Measurement Year		
Aetna	813	10.9%
HealthKeepers	2,124	28.5%
Molina	458	6.1%
Sentara	3,250	43.5%
United	614	8.2%
Other*	204	2.7%

Category	Number	Percent
Latest Medicaid Population in the Measurement Year		
MLTSS	112	1.5%
Acute	7,143	95.7%
Other**	208	2.8%

* Includes members only enrolled in FFS.

** Includes members enrolled in Family Access to Medical Insurance Security Plan (FAMIS) and members only enrolled in FFS.

Children in foster care were disproportionately male (51.3 percent) and Black or African American (34.0 percent) compared to the general population in Virginia, which was 49.4 percent male and 20.0 percent Black or African American in 2023.^{37,38} Children in foster care were mostly from the Central (22.1 percent), Charlottesville/Western (18.9 percent), and Tidewater (17.5 percent) regions. The region for a small proportion of children in foster care (0.3 percent) was unknown; these children tended to be missing address information or had an out-of-state address. Children in foster care were most likely to be enrolled with Sentara (43.5 percent) or HealthKeepers (28.5 percent). Only 2.7 percent of children in foster care were only enrolled in FFS during MY 2024.³⁹ Children in foster care were most likely to be in the Acute population (95.7 percent). The Medicaid population for 2.8 percent of children in foster care was Other, meaning they were enrolled through FAMIS or were only enrolled in FFS during MY 2024.

The study population consisted of those in the eligible population who were continuously enrolled in Medicaid managed care with any MCO or a combination of MCOs during the study period and who could be matched to a control (i.e., a member not in a child welfare program). Continuous enrollment was defined as no more than 45 days of enrollment gaps during MY 2024. Among the children in foster care eligible population, 39.5 percent (n=2,948) of children met the requirements for the study population, compared to 46.2 percent for MY 2023 and 52.7 percent for MY 2022. The demographic makeup of the study population mirrored the demographic makeup of the foster care eligible population, except that there were 2.4 percentage points fewer children 2 years of age or younger, 2.0 percentage points more children 6 to 10 years of age, 3.4 percentage points more children enrolled with Sentara, and 2.8 percentage points more members in the Acute population. 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=3,071). Continuously enrolled children in foster care were older, more likely to be male and White, less likely to be in the MLTSS population, and more likely to be enrolled with Sentara compared to the continuously enrolled controls. Furthermore, continuously enrolled children in foster care were more likely to live in the Charlottesville/Western, Roanoke & Alleghany, and Southwest regions. In terms of health characteristics, continuously enrolled children in foster care were more likely to have diagnoses for several health conditions, primarily mental illnesses (e.g., adjustment disorder, anxiety disorder). Additionally, children in foster care were more likely to have ED visits for mental health than the controls, which may indicate greater severity of mental illness among children in foster care. The higher

³⁷ United States Census Bureau. Virginia QuickFacts. Available at: <https://www.census.gov/quickfacts/VA>. Accessed on: Nov 18, 2025.

³⁸ MY 2024 census data were not available as of October 2025.

³⁹ Children in foster care may temporarily move to FFS and may not be enrolled with an MCO during the measurement year.

rate of ED 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 96.0 percent (n=2,948) of continuously enrolled children in foster care to 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 the demographic and health characteristics between the study population and the controls, except that the percentage of members in the MLTSS population was 1.8 percentage points higher among controls than children in foster care.

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 2024. 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 MY 2024 rates for All Eligible Members to the national Medicaid 50th percentile, discusses the change in the rates for All Eligible Members from MY 2023 to MY 2024, and discusses health disparities identified in MY 2024.

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 2022 and MY 2023, may also be impacted by the COVID-19 pandemic; however, rate comparisons within MY 2022 and MY 2023 (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 2022, MY 2023, and MY 2024 *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. Additionally, 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 2022		MY 2023		MY 2024	
	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%	57.7%	65.6% ⁺	52.5%	63.3%	66.7%
Sex						
Male	67.4%	60.4%	64.2%	55.7%	63.8%	68.9%
Female	62.5%	54.4%	67.1%	49.3%	62.9%	63.9%
Race						
Black or African American	65.5%	53.2%	68.9%	51.2%	54.8%	68.6%
White	64.5%	59.3%	63.3%	52.6%	67.0%	66.3%
Other	100.0%	80.0%	100.0% [^]	66.7% [^]	63.6%	62.5%
Region						
Central	61.3%	56.0%	61.5%	48.3%	57.1%	64.3%
Charlottesville/Western	70.0%	60.0%	56.3%	43.8%	80.0%	65.4%
Northern & Winchester	64.3%	64.1%	60.0%	59.1%	60.0%	50.0%
Roanoke/Alleghany	73.5%	44.1%	72.7%	56.3%	69.6%	61.9%
Southwest	52.6%	71.4%	80.0%	56.3%	71.4%	78.3%
Tidewater	62.5%	57.9%	71.4%	57.7%	46.4%	72.0%
MCO						
Aetna	64.7%	64.0%	87.5%	62.5%	68.8%	56.5%
HealthKeepers	68.8%	54.2%	71.9%	52.2%	60.0%	77.4%
Molina	44.4%	60.0%	66.7%	57.1%	36.4%	42.9%
Sentara*	70.3%	57.1%	56.3%	46.3%	69.6%	61.4%
United	69.2%	61.5%	66.7%	80.0%	58.8%	85.7%
More Than One MCO	33.3%	50.0%	25.0%	16.7%	80.0% [^]	100.0% [^]

Blue shading indicates that a disparity was identified (i.e., had a p-value less than 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 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.

* HSAG combined Optima and VA Premier for MY 2022 in this year's report and displayed the rates as Sentara. For MY 2023, HSAG included members with enrollment in Optima or VA Premier prior to July 2023 in the rate for Sentara.

Table 3-2 shows that 63.3 percent of children in foster care and 66.7 percent of controls who turned 15 months old during MY 2024 received six or more well-child visits with a PCP, and the difference was not statistically significant ($p=0.56$). The rates for children in foster care were notably higher than controls for members enrolled with Sentara (by 8.2 percentage points). Conversely, the rates for children in foster care were notably lower than controls for male members (by 5.1 percentage points), members enrolled with HealthKeepers (by 17.4 percentage points), and Black or African American members (by 13.8 percentage points). While there were large rate differences between children in foster care and controls for members for all regions and members enrolled with Aetna, Molina, United, and More Than One MCO, these rates had small denominators, so the rates may be less reliable.

For all eligible members, the MY 2024 rate for children in foster care was below the national Medicaid 50th percentile, while the rate for controls was above it. The rate for children in foster care decreased by 2.3 percentage points from MY 2023 to MY 2024, while the rate for controls increased by 14.2 percentage points. For children in foster care, members in the Tidewater region were significantly less likely to have well-child visits compared to members in other regions during MY 2024, while members in the Charlottesville/Western region were significantly more likely. For children in foster care, members enrolled with Sentara were significantly less likely to have a well-child visit during MY 2023; however, this disparity no longer existed during MY 2024 due to an increase in the rate for Sentara (by 13.3 percentage points).

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 2022, MY 2023, and MY 2024 *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. Additionally, 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 2022		MY 2023		MY 2024	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
All Eligible Members	77.9% ⁺	65.0%	83.5%	79.2%	82.6%	76.5%

Category	MY 2022		MY 2023		MY 2024	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
Sex						
Male	85.4%	64.9%	86.6%	77.2%	83.5%	73.6%
Female	68.9%	65.1%	80.0%	82.1%	81.6%	81.0%
Race						
Black or African American	75.6%	57.6%	80.7%	77.8%	81.1%	76.9%
White	79.0%	69.7%	84.3%	80.0%	82.9%	75.0%
Other	83.3%	66.7%	100.0%^	75.0%^	100.0%^	100.0%^
Region						
Central	78.4%	51.4%	71.4%	80.0%	81.1%	87.1%
Charlottesville/Western	71.8%	66.0%	94.6%	80.0%	83.3%	70.4%
Northern & Winchester	75.6%	69.4%	80.8%	90.9%	90.0%	90.5%
Roanoke/Alleghany	80.0%	76.9%	79.3%	74.3%	84.2%	60.0%
Southwest	81.0%	70.6%	85.7%	66.7%	80.0%	66.7%
Tidewater	81.8%	58.8%	85.3%	83.7%	79.3%	77.1%
MCO						
Aetna	66.7%	60.0%	87.0%	91.7%	78.9%	82.4%
HealthKeepers	86.9%	73.1%	82.4%	85.7%	90.2%	88.9%
Molina	72.2%	52.6%	71.4%	64.3%	80.0%	61.5%
Sentara*	80.2%	63.9%	82.7%	76.8%	76.4%	65.6%
United	55.6%	58.8%	84.6%	61.1%	100.0%^	93.8%^
More Than One MCO	100.0%^	80.0%^	100.0%^	100.0%^	66.7%	83.3%

Blue shading indicates that a disparity was identified (i.e., had a p-value less than 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 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.

* HSAG combined Optima and VA Premier for MY 2022 in this year's report and displayed the rates as Sentara. For MY 2023, HSAG included members with enrollment in Optima or VA Premier prior to July 2023 in the rate for Sentara.

Table 3-3 shows that 82.6 percent of children in foster care and 76.5 percent of controls who turned 15 months old during MY 2024 received two or more well-child visits with a PCP, and the difference was not statistically significant ($p=0.18$). The rates for children in foster care were notably higher than controls for male members (by 9.9 percentage points), White members (by 7.9 percentage points), and members enrolled with Sentara (by 10.8 percentage points). Conversely, the rates for children in foster care were notably lower than controls for members in the Central region (by 6.0 percentage points). While there were large rate differences between children in foster care and controls for members in the Charlottesville/Western, Roanoke/Alleghany, and Southwest regions and members enrolled with Molina, United, and More Than One MCO, these rates had small denominators, so the rates may be less reliable.

For all eligible members, the MY 2024 rates for children in foster care and controls were above the national Medicaid 50th percentile. The rates for children in foster care and controls decreased from MY 2023 to MY 2024 (by 0.9 and 2.7 percentage points, respectively).

Child and Adolescent Well-Care Visits (WCV)

Table 3-4 displays the MY 2022, MY 2023, and MY 2024 *Child and Adolescent Well-Care Visits* rates among children in foster care and controls stratified by member characteristics. Additionally, 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. 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 3-4—Rates of *Child and Adolescent Well-Care Visits* Among Children in Foster Care and Controls

Category	MY 2022		MY 2023		MY 2024	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
All Eligible Members	61.5% ⁺	52.9%	62.7% ⁺	55.2%	67.4% ⁺	58.1%
Age Category						
3 to 11 Years	64.7%	59.6%	66.2%	60.9%	70.7%	62.5%
12 to 17 Years	60.8%	47.4%	60.0%	49.7%	66.3%	54.8%
18 to 21 Years	44.8%	32.7%	46.5%	36.8%	45.2%	40.9%
Sex						
Male	60.6%	55.4%	61.6%	54.7%	67.5%	58.2%
Female	62.5%	49.7%	64.0%	55.8%	67.3%	57.9%
Race						
Black or African American	63.1%	55.6%	62.5%	56.0%	68.8%	59.3%
White	60.7%	51.4%	62.5%	54.6%	66.8%	57.2%
Other	60.3%	54.2%	72.7%	59.7%	62.7%	60.3%
Region						
Central	60.1%	51.6%	60.4%	53.7%	68.0%	57.5%
Charlottesville/Western	59.9%	49.7%	63.9%	54.4%	67.7%	60.3%
Northern & Winchester	64.9%	60.2%	62.4%	64.3%	67.8%	65.3%
Roanoke/Alleghany	62.2%	51.0%	65.3%	52.6%	62.8%	50.1%
Southwest	62.0%	46.0%	62.4%	46.8%	64.0%	46.1%
Tidewater	60.9%	58.5%	62.5%	60.3%	72.7%	66.9%
MCO						
Aetna	62.5%	52.1%	54.9%	49.2%	63.9%	50.4%
HealthKeepers	63.6%	57.0%	63.9%	59.5%	68.9%	63.5%
Molina	60.1%	43.6%	52.3%	54.0%	64.0%	51.3%
Sentara*	59.1%	51.1%	64.4%	54.3%	66.9%	57.4%

Category	MY 2022		MY 2023		MY 2024	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
United	63.3%	56.8%	61.9%	53.3%	65.5%	51.3%
More Than One MCO	80.3%	53.7%	73.8%	52.5%	90.0%	67.5%

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

+ 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.

** HSAG combined Optima and VA Premier for MY 2022 in this year's report and displayed the rates as Sentara. For MY 2023, HSAG included members with enrollment in Optima or VA Premier prior to July 2023 in the rate for Sentara.*

Table 3-4 shows that 67.4 percent of children in foster care and 58.1 percent of controls had a well-care visit with a PCP or an OB/GYN during MY 2024, 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 being for members 12 to 17 years of age (by 11.5 percentage points); female members (by 9.4 percentage points); Black or African American and White members (by 9.5 and 9.6 percentage points, respectively); members in the Central, Roanoke/Alleghany, and Southwest regions (by 10.5, 12.7, and 17.9 percentage points, respectively); and members enrolled with Aetna, Molina, Sentara, United, and More Than One MCO (by 13.5, 12.7, 9.5, 14.2, and 22.5 percentage points, respectively).

The MY 2024 rates for children in foster care were above the national Medicaid 50th percentile for members 3 to 11 years of age and members 12 to 17 years of age. For controls, only the rate for members 3 to 11 years of age exceeded the national Medicaid 50th percentile for members. The rate for the 18 to 21 years age group was not comparable to the national Medicaid 50th percentile, since members 19 to 21 years of age are excluded from this study population, and older members are less likely to have well-care visits. The rates for children in foster care and controls increased from MY 2023 to MY 2024 by 4.7 and 2.9 percentage points, respectively. For both children in foster care and controls, members 18 to 21 years of age were significantly less likely to have a well-care visit compared to members in other age groups during MY 2024, while members 3 to 11 years of age were significantly more likely. The disparities for members 3 to 11 and 18 to 21 years of age also existed during MY 2022 and MY 2023. For children in foster care, members 12 to 17 years of age were significantly less likely to have a well-care visit compared to members in other age groups during MY 2023; however, this disparity no longer existed during MY 2024 due to an increase in the rate for members 12 to 17 years of age (by 6.3 percentage points). For both children in foster care and controls, members in the Roanoke/Alleghany region were significantly less likely to have a well-care visit compared to members in other regions during MY 2024, while members in the Tidewater region were significantly more likely. For children in foster care, members enrolled with Aetna and Molina were significantly less likely to have a well-care visit during MY 2023; however, this disparity no longer existed during MY 2024 due to increases in the rates for Aetna and Molina (by 9.0 and 11.7 percentage points, respectively).

Oral Health

Annual Dental Visit (ADV)

Table 3-5 displays the MY 2022, MY 2023, and MY 2024 *Annual Dental Visit* rates among children in foster care and controls stratified by member characteristics. Additionally, 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.⁴⁰ 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 2022		MY 2023		MY 2024	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
All Eligible Members	68.6% ⁺	53.7%	72.1% ⁺	56.6%	79.6% ⁺	63.2%
Age Category						
≤ 2 Years	56.7%	36.8%	63.9%	39.0%	73.6%	49.7%
3 to 5 Years	69.8%	56.9%	70.5%	61.9%	82.4%	68.1%
6 to 10 Years	71.5%	61.8%	75.5%	65.7%	83.1%	70.7%
11 to 13 Years	76.4%	56.2%	76.8%	58.6%	81.1%	65.2%
≥ 14 Years	67.4%	51.2%	71.3%	51.1%	76.4%	57.9%
Sex						
Male	67.5%	53.1%	71.1%	55.9%	78.3%	62.8%
Female	69.9%	54.4%	73.1%	57.4%	81.1%	63.6%
Race						
Black or African American	68.8%	50.3%	70.9%	55.3%	79.9%	63.2%
White	68.6%	55.3%	72.4%	57.2%	79.1%	63.2%
Other	65.4%	57.7%	79.5%	58.0%	86.4%	64.0%
Region						
Central	69.4%	53.6%	70.1%	61.4%	81.9%	67.0%
Charlottesville/Western	67.6%	53.5%	70.7%	52.0%	74.7%	59.4%
Northern & Winchester	67.9%	64.2%	74.8%	64.2%	82.7%	71.8%
Roanoke/Alleghany	65.1%	51.0%	69.8%	53.2%	74.1%	61.3%
Southwest	74.1%	51.5%	77.2%	54.7%	83.9%	59.3%
Tidewater	68.8%	49.4%	71.9%	54.8%	81.2%	60.4%
MCO						
Aetna	68.0%	50.1%	65.1%	51.5%	75.3%	61.7%
HealthKeepers	70.8%	58.8%	74.0%	60.5%	82.6%	68.2%

⁴⁰ HSAG modified the specifications for this measure beginning in MY 2023 to allow visits with any provider authorized to provide dental services but restricted visits to those with a CDT code to ensure only visits for dental services were counted. Please see the Healthcare Utilization Analysis section in the Overview and Methodology for more details regarding these updates.

Category	MY 2022		MY 2023		MY 2024	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
Molina	60.7%	41.1%	66.9%	46.6%	72.8%	46.2%
Sentara*	67.6%	53.2%	72.6%	56.3%	79.7%	62.6%
United	68.3%	50.0%	70.8%	53.8%	73.2%	58.8%
More Than One MCO	87.3%	56.8%	85.5%	69.1%	90.5%	62.8%

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

+ 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.

* HSAG combined Optima and VA Premier for MY 2022 in this year's report and displayed the rates as Sentara. For MY 2023, HSAG included members with enrollment in Optima or VA Premier prior to July 2023 in the rate for Sentara.

Table 3-5 shows that 79.6 percent of children in foster care and 63.2 percent of controls had a dental visit during MY 2024, 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 being for members who were 2 years of age and younger and 14 years of age and older (by 23.9 and 18.5 percentage points, respectively); female members (by 17.5 percentage points); Black or African American members and members in the Other racial group (by 16.7 and 22.4 percentage points, respectively); members in the Southwest and Tidewater regions (by 24.6 and 20.8 percentage points, respectively); and members enrolled with Molina, Sentara, and More Than One MCO (by 26.6, 17.1, and 27.7 percentage points, respectively).

Rates could not be compared to a benchmark for this indicator since national Medicaid benchmarks were not available after MY 2021. The rates for both children in foster care and controls increased from MY 2023 to MY 2024 by 7.5 and 6.6 percentage points, respectively. For both children in foster care and controls, members 2 years of age and younger and members 14 years of age and older were significantly less likely to have a dental visit compared to members in other age groups during MY 2024, while members 6 to 10 years of age were significantly more likely. The disparities for members 2 years of age and younger and 6 to 10 years of age also existed during MY 2022 and MY 2023. For both children in foster care and controls, members in the Charlottesville/Western region were significantly less likely to have a dental visit compared to members in other regions during MY 2024. For children in foster care only, members in the Roanoke/Alleghany region were significantly less likely to have a dental visit during MY 2024, while members in the Southwest region were significantly more likely. For both children in foster care and controls, members enrolled with HealthKeepers were significantly more likely to have a dental visit compared to members enrolled with other MCOs during MY 2024. For children in foster care only, members enrolled with United were significantly less likely to have a dental visit during MY 2024. Additionally, members enrolled with Aetna were significantly less likely to have a dental visit during MY 2023; however, this disparity no longer existed during MY 2024 due to an increase in the rate for Aetna (by 10.2 percentage points).

Preventive Dental Services (PDENT-CH)

Table 3-6 displays the MY 2022, MY 2023, and MY 2024 *Preventive Dental Services* rates among children in foster care and controls stratified by member characteristics. Additionally, 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 2022		MY 2023		MY 2024	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
All Eligible Members	63.3% ⁺	47.7%	67.1% ⁺	50.8%	73.7% ⁺	56.4%
Age Category						
≤ 2 Years	49.0%	28.1%	54.6%	31.3%	61.0%	38.4%
3 to 5 Years	67.0%	54.2%	68.0%	59.0%	80.6%	66.1%
6 to 10 Years	69.2%	58.8%	73.0%	62.7%	80.4%	67.9%
11 to 13 Years	73.0%	51.8%	73.7%	54.8%	76.7%	59.8%
≥ 14 Years	60.7%	44.8%	65.4%	43.9%	69.8%	49.1%
Sex						
Male	63.0%	47.7%	66.8%	50.2%	72.1%	56.8%
Female	63.7%	47.6%	67.4%	51.4%	75.5%	56.0%
Race						
Black or African American	63.5%	44.7%	67.1% [^]	50.5% [^]	74.5%	56.7%
White	63.3%	49.0%	66.7%	50.8%	73.1%	56.2%
Other	59.8%	51.2%	77.6%	53.6%	76.2%	57.0%
Region						
Central	64.9%	48.9%	65.6%	55.8%	76.3%	60.9%
Charlottesville/Western	62.2%	47.4%	65.8%	45.6%	66.9%	50.9%
Northern & Winchester	63.2%	58.6%	71.8%	58.3%	79.2%	65.6%
Roanoke/Alleghany	56.5%	42.1%	62.5%	47.0%	64.5%	54.0%
Southwest	69.0%	46.2%	71.2%	46.9%	78.3%	53.4%
Tidewater	65.2%	43.6%	67.6%	51.3%	78.2%	53.8%
MCO						
Aetna	62.1%	44.0%	61.0%	46.4%	68.4%	52.1%
HealthKeepers	65.0%	52.3%	69.6%	55.3%	76.5%	62.0%
Molina	54.3%	31.8%	59.8%	40.9%	67.1%	41.5%
Sentara*	62.9%	47.7%	67.7%	50.6%	74.4%	56.1%
United	64.1%	47.2%	63.8%	46.1%	67.4%	50.5%
More Than One MCO	78.8%	47.5%	79.5%	55.8%	80.0%	57.1%

Blue shading indicates that a disparity was identified (i.e., had a p-value less than 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 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.

* HSAG combined Optima and VA Premier for MY 2022 in this year's report and displayed the rates as Sentara. For MY 2023, HSAG included members with enrollment in Optima or VA Premier prior to July 2023 in the rate for Sentara.

Table 3-6 shows that 73.7 percent of children in foster care and 56.4 percent of controls had at least one preventive dental service during MY 2024, 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 being for members 2 years of age and younger and 14 years of age and older (by 22.6 and 20.7 percentage points, respectively); female members (by 19.5 percentage points); Black or African American members and members in the Other racial group (by 17.8 and 19.2 percentage points, respectively); members in the Southwest and Tidewater regions (by 24.9 and 24.4 percentage points, respectively); and members enrolled with Molina, Sentara, and More Than One MCO (by 25.6, 18.3, and 22.9 percentage points, respectively).

Rates could not be compared to a benchmark since national Medicaid benchmarks were not available for this indicator. The rates for both children in foster care and controls increased from MY 2023 to MY 2024 by 6.6 and 5.6 percentage points, respectively. For both children in foster care and controls, members 2 years of age and younger and 14 years of age and older were significantly less likely to have a preventive dental service compared to members in other age groups during MY 2024, while members 3 to 5 years of age and 6 to 10 years of age were significantly more likely. These disparities also existed during MY 2022 and MY 2023, except for members 3 to 5 years of age and 14 years of age and older during MY 2023. For children in foster care only, female members were significantly more likely to have a preventive dental service during MY 2024, while male members were significantly less likely. 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 2024, while members in the Northern & Winchester region were significantly more likely. For children in foster care only, members in the Roanoke/Alleghany region were significantly less likely to have a preventive dental service compared to members in other regions during MY 2024, while members in the Southwest and Tidewater regions were significantly more likely. For both children in foster care 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 2024. For children in foster care, members enrolled with Aetna and United were significantly less likely to have a preventive dental service during MY 2024. For children in foster care, members enrolled with Molina were significantly less likely to have a preventive dental service compared to members enrolled with other MCOs during MY 2023; however, this disparity no longer existed during MY 2024 due to an increase in the rate for members enrolled with Molina (by 7.3 percentage points).

Oral Evaluation, Dental Services (OEV-CH)

Table 3-7 displays the MY 2022, MY 2023, and MY 2024 *Oral Evaluation, Dental Services* rates among children in foster care and controls stratified by member characteristics. Additionally, 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 2022		MY 2023		MY 2024	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
All Eligible Members	61.8% ⁺	46.2%	66.3% ⁺	49.5%	73.3% ⁺	55.7%
Age Category						
≤ 2 Years	50.3%	27.3%	55.1%	31.1%	61.8%	37.6%
3 to 5 Years	65.2%	51.7%	67.9%	56.9%	79.1%	65.1%
6 to 10 Years	67.2%	57.4%	71.8%	60.5%	79.8%	66.7%
11 to 13 Years	69.8%	50.4%	72.0%	53.5%	75.7%	58.3%
≥ 14 Years	58.9%	43.9%	64.4%	43.9%	69.8%	50.3%
Sex						
Male	61.7%	46.1%	66.0%	49.1%	71.8%	55.8%
Female	61.9%	46.3%	66.7%	49.9%	74.9%	55.7%
Race						
Black or African American	62.2%	43.5%	66.5%	49.8%	74.5%	56.7%
White	61.8%	47.6%	65.8%	49.2%	72.4%	55.1%
Other	56.1%	46.3%	76.5%	52.9%	76.2%	56.4%
Region						
Central	63.4%	47.9%	65.3%	54.9%	75.6%	60.1%
Charlottesville/Western	59.4%	45.6%	66.2%	44.2%	68.0%	51.0%
Northern & Winchester	62.6%	56.1%	71.2%	57.8%	78.4%	64.9%
Roanoke/Alleghany	54.5%	41.2%	60.9%	46.1%	64.7%	53.2%
Southwest	67.3%	43.9%	67.9%	43.6%	75.7%	50.5%
Tidewater	64.9%	42.8%	67.5%	50.5%	77.8%	54.3%
MCO						
Aetna	59.8%	42.5%	58.8%	45.0%	66.6%	50.9%
HealthKeepers	64.4%	51.2%	69.0%	53.8%	76.8%	60.9%
Molina	54.8%	29.7%	59.3%	39.7%	67.8%	40.6%
Sentara*	61.0%	46.2%	67.0%	49.4%	73.6%	55.9%
United	62.8%	44.9%	63.0%	45.7%	68.4%	50.3%
More Than One MCO	72.3%	47.0%	78.5%	54.4%	74.5%	54.9%

- Blue shading indicates that a disparity was identified (i.e., had a p-value less than 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 0.05) and the stratified rate was lower than the reference group rate.
- + 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.
- * HSAG combined Optima and VA Premier for MY 2022 in this year's report and displayed the rates as Sentara. For MY 2023, HSAG included members with enrollment in Optima or VA Premier prior to July 2023 in the rate for Sentara.

Table 3-7 shows that 73.3 percent of children in foster care and 55.7 percent of controls received a comprehensive or periodic oral evaluation during MY 2024, 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 and 14 years of age and older (by 24.2 and 19.5 percentage points, respectively); female members (by 19.2 percentage points); Black or African American members and members in the Other racial group (by 17.8 and 19.8 percentage points, respectively); members in the Southwest and Tidewater regions (by 25.2 and 23.5 percentage points, respectively); and members enrolled with Molina, Sentara, United, and More Than One MCO (by 27.2, 17.7, 18.1, and 19.6 percentage points, respectively).

For all eligible members, the MY 2024 rates for both children in foster care and controls were above the national Medicaid 50th percentile. The rates for children in foster care and controls increased from MY 2023 to MY 2024 by 7.0 and 6.2 percentage points, respectively. For both children in foster care and controls, members 2 years of age and younger and members 14 years of age and older were significantly less likely to have an oral evaluation compared to members in other age groups during MY 2024, while members 3 to 5 years of age and members 6 to 10 years of age were significantly more likely. These disparities also existed during MY 2022 and MY 2023 for members 2 years of age and younger and members 6 to 10 years of age. For both children in foster care and controls, members in the Northern & Winchester region were significantly more likely to have an oral evaluation compared to members in other regions during MY 2024, while members in the Charlottesville/Western region were significantly less likely. Additionally, for children in foster care only, members in the Roanoke/Alleghany region were significantly less likely to have an oral evaluation during MY 2024, while members in the Tidewater region were significantly more likely. For both children in foster care and controls, members enrolled with HealthKeepers were significantly more likely to have an oral evaluation compared to members enrolled with other MCOs during MY 2024, and this disparity existed during MY 2022 and MY 2023. Additionally, for children in foster care only, members enrolled with Aetna were significantly less likely to have an oral evaluation during MY 2024. For children in foster care, members enrolled with Molina were significantly less likely to have an oral evaluation during MY 2023; however, this disparity no longer existed during MY 2024 due to an increase in the rate for Molina (by 8.5 percentage points).

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

Table 3-8 displays the MY 2022, MY 2023, and MY 2024 *Topical Fluoride for Children—Dental or Oral Health Services* rates among children in foster care and controls stratified by member characteristics. Additionally, 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 2022		MY 2023		MY 2024	
	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% ⁺	19.3%	33.4% ⁺	21.5%	39.4% ⁺	25.4%
Age Category						
≤ 2 Years	26.1%	16.8%	29.6%	18.5%	38.6%	21.8%
3 to 5 Years	31.8%	21.4%	36.5%	24.2%	46.5%	30.4%
6 to 10 Years	33.7%	24.4%	40.8%	28.3%	45.3%	29.7%
11 to 13 Years	35.5%	19.9%	36.7%	23.9%	35.0%	30.3%
≥ 14 Years	22.4%	15.0%	24.9%	13.5%	32.2%	17.8%
Sex						
Male	30.9%	19.9%	33.4%	20.8%	39.7%	25.6%
Female	27.1%	18.7%	33.4%	22.3%	39.1%	25.2%
Race						
Black or African American	30.9%	17.3%	34.0%	20.9%	40.8%	24.1%
White	28.4%	20.2%	33.3%	21.7%	38.7%	26.1%
Other	24.7%	24.4%	29.4%	22.6%	38.6%	26.8%
Region						
Central	30.6%	21.7%	32.8%	23.8%	39.8%	27.7%
Charlottesville/Western	29.5%	14.6%	32.7%	19.9%	34.7%	21.9%
Northern & Winchester	32.3%	29.8%	39.5%	28.8%	45.3%	35.9%
Roanoke/Alleghany	21.3%	14.5%	28.4%	18.9%	31.5%	23.6%
Southwest	26.6%	15.3%	32.0%	17.4%	38.9%	17.0%
Tidewater	33.4%	20.0%	36.3%	20.4%	47.0%	26.2%
MCO						
Aetna	26.7%	16.9%	28.3%	21.1%	35.0%	19.2%
HealthKeepers	32.0%	23.1%	37.7%	24.9%	42.3%	29.7%
Molina	24.4%	14.7%	28.7%	14.1%	37.6%	18.4%
Sentara*	27.9%	18.2%	32.0%	19.9%	39.6%	24.4%
United	27.5%	21.0%	36.9%	22.7%	31.3%	27.4%
More Than One MCO	47.4%	13.9%	35.1%	27.6%	43.8%	25.0%

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

+ 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.

* HSAG combined Optima and VA Premier for MY 2022 in this year's report and displayed the rates as Sentara. For MY 2023, HSAG included members with enrollment in Optima or VA Premier prior to July 2023 in the rate for Sentara.

Table 3-8 shows that 39.4 percent of children in foster care and 25.4 percent of controls received at least two topical fluoride applications as dental or oral health services during MY 2024, 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. 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).⁴¹ The rates for children in foster care were higher than controls across all stratified rates, with the largest differences being for members 2 years of age and younger, 3 to 5 and 6 to 10 years of age, and 14 years of age and older (by 16.8, 16.1, 15.6, and 14.4 percentage points, respectively); male members (by 14.1 percentage points); Black or African American members (by 16.7 percentage points); members in the Southwest and Tidewater regions (by 21.9 and 20.8 percentage points, respectively); and members enrolled with Aetna, Molina, Sentara, and More Than One MCO (by 15.8, 19.2, 15.2, and 18.8 percentage points, respectively).

For all eligible members, the MY 2024 rates for both children in foster care and controls were above the national Medicaid 50th percentile. The rates for children in foster care and controls increased from MY 2023 to MY 2024 by 6.0 and 3.9 percentage points, respectively. For both children in foster care and controls, members 14 years of age and older were significantly less likely to receive at least two topical fluoride applications compared to members in other age groups during MY 2024, while members 3 to 5 and 6 to 10 years of age were significantly more likely. The disparities for members 6 to 10 years of age and members 14 years of age and older also existed during MY 2022 and MY 2023. For children in foster care, members 2 years of age and younger were also significantly less likely to receive at least two topical fluoride applications during MY 2023; however, this disparity no longer existed during MY 2024 due to an increase in the rate for members 2 years of age and younger (by 9.0 percentage points). For both children in foster care and controls, members in the Charlottesville/Western region were significantly less likely to receive at least two topical fluoride applications compared to members in other regions during MY 2024, while members in the Northern & Winchester region were significantly more likely. For children in foster care only, 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 2024, while members in the Tidewater region were significantly more likely. This disparity for the Roanoke/Alleghany region also existed during MY 2022 and MY 2023. For both children in foster care and controls, members enrolled with HealthKeepers were significantly more likely to receive at least two topical fluoride applications during MY 2024. These disparities also existed during MY 2022 and MY 2023. For children in foster care only, members enrolled with United were significantly less likely to receive at least two topical fluoride applications compared to members enrolled with other MCOs during MY 2024.

⁴¹ American Dental Association. Fluoride: Topical and Systemic Supplements. Available at: <https://www.ada.org/resources/ada-library/oral-health-topics/fluoride-topical-and-systemic-supplements>. Accessed on: Nov 18, 2025.

Behavioral Health

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

Table 3-9 displays the MY 2022, MY 2023, and MY 2024 *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* rates among children in foster care and controls stratified by member characteristics. Additionally, 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 2022		MY 2023		MY 2024	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
All Eligible Members	35.6%	57.6%	57.7%	58.9%	57.2%	57.3%
Age Category						
3 to 5 Years	—	—	—	—	50.0%	—
6 to 10 Years	58.3%	62.5%	59.1%	54.5%	55.6%	62.5%
11 to 13 Years	31.6%	58.8%	75.8%	66.7%	59.5%	50.0%
≥ 14 Years	32.2%	56.1%	51.5%	57.4%	57.0%	60.0%
Sex						
Male	35.5%	60.0%	60.0%	50.0%	54.5%	53.6%
Female	35.6%	56.1%	56.8%	65.9%	58.8%	59.3%
Race						
Black or African American	23.5%	50.0%	63.3%	61.9%	60.0%	51.7%
White	42.3%	60.9%	53.8%	58.8%	54.0%	59.6%
Other	50.0%	—	100.0%^	0.0%^	80.0%^	100.0%^
Region						
Central	36.4%	55.6%	57.1%	66.7%	58.1%	48.0%
Charlottesville/Western	23.1%	53.8%	62.1%	76.9%	54.5%	52.9%
Northern & Winchester	50.0%	80.0%	44.4%	50.0%	61.1%	85.7%
Roanoke/Alleghany	50.0%	62.5%	60.6%	30.0%	62.1%	88.9%
Southwest	33.3%	60.0%	42.9%^	0.0%^	33.3%	33.3%
Tidewater	30.8%	41.7%	61.8%	60.0%	58.1%	55.6%
MCO						
Aetna	42.9%	50.0%	78.6%	75.0%	76.9%	40.0%
HealthKeepers	33.3%	46.7%	61.1%	65.0%	57.8%	68.2%
Molina	40.0%^	0.0%^	25.0%^	100.0%^	44.4%	75.0%

Category	MY 2022		MY 2023		MY 2024	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
Sentara*	35.2%	73.5%	58.5%	52.3%	56.5%	57.1%
United	50.0%	33.3%	50.0%^	100.0%^	50.0%^	0.0%^
More Than One MCO	0.0%^	33.3%^	25.0%^	0.0%^	—	60.0%

Blue shading indicates that a disparity was identified (i.e., had a p-value less than 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 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.

* HSAG combined Optima and VA Premier for MY 2022 in this year's report and displayed the rates as Sentara. For MY 2023, HSAG included members with enrollment in Optima or VA Premier prior to July 2023 in the rate for Sentara.

Table 3-9 shows that 57.2 percent of children in foster care and 57.3 percent of controls had a follow-up visit with a mental health provider within seven days after discharge during MY 2024, and the difference was not statistically significant ($p=0.99$). The rate for children in foster care was notably lower than controls for White members (by 5.6 percentage points). While there were large rate differences between children in foster care and controls for most of the other stratified rates, these rates had small denominators, so the rates may be less reliable.

For all eligible members, the MY 2024 rates for both children in foster care and controls were above the national Medicaid 50th percentile for members 6 to 17 years of age. The rates for children in foster care and controls decreased from MY 2023 to MY 2024 by 0.5 and 1.6 percentage points, respectively.

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

Table 3-10 displays the MY 2022, MY 2023, and MY 2024 *Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up* rates among children in foster care and controls stratified by member characteristics. Additionally, 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 2022		MY 2023		MY 2024	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
All Eligible Members	87.7%	74.4%	76.7%	66.7%	73.8%	89.7%
Age Category						
3 to 5 Years	—	100.0%^	—	—	100.0%^	50.0%^
6 to 10 Years	87.5%	60.0%	100.0%^	77.8%^	83.3%	71.4%
11 to 13 Years	92.3%	70.0%	75.0%	87.5%	71.4%^	100.0%^
≥ 14 Years	86.1%	83.3%	70.8%	50.0%	70.4%	94.4%
Sex						
Male	82.6%	70.6%	66.7%	66.7%	81.0%	88.2%
Female	90.5%	77.3%	84.0%	66.7%	66.7%	90.9%
Race						
Black or African American	88.2%	57.1%	68.4%	62.5%	61.1%^	100.0%^
White	87.5%	78.1%	87.0%	68.0%	87.0%^	84.0%^
Other	—	—	0.0%^	—	0.0%^	100.0%^
Region						
Central	93.8%	70.0%	33.3%	33.3%	50.0%	90.9%
Charlottesville/Western	82.4%	66.7%	85.7%	75.0%	50.0%	80.0%
Northern & Winchester	100.0%^	83.3%^	83.3%	80.0%	75.0%^	100.0%^
Roanoke/Alleghany	83.3%	76.9%	83.3%	88.9%	88.9%	75.0%
Southwest	80.0%^	100.0%^	100.0%^	100.0%^	100.0%^	66.7%^
Tidewater	90.9%	33.3%	77.8%	50.0%	77.8%^	100.0%^
MCO						
Aetna	50.0%^	100.0%^	100.0%^	50.0%^	100.0%^	100.0%^
HealthKeepers	88.2%	45.5%	61.5%	58.3%	69.2%	92.9%
Molina	50.0%	—	100.0%^	—	100.0%^	100.0%^
Sentara*	89.5%	82.6%	87.5%	76.9%	71.4%	82.4%
United	100.0%^	100.0%^	60.0%	75.0%	66.7%^	100.0%^
More Than One MCO	100.0%^	100.0%^	75.0%	—	—	100.0%^

Blue shading indicates that a disparity was identified (i.e., had a p-value less than 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 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.

* HSAG combined Optima and VA Premier for MY 2022 in this year's report and displayed the rates as Sentara. For MY 2023, HSAG included members with enrollment in Optima or VA Premier prior to July 2023 in the rate for Sentara.

Table 3-10 shows that 73.8 percent of children in foster care and 89.7 percent of controls had a follow-up visit for mental illness within 30 days of the ED visit during MY 2024, and the difference was not statistically significant ($p=0.09$). 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 2024 rates for children in foster care and controls were above the national Medicaid 50th percentile for members 6 to 17 years of age. The rate for children in foster care and controls decreased from MY 2023 to MY 2024 by 2.9 percentage points, and the rate for controls increased by 23.0 percentage points. Approximately 10 percent of children in foster care in the denominator had a follow-up visit within 31 to 90 days of the ED visit, indicating some members are still receiving a follow-up visit, though not within the 30-day timeframe. For children in foster care, members in the Central region were significantly less likely to have a follow-up visit during MY 2023; however, this disparity no longer existed during MY 2024 due to an increase in the rate for members in the Central region (by 16.7 percentage points).

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

Table 3-11 displays the MY 2022, MY 2023, and MY 2024 *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. Additionally, 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.

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 2022		MY 2023		MY 2024	
	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%	31.3%	36.4%	38.5%	37.6%	32.7%
Age Category						
≤ 2 Years	—	0.0%^	—	—	0.0%	—
3 to 5 Years	40.0%	33.3%	25.0%	25.0%	21.4%	37.5%
6 to 10 Years	40.0%	19.4%	33.8%	30.6%	26.7%	22.2%
11 to 13 Years	36.8%	32.3%	31.7%	45.5%	39.7%	22.6%
≥ 14 Years	37.7%	37.5%	40.6%	41.8%	46.6%	46.3%
Sex						
Male	37.4%	25.6%	30.8%	41.8%	40.1%	34.3%
Female	39.3%	41.3%	43.1%	34.0%	33.6%	30.0%
Race						
Black or African American	40.2%	36.0%	35.6%	44.4%	25.2%	32.3%
White	38.0%	30.4%	37.6%	35.0%	45.6%	33.8%

Category	MY 2022		MY 2023		MY 2024	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
Other	0.0%^	0.0%^	0.0%^	100.0%^	25.0%^	0.0%^
Region						
Central	40.4%	22.2%	31.9%	32.0%	26.0%	23.3%
Charlottesville/Western	36.0%	31.6%	35.3%	47.6%	41.5%	46.2%
Northern & Winchester	44.1%	47.4%	61.5%	40.0%	43.8%	26.7%
Roanoke/Alleghany	37.0%	38.5%	31.3%	20.8%	33.3%	23.1%
Southwest	37.0%	41.2%	37.5%	57.9%	66.7%	40.0%
Tidewater	36.2%	10.0%	27.7%	38.9%	35.3%	42.9%
MCO						
Aetna	43.5%	35.7%	33.3%	22.2%	44.0%	22.2%
HealthKeepers	31.9%	30.6%	34.5%	30.8%	29.3%	31.3%
Molina	62.5%	50.0%	30.0%^	0.0%^	33.3%	66.7%
Sentara*	37.7%	28.3%	35.7%	45.3%	39.5%	29.8%
United	66.7%	54.5%	57.1%	25.0%	61.5%	50.0%
More Than One MCO	22.2%^	0.0%^	45.5%^	0.0%^	33.3%^	100.0%^

Blue shading indicates that a disparity was identified (i.e., had a p-value less than 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 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.

* HSAG combined Optima and VA Premier for MY 2022 in this year's report and displayed the rates as Sentara. For MY 2023, HSAG included members with enrollment in Optima or VA Premier prior to July 2023 in the rate for Sentara.

Table 3-11 shows that 37.6 percent of children in foster care and 32.7 percent of controls with two or more antipsychotic prescriptions received blood glucose and cholesterol testing during MY 2024, and the difference was not statistically significant ($p=0.37$). The rate for children in foster care was notably higher than controls for members 11 to 13 years of age (by 17.1 percentage points), male members (by 5.8 percentage points), White members (by 11.8 percentage points), and members enrolled with Sentara (by 9.7 percentage points). Conversely, the rates for children in foster care were notably lower than controls for Black or African American members (by 7.1 percentage points). While there were large rate differences between children in foster care and controls for most of the other stratified rates, these rates had small denominators, so the rates may be less reliable.

For all eligible members, the MY 2024 rate for children in foster care was similar to the national Medicaid 50th percentile, while the rate for the controls was below the national Medicaid 50th percentile. The rates for children in foster care increased from MY 2023 to 2024 by 1.2 percentage points, while the rate for controls decreased by 5.8 percentage points. For both children in foster care and controls, members 14 years of age and older were significantly more likely to receive blood glucose

and cholesterol testing during MY 2024. For children in foster care only, members 6 to 10 years of age were significantly less likely to receive blood glucose and cholesterol testing during MY 2024. For children in foster care only, Black or African American members were significantly less likely to receive blood glucose and cholesterol testing during MY 2024, while White members were significantly more likely. For children in foster care only, members in the Central region were significantly less likely to receive blood glucose and cholesterol testing compared to members in other regions during MY 2024, while members in the Southwest region were significantly more likely.

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

Table 3-12 displays the MY 2022, MY 2023, and MY 2024 *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics* rates among children in foster care and controls stratified by member characteristics. Additionally, 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.

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 2022		MY 2023		MY 2024	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
All Eligible Members	77.9% ⁺	60.8%	86.3%	72.5%	83.0%	74.3%
Age Category						
≤ 2 Years	—	0.0% [^]	—	—	—	—
3 to 5 Years	60.0%	62.5%	0.0% [^]	100.0% [^]	80.0%	33.3%
6 to 10 Years	87.1%	37.5%	96.2%	75.0%	93.1%	87.5%
11 to 13 Years	75.0%	50.0%	83.3%	66.7%	84.0%	75.0%
≥ 14 Years	70.8%	75.0%	85.3%	71.4%	73.3%	75.0%
Sex						
Male	71.8%	53.8%	80.0%	60.9%	85.1%	62.5%
Female	86.2%	68.0%	92.5%	88.2%	80.9%	84.2%
Race						
Black or African American	86.4%	54.5%	90.9%	80.0%	87.2%	80.0%
White	75.6%	62.5%	82.6%	68.0%	79.6%	68.4%
Other	0.0% [^]	—	100.0% [^]	—	100.0% [^]	100.0% [^]
Region						
Central	80.0%	66.7%	84.2%	66.7%	80.0%	71.4%
Charlottesville/Western	84.2%	88.9%	90.0%	70.0%	91.7%	75.0%
Northern & Winchester	80.0%	71.4%	92.3%	75.0%	81.8%	71.4%
Roanoke/Alleghany	90.0%	41.7%	92.3%	77.8%	82.4%	71.4%
Southwest	81.8%	50.0%	66.7%	60.0%	87.5% [^]	100.0% [^]

Category	MY 2022		MY 2023		MY 2024	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
Tidewater	53.8%	44.4%	87.5%	83.3%	81.3%	71.4%
MCO						
Aetna	100.0%^	57.1%^	100.0%^	66.7%^	77.8%	33.3%
HealthKeepers	62.5%	53.8%	85.7%	50.0%	81.5%	72.7%
Molina	66.7%	50.0%	100.0%^	100.0%^	83.3%^	100.0%^
Sentara*	85.0%	71.4%	87.8%	76.9%	84.8%	77.8%
United	100.0%^	40.0%^	33.3%^	100.0%^	83.3%^	100.0%^
More Than One MCO	50.0%	66.7%	100.0%^	100.0%^	—	—

Blue shading indicates that a disparity was identified (i.e., had a p-value less than 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 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.

* HSAG combined Optima and VA Premier for MY 2022 in this year’s report and displayed the rates as Sentara. For MY 2023, HSAG included members with enrollment in Optima or VA Premier prior to July 2023 in the rate for Sentara.

Table 3-12 shows that 83.0 percent of children in foster care and 74.3 percent of controls had documentation of psychosocial care as first-line treatment during MY 2024, and the difference was not statistically significant ($p=0.27$). While there were large rate differences between children in foster care and controls for members in most of the stratified rates, these rates had small denominators, so the rates may be less reliable.

For all eligible members, the MY 2024 rates for both children in foster care and controls were above the national Medicaid 50th percentile. The rate for children in foster care decreased from MY 2023 to MY 2024 by 3.3 percentage points, while the rate for controls increased by 1.8 percentage points.

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

Table 3-13 displays the MY 2022, MY 2023, and MY 2024 *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 2022, MY 2023, and MY 2024 *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. Additionally, 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 2022		MY 2023		MY 2024	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
One-Month	77.3%	75.0%	76.1%	66.0%	79.0%	66.9%
Two-Months	90.0%	90.1%	88.8%	81.3%	92.7%	82.7%
Three-Months	93.6%	93.4%	91.8%	88.2%	94.4%	89.5%
Six-Months	97.3%	97.4%	94.0%	95.8%	97.6%	96.2%
Nine-Month	97.3%	98.7%	95.5%	99.3%	98.4%	97.7%

Table 3-13 shows that 79.0 percent of children in foster care had a follow-up visit within one month of when their first ADHD medication was dispensed, and 98.4 percent of children in foster care had a follow-up visit within nine months. For children in foster care, the rate of follow-up visits within one month increased by 2.9 percentage points from MY 2023 to MY 2024. While the rates for children in foster care were 12.1 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. 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 such that children in foster care and controls are similarly likely to have a follow-up visit within six months and within nine months of when their first ADHD medication was dispensed.

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 2022		MY 2023		MY 2024	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
All Eligible Members	77.3%	75.0%	76.1%	66.0%	79.0% ⁺	66.9%
Age Category						
6 to 10 Years	77.8%	77.2%	79.0%	66.0%	77.3%	69.3%
11 to 13 Years	75.9%	68.4%	67.6%	66.0%	85.2%	59.4%
Sex						
Male	73.3%	72.4%	75.0%	63.9%	81.9%	69.5%
Female	82.0%	78.5%	77.3%	70.2%	75.0%	62.7%
Race						
Black or African American	70.6%	77.0%	74.5%	71.4%	77.8%	73.5%
White	81.1%	73.3%	76.9%	62.1%	81.2%	64.6%
Other	50.0% [^]	100.0% [^]	100.0% [^]	100.0% [^]	0.0% [^]	40.0% [^]
Region						
Central	55.6%	78.8%	80.0%	78.1%	87.0%	77.1%

Category	MY 2022		MY 2023		MY 2024	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
Charlottesville/Western	87.5%	84.0%	75.0%	71.4%	63.0%	66.7%
Northern & Winchester	71.4%	64.3%	72.7%	66.7%	93.3%	83.3%
Roanoke/Alleghany	87.5%	70.4%	55.6%	57.1%	78.3%	50.0%
Southwest	88.2%	76.2%	88.0%	73.7%	80.0%	62.5%
Tidewater	71.4%	71.9%	85.7%	53.1%	81.3%	75.0%
MCO						
Aetna	55.6%	87.5%	85.7%	57.1%	62.5%	60.0%
HealthKeepers	78.0%	72.5%	81.0%	66.0%	86.8%	77.4%
Molina	33.3%	80.0%	62.5%	66.7%	66.7%	66.7%
Sentara*	82.7%	74.6%	74.2%	67.2%	76.2%	70.3%
United	100.0%^	75.0%^	33.3%	75.0%	87.5%	30.8%
More Than One MCO	66.7%^	0.0%^	100.0%^	—	100.0%^	50.0%^

Blue shading indicates that a disparity was identified (i.e., had a p-value less than 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 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.

* HSAG combined Optima and VA Premier for MY 2022 in this year's report and displayed the rates as Sentara. For MY 2023, HSAG included members with enrollment in Optima or VA Premier prior to July 2023 in the rate for Sentara.

Table 3-14 shows that 79.0 percent of children in foster care and 66.9 percent of controls had a follow-up care visit within 30 days of when their first ADHD medication was dispensed during MY 2024, and the difference was statistically significant ($p=0.03$). The rates for children in foster care were notably higher than controls for female members (by 12.3 percentage points) and White members (by 16.6 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 Roanoke/Alleghany and Southwest regions, and members enrolled with United and More Than One MCO, these rates had small denominators, so the rates may be less reliable.

For all eligible members, the MY 2024 rates for both children in foster care and controls were above the national Medicaid 50th percentile. The rates for children in foster care and controls increased from MY 2023 to MY 2024 by 2.9 and 0.9 percentage points, respectively. For children in foster care only, members in the Charlottesville/Western region were significantly less likely to have a follow-up care visit within 30 days of when their first ADHD medication was dispensed compared to members in other regions during MY 2024. For children in foster care, members in the Roanoke/Alleghany region were significantly less likely to have a follow-up visit during MY 2023; however, this disparity no longer existed during MY 2024 due to an increase in the rate for the Roanoke/Alleghany region (by 22.7 percentage points).

Substance Use

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

Table 3-15 displays the MY 2022, MY 2023, and MY 2024 *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. Additionally, 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. 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 3-15—Rates of Initiation and Engagement of SUD Treatment—Initiation of SUD Treatment Among Children in Foster Care and Controls

Category	MY 2022		MY 2023		MY 2024	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
All Eligible Members	40.4%	50.0%	33.9%	28.1%	50.0%	35.3%
Age Category						
11 to 13 Years	66.7%	75.0%	50.0%^	0.0%^	75.0%^	100.0%^
≥ 14 Years	38.9%	47.5%	32.7%^	31.0%^	47.8%^	31.3%^
Sex						
Male	38.5%	40.9%	34.5%	25.0%	66.7%	35.7%
Female	41.9%	59.1%	33.3%	31.3%	40.6%	35.0%
Race						
Black or African American	35.7%	75.0%	25.0%	33.3%	73.3%	25.0%
White	40.5%	42.9%	38.5%	26.1%	41.2%	40.9%
Other	100.0%^	100.0%^	0.0%^	—	0.0%^	—
Region						
Central	44.4%	80.0%	33.3%	33.3%	50.0%	42.9%
Charlottesville/Western	57.1%	44.4%	9.1%^	100.0%^	50.0%	42.9%
Northern & Winchester	33.3%	20.0%	50.0%	7.7%	42.9%^	0.0%^
Roanoke/Alleghany	22.2%	77.8%	12.5%	40.0%	75.0%	66.7%
Southwest	42.9%	50.0%	60.0%	50.0%	0.0%^	50.0%^
Tidewater	33.3%	40.0%	50.0%	33.3%	50.0%	40.0%
MCO						
Aetna	0.0%^	50.0%^	62.5%^	0.0%^	37.5%^	100.0%^
HealthKeepers	50.0%	23.1%	36.8%^	0.0%^	44.4%	18.2%
Molina	50.0%	66.7%	0.0%^	100.0%^	40.0%^	100.0%^
Sentara*	36.0%	60.9%	24.0%	37.5%	55.6%	42.9%
United	50.0%	50.0%	—	100.0%^	100.0%^	0.0%^
More Than One MCO	0.0%^	100.0%^	100.0%^	100.0%^	—	20.0%

- Blue shading indicates that a disparity was identified (i.e., had a p-value less than 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 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.
- * HSAG combined Optima and VA Premier for MY 2022 in this year’s report and displayed the rates as Sentara. For MY 2023, HSAG included members with enrollment in Optima or VA Premier prior to July 2023 in the rate for Sentara.

Table 3-15 shows that 50.0 percent of new SUD episodes among children in foster care and 35.3 percent of new SUD episodes among controls resulted in initiation of treatment within 14 days of diagnosis during MY 2024, and the difference was not statistically significant ($p=0.18$). The rate for children in foster care was notably higher than controls for members 14 years of age and older (by 16.5 percentage points). While there were large rate differences between children in foster care and controls for most of the other stratified rates, these rates had small denominators, so the rates may be less reliable.

For all eligible members, the MY 2024 rate for children in foster care was above the national Medicaid 50th percentile, while the rate for controls was below. The rates for children in foster care and controls increased from MY 2023 to MY 2024 by 16.1 and 7.2 percentage points, respectively. For children in foster care only, Black or African American members were significantly more likely to initiate treatment within 14 days of an SUD diagnosis during MY 2024 compared to other racial groups.

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

Table 3-16 displays the MY 2022, MY 2023, and MY 2024 *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. Additionally, 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.⁴² 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.

⁴² 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 3-16—Rates of Initiation and Engagement of SUD Treatment—Engagement of SUD Treatment Among Children in Foster Care and Controls

Category	MY 2022		MY 2023		MY 2024	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
All Eligible Members	10.5%	13.6%	19.6% ⁺	3.1%	18.0% ⁺	2.9%
Age Category						
11 to 13 Years	33.3%	25.0%	50.0% [^]	0.0% [^]	25.0% [^]	50.0% [^]
≥ 14 Years	9.3%	12.5%	17.3% [^]	3.4% [^]	17.4% [^]	0.0% [^]
Sex						
Male	19.2%	13.6%	27.6% [^]	6.3% [^]	22.2% [^]	7.1% [^]
Female	3.2%	13.6%	11.1% [^]	0.0% [^]	15.6% [^]	0.0% [^]
Race						
Black or African American	7.1%	25.0%	12.5% [^]	0.0% [^]	20.0% [^]	0.0% [^]
White	9.5%	8.6%	23.1% [^]	4.3% [^]	17.6% [^]	4.5% [^]
Other	100.0% [^]	100.0% [^]	0.0% [^]	—	0.0% [^]	—
Region						
Central	0.0% [^]	0.0% [^]	13.3% [^]	0.0% [^]	7.1% [^]	0.0% [^]
Charlottesville/Western	7.1%	11.1%	0.0% [^]	0.0% [^]	33.3% [^]	0.0% [^]
Northern & Winchester	16.7%	10.0%	33.3% [^]	0.0% [^]	0.0% [^]	0.0% [^]
Roanoke/Alleghany	11.1%	33.3%	0.0% [^]	10.0% [^]	37.5% [^]	33.3% [^]
Southwest	28.6%	16.7%	60.0% [^]	0.0% [^]	0.0% [^]	0.0% [^]
Tidewater	8.3% [^]	0.0% [^]	16.7% [^]	0.0% [^]	25.0% [^]	0.0% [^]
MCO						
Aetna	0.0% [^]	0.0% [^]	50.0% [^]	0.0% [^]	12.5% [^]	100.0% [^]
HealthKeepers	5.0%	15.4%	26.3% [^]	0.0% [^]	33.3% [^]	0.0% [^]
Molina	0.0% [^]	0.0% [^]	0.0% [^]	100.0% [^]	20.0% [^]	0.0% [^]
Sentara*	12.0%	17.4%	8.0% [^]	0.0% [^]	14.8% [^]	0.0% [^]
United	50.0% [^]	0.0% [^]	—	0.0% [^]	0.0% [^]	0.0% [^]
More Than One MCO	0.0% [^]	0.0% [^]	0.0% [^]	0.0% [^]	—	0.0% [^]

Blue shading indicates that a disparity was identified (i.e., had a p-value less than 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 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.

* HSAG combined Optima and VA Premier for MY 2022 in this year's report and displayed the rates as Sentara. For MY 2023, HSAG included members with enrollment in Optima or VA Premier prior to July 2023 in the rate for Sentara.

Table 3-16 shows that 18.0 percent of new SUD episodes among children in foster care and 2.9 percent of new SUD episodes among controls resulted in initiation of SUD treatment within 14 days of

diagnosis and engagement in ongoing SUD treatment during MY 2024, and the difference was statistically significant ($p=0.04$). The rate for children in foster care was notably higher than controls for members 14 years of age and older (by 17.4 percentage points). While there were large rate differences between children in foster care and controls for members 11 to 13 years of age; female members; Black or African American members; members in the Charlottesville/Western and Tidewater regions; and members enrolled with Aetna, HealthKeepers, and Molina, these rates had small denominators, so the rates may be less reliable.

For all eligible members, the MY 2024 rate for children in foster care was above the national Medicaid 50th percentile, while the rate for controls was below the national Medicaid 50th percentile. The rates for both children in foster care and controls decreased by 1.6 and 0.2 percentage points, respectively, from MY 2023 to MY 2024.

Respiratory Health

Asthma Medication Ratio (AMR)

Table 3-17 displays the MY 2022, MY 2023, and MY 2024 *Asthma Medication Ratio* rates among children in foster care and controls stratified by member characteristics. Additionally, 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 Asthma Medication Ratio Among Children in Foster Care and Controls

Category	MY 2022		MY 2023		MY 2024	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
All Eligible Members	82.5%	76.1%	77.1%	77.8%	71.0%	76.7%
Age Category						
5 to 11 Years	83.3%	85.7%	85.7%	85.2%	81.3%	89.7%
12 to 18 Years	81.8%	69.8%	70.4%	70.4%	60.0%	64.5%
Sex						
Male	84.6%	73.3%	74.1%	74.2%	70.6%	69.2%
Female	78.6%	80.8%	81.0%	82.6%	71.4%	90.5%
Race						
Black or African American	68.4%	73.7%	71.4%	73.3%	63.6%	68.8%
White	94.7%	78.8%	83.3%	83.3%	73.7%	84.0%
Other	100.0% [^]	—	66.7%	—	100.0% [^]	100.0% [^]
Region						
Central	80.0%	77.8%	61.5%	71.4%	80.0%	62.5%
Charlottesville/Western	83.3%	86.7%	83.3%	70.0%	83.3%	66.7%
Northern & Winchester	66.7%	71.4%	100.0% [^]	100.0% [^]	66.7%	80.0%

Category	MY 2022		MY 2023		MY 2024	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
Roanoke/Alleghany	83.3%	50.0%	100.0%^	75.0%^	0.0%^	100.0%^
Southwest	75.0%	90.9%	33.3%^	100.0%^	71.4%^	100.0%^
Tidewater	90.9%	62.5%	60.0%	81.3%	50.0%	77.8%
MCO						
Aetna	83.3%^	100.0%^	50.0%	66.7%	50.0%	80.0%
HealthKeepers	81.8%	72.2%	86.7%	75.0%	77.8%	75.0%
Molina	100.0%^	80.0%^	100.0%^	100.0%^	0.0%^	100.0%^
Sentara*	88.2%	76.3%	82.6%	81.1%	85.7%	75.0%
United	33.3%	66.7%	25.0%	—	25.0%^	100.0%^
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 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 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.

* HSAG combined Optima and VA Premier for MY 2022 in this year's report and displayed the rates as Sentara. For MY 2023, HSAG included members with enrollment in Optima or VA Premier prior to July 2023 in the rate for Sentara.

Table 3-17 shows that 71.0 percent of children in foster care and 76.7 percent of controls who were identified as having persistent asthma had a ratio of controller medications to total asthma medications of 0.50 or greater during MY 2024, and the difference was not statistically significant ($p=0.55$). While there were large rate differences between children in foster care and controls for members in many of the 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 national Medicaid 50th percentile for members 5 to 11 years of age, but below the national Medicaid 50th percentile for members 12 to 18 years of age. The rates for children in foster care and controls decreased by 6.1 and 1.1 percentage points, respectively, from MY 2023 to MY 2024.

Service Utilization

Ambulatory Care Visits

Table 3-18 displays the MY 2022, MY 2023, and MY 2024 *Ambulatory Care Visits* rates among children in foster care and controls stratified by member characteristics. Additionally, 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 2022		MY 2023		MY 2024	
	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%	88.1%	86.8%	88.0%	91.6%	90.7%
Age Category						
≤ 2 Years	90.3%	91.8%	92.2%	93.6%	94.8%	95.0%
3 to 5 Years	86.6%	89.5%	88.1%	89.0%	90.3%	91.3%
6 to 10 Years	85.0%	87.6%	85.2%	88.2%	90.9%	89.8%
11 to 13 Years	89.1%	87.9%	83.9%	84.7%	91.8%	90.8%
≥ 14 Years	85.0%	85.5%	85.5%	85.1%	90.7%	88.1%
Sex						
Male	86.9%	88.4%	85.3%	87.1%	90.9%	90.0%
Female	86.8%	87.9%	88.5%	89.0%	92.2%	91.4%
Race						
Black or African American	85.1%	85.1%	85.7%	85.0%	91.5%	88.1%
White	88.0%	89.8%	87.2%	89.7%	91.7%	92.2%
Other	80.5%	87.8%	92.9%	83.5%	89.1%	90.1%
Region						
Central	83.4%	84.0%	82.9%	85.7%	91.9%	89.6%
Charlottesville/Western	87.8%	89.8%	88.4%	88.2%	90.4%	91.7%
Northern & Winchester	84.2%	89.7%	85.3%	88.0%	88.3%	89.9%
Roanoke/Alleghany	90.8%	91.1%	91.7%	87.4%	91.9%	90.5%
Southwest	92.4%	92.2%	91.0%	93.3%	96.0%	94.9%
Tidewater	84.3%	84.3%	83.4%	86.8%	91.2%	88.6%
MCO						
Aetna	83.7%	87.2%	82.6%	85.9%	90.8%	86.0%
HealthKeepers	87.4%	88.2%	87.1%	89.5%	90.5%	92.8%
Molina	79.0%	80.8%	77.8%	84.5%	82.5%	81.1%
Sentara*	87.7%	88.8%	88.4%	87.6%	93.2%	92.1%
United	86.8%	89.7%	85.4%	87.7%	90.2%	85.0%
More Than One MCO	97.6%	92.8%	97.5%	96.2%	100.0%	92.2%

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

+ 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.

* HSAG combined Optima and VA Premier for MY 2022 in this year's report and displayed the rates as Sentara. For MY 2023, HSAG included members with enrollment in Optima or VA Premier prior to July 2023 in the rate for Sentara.

Table 3-18 shows that 91.6 percent of children in foster care and 90.7 percent of controls had an ambulatory care visit during MY 2024, and the difference was not statistically significant ($p=0.23$). The

rates for children in foster care were notably higher than controls for members enrolled with United and More Than One MCO (by 5.2 and 7.8 percentage points).

Rates could not be compared to a national Medicaid benchmark since this indicator is a custom indicator developed for this analysis. The rates for both children in foster care and controls increased from MY 2023 to MY 2024 by 4.8 and 2.7 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 2024. The disparity for members 2 years of age and older also existed during MY 2022 and MY 2023. For children in foster care, members 11 to 13 years of age were significantly less likely to have an ambulatory care visit during MY 2023; however, this disparity no longer existed during MY 2024 due to an increase in the rate for these members (by 7.9 percentage points). For children in foster care, male members were significantly less likely to have an ambulatory care visit during MY 2023; however, this disparity no longer existed during MY 2024 due to an increase in the rate for male members (by 5.6 percentage points). For children in foster care only, members in the Northern & Winchester region were significantly less likely to have an ambulatory care visit, while members in the Southwest region were significantly more likely for both children in foster care and controls. The disparity in the Southwest region also existed during MY 2022 and MY 2023. For children in foster care, members in the Central and Tidewater regions were significantly less likely to have an ambulatory care visit compared to members enrolled in other regions during MY 2023; however, these disparities no longer existed during MY 2024 due to increases in the rates for the Central and Tidewater regions (by 9.0 and 7.8 percentage points, respectively). 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 2024, while members enrolled with Sentara were significantly more likely. For children in foster care, members enrolled with Aetna were significantly less likely to have an ambulatory care visit compared to members enrolled with other MCOs during MY 2023; however, this disparity no longer existed during MY 2024 due to an increase in the rate for Aetna (by 8.2 percentage points).

ED Visits

Table 3-19 displays the MY 2022, MY 2023, and MY 2024 *ED Visits* rates among children in foster care and controls stratified by member characteristics. Additionally, 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 2022		MY 2023		MY 2024	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
All Eligible Members	26.9% ⁻	35.5%	26.7% ⁻	36.7%	28.7% ⁻	37.2%
Age Category						
≤ 2 Years	30.6%	48.7%	29.1%	47.3%	31.1%	46.9%
3 to 5 Years	19.6%	37.2%	22.7%	40.1%	26.2%	37.0%
6 to 10 Years	19.4%	30.0%	20.6%	31.6%	22.5%	32.4%
11 to 13 Years	24.6%	27.6%	25.1%	30.6%	23.3%	33.5%
≥ 14 Years	36.6%	34.4%	34.7%	35.2%	37.3%	37.2%

Category	MY 2022		MY 2023		MY 2024	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
Sex						
Male	25.3%	35.6%	25.0%	36.0%	28.4%	37.2%
Female	28.8%	35.4%	28.7%	37.4%	29.1%	37.2%
Race						
Black or African American	26.1%	38.7%	28.2%	37.3%	27.8%	39.7%
White	27.7%	34.5%	26.1%	36.7%	29.5%	36.4%
Other	17.1%	18.3%	22.4%	27.1%	23.8%	24.8%
Region						
Central	27.3%	34.3%	29.7%	40.7%	33.9%	43.6%
Charlottesville/Western	24.9%	32.4%	22.9%	30.6%	23.9%	32.2%
Northern & Winchester	26.1%	38.8%	24.0%	35.9%	24.4%	30.6%
Roanoke/Alleghany	29.7%	36.7%	29.1%	38.3%	32.1%	38.2%
Southwest	32.7%	40.8%	29.1%	40.5%	27.3%	39.8%
Tidewater	22.9%	32.7%	25.2%	34.4%	28.5%	36.3%
MCO						
Aetna	26.9%	36.9%	24.9%	40.3%	25.9%	38.2%
HealthKeepers	26.6%	35.5%	25.5%	35.1%	28.8%	38.8%
Molina	27.9%	35.2%	26.3%	37.6%	32.2%	33.6%
Sentara*	26.8%	34.1%	26.7%	36.4%	28.5%	36.7%
United	28.2%	43.2%	31.5%	40.6%	28.0%	32.6%
More Than One MCO	28.9%	38.6%	39.2%	31.6%	41.2%	45.1%

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

+ 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.

* HSAG combined Optima and VA Premier for MY 2022 in this year's report and displayed the rates as Sentara. For MY 2023, HSAG included members with enrollment in Optima or VA Premier prior to July 2023 in the rate for Sentara.

Table 3-19 shows that 28.7 percent of children in foster care and 37.2 percent of controls had an ED visit during MY 2024, and the difference was statistically significant ($p < 0.001$). The rates for children in foster care were notably lower than controls for members 2 years of age and younger, 3 to 5 years of age, 6 to 10 years of age, and 11 to 13 years of age (by 15.8, 10.8, 9.9, and 10.2 percentage points, respectively); male members (by 8.8 percentage points); Black or African American members (by 11.9 percentage points); members in the Central and Southwest regions (by 9.7 and 12.5 percentage points, respectively); and members enrolled with Aetna and HealthKeepers (by 12.3 and 10.0 percentage points, respectively).

Rates could not be compared to a national Medicaid benchmark since this indicator is a custom indicator developed for this analysis. The rate for both children in foster care and controls increased from MY 2023 to MY 2024 by 2.0 percentage points and 0.5 percentage points, respectively. For both

children in foster care and controls, members 6 to 10 years of age were significantly less likely to have an ED visit compared to members in other age groups during MY 2024. These disparities also existed during MY 2022 and MY 2023. For children in foster care only, members 11 to 13 years of age were significantly less likely to have an ED visit during MY 2024, while members 14 years of age and older were significantly more likely. The disparity for members 14 years of age and older also existed during MY 2022 and MY 2023. For both children in foster care and controls, members in the Charlottesville/Western and Northern & Winchester regions were significantly less likely to have an ED visit compared to members in other regions during MY 2024, while members in the Central region were significantly more likely. The disparities for the Central region and the Charlottesville/Western region also existed during MY 2023.

Inpatient Visits

Table 3-20 displays the MY 2022, MY 2023, and MY 2024 *Inpatient Visits* rates among children in foster care and controls stratified by member characteristics. Additionally, 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 2022		MY 2023		MY 2024	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
All Eligible Members	5.1%	4.2%	6.0% ⁺	4.8%	7.1% ⁺	4.4%
Age Category						
≤ 2 Years	3.4%	7.2%	5.6%	8.4%	6.3%	6.5%
3 to 5 Years	1.9%	1.8%	1.6%	1.4%	1.9%	2.3%
6 to 10 Years	2.5%	1.7%	3.8%	2.5%	4.4%	1.9%
11 to 13 Years	5.4%	4.4%	6.8%	4.5%	9.2%	6.0%
≥ 14 Years	10.2%	5.8%	11.0%	7.1%	12.4%	5.8%
Sex						
Male	3.7%	3.6%	4.5%	4.3%	5.7%	3.5%
Female	6.7%	5.0%	7.6%	5.3%	8.7%	5.3%
Race						
Black or African American	5.9%	3.8%	5.7%	4.3%	7.4%	3.8%
White	4.6%	4.5%	6.1%	5.0%	7.1%	4.7%
Other	6.1%	1.2%	5.9%	5.9%	3.0%	5.0%
Region						
Central	6.6%	3.9%	7.1%	5.8%	8.7%	5.0%
Charlottesville/Western	5.8%	4.4%	6.4%	5.2%	5.1%	6.2%
Northern & Winchester	4.2%	6.5%	4.6%	4.4%	6.0%	4.4%
Roanoke/Alleghany	5.3%	3.8%	6.8%	3.9%	10.2%	2.7%
Southwest	3.3%	4.0%	3.6%	3.8%	4.8%	4.0%
Tidewater	4.2%	3.0%	6.3%	5.0%	7.0%	3.2%

Category	MY 2022		MY 2023		MY 2024	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
MCO						
Aetna	4.3%	3.8%	5.5%	3.6%	5.5%	3.1%
HealthKeepers	4.4%	4.2%	4.4%	4.1%	6.7%	4.0%
Molina	5.0%	4.1%	6.7%	4.6%	7.0%	2.1%
Sentara*	5.8%	4.3%	6.9%	5.4%	7.9%	5.1%
United	4.3%	2.6%	5.9%	4.1%	6.2%	2.6%
More Than One MCO	4.8%	10.8%	5.1%	7.6%	5.9%	11.8%

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

+ 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.

* HSAG combined Optima and VA Premier for MY 2022 in this year's report and displayed the rates as Sentara. For MY 2023, HSAG included members with enrollment in Optima or VA Premier prior to July 2023 in the rate for Sentara.

Table 3-20 shows that 7.1 percent of children in foster care and 4.4 percent of controls had an inpatient visit during MY 2024, and the difference was statistically significant ($p < 0.001$). The rates for children in foster care were notably higher than controls for members 14 years of age and older (by 6.6 percentage points) and members in the Roanoke/Alleghany region (by 7.5 percentage points), while rates were notably lower than controls for members enrolled with More Than One MCO (by 5.9 percentage points).

Rates could not be compared to a national Medicaid benchmark since this indicator is a custom indicator developed for this analysis. The rate for children in foster care increased from MY 2023 to MY 2024 by 1.1 percentage points, while the rate for controls decreased by 0.4 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 2024, while members 14 years of age and older were significantly more likely. These disparities also existed during MY 2022 and MY 2023. For both children in foster care and controls, male members were significantly less likely to have an inpatient visit during MY 2024, while female members were significantly more likely. These disparities existed for children in foster care during MY 2022 and MY 2023. For children in foster care only, members in the Charlottesville/Western region were significantly less likely to have an inpatient visit compared to members in other regions during MY 2024, while members in the Roanoke/Alleghany region were significantly more likely.

Behavioral Health Encounters—Total

Table 3-21 displays the MY 2022, MY 2023, and MY 2024 Behavioral Health Encounters—Total rates among children in foster care and controls stratified by member characteristics. Additionally, 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 2022		MY 2023		MY 2024	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
All Eligible Members	65.4% ⁺	51.9%	68.5% ⁺	56.1%	74.3% ⁺	59.6%
Age Category						
≤ 2 Years	46.0%	34.6%	50.2%	37.2%	52.9%	39.1%
3 to 5 Years	52.0%	35.4%	55.0%	38.3%	65.1%	44.4%
6 to 10 Years	69.6%	53.6%	73.7%	62.1%	82.3%	63.6%
11 to 13 Years	79.4%	67.3%	83.0%	70.9%	81.4%	72.5%
≥ 14 Years	76.0%	64.7%	77.7%	67.6%	83.5%	72.9%
Sex						
Male	64.4%	52.1%	68.8%	57.1%	75.9%	61.4%
Female	66.5%	51.7%	68.2%	54.9%	72.4%	57.6%
Race						
Black or African American	64.3%	51.5%	67.6%	53.7%	74.1%	58.0%
White	66.3%	52.4%	68.9%	57.7%	74.4%	60.9%
Other	52.4%	45.1%	71.8%	45.9%	73.3%	52.5%
Region						
Central	65.0%	51.7%	64.9%	53.3%	74.4%	61.8%
Charlottesville/Western	63.2%	52.5%	69.6%	55.0%	73.1%	60.4%
Northern & Winchester	59.2%	41.7%	64.5%	47.2%	69.4%	51.2%
Roanoke/Alleghany	70.7%	58.2%	73.5%	60.5%	76.2%	60.2%
Southwest	70.4%	53.5%	74.0%	62.5%	76.7%	66.6%
Tidewater	64.9%	53.2%	65.9%	57.8%	75.4%	56.3%
MCO						
Aetna	62.8%	48.2%	63.0%	53.0%	69.3%	50.5%
HealthKeepers	66.4%	52.3%	69.6%	57.4%	74.9%	61.4%
Molina	61.6%	42.9%	57.2%	41.8%	67.1%	42.7%
Sentara*	64.6%	53.5%	69.8%	58.4%	76.2%	63.1%
United	66.2%	49.6%	68.0%	50.2%	66.3%	51.3%
More Than One MCO	88.0%	62.7%	83.5%	58.2%	90.2%	62.7%

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

+ 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.

* HSAG combined Optima and VA Premier for MY 2022 in this year's report and displayed the rates as Sentara. For MY 2023, HSAG included members with enrollment in Optima or VA Premier prior to July 2023 in the rate for Sentara.

Table 3-21 shows that 74.3 percent of children in foster care and 59.6 percent of controls had a behavioral health encounter during MY 2024, 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 difference being for members 3 to 5 and 6 to 10 years of age (by 20.7 and 18.7 percentage points, respectively); female members (by 14.8 percentage points); Black or African American members and members in the Other racial group (by 16.1 and 20.8 percentage points, respectively); members in the Northern & Winchester, Roanoke/Alleghany, and Tidewater regions (by 18.2, 16.0, and 19.1 percentage points, respectively); and members enrolled with Aetna, Molina, United, and More Than One MCO (by 18.8, 24.4, 15.0, and 27.5 percentage points, respectively).

Rates could not be compared to a national Medicaid benchmark since this indicator is a custom indicator developed for this analysis. The rates for both children in foster care and controls increased from MY 2023 to MY 2024 by 5.8 and 3.5 percentage points, respectively. For both children in foster care 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 compared to members in other age groups during MY 2024, while members 6 to 10, 11 to 13, and 14 years of age and older were significantly more likely. Most of these disparities also existed during MY 2022 and MY 2023. These identified disparities may reflect that behavioral health conditions are more likely to be diagnosed later in life. For both children in foster care and controls, male members were significantly more likely to have a behavioral health encounter during MY 2024, while female members were significantly less likely. 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 2024. For children in foster care, members in the Central region were significantly less likely to have a behavioral health encounter compared to members in other regions during MY 2023; however, this disparity no longer existed during MY 2024 due to an increase in the rate for the Central region (by 9.5 percentage points). For both children in foster care and controls, members enrolled with Aetna, Molina, and United were significantly less likely to have a behavioral health encounter compared to members enrolled with other MCOs during MY 2024, while members enrolled with Sentara were significantly more likely. For children in foster care only, members enrolled with More Than One MCO were significantly more likely to have a behavioral health encounter during MY 2024.

Behavioral Health Encounters—ARTS

Table 3-22 displays the MY 2022, MY 2023, and MY 2024 *Behavioral Health Encounters—ARTS* rates among children in foster care and controls stratified by member characteristics. Additionally, 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 2022		MY 2023		MY 2024	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
All Eligible Members	2.8% ⁺	1.5%	3.9% ⁺	1.8%	3.7% ⁺	2.1%

Category	MY 2022		MY 2023		MY 2024	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
Age Category						
≤ 2 Years	0.0%^	0.3%^	0.2%	0.2%	0.0%^	0.2%^
3 to 5 Years	0.2%^	0.0%^	0.5%	0.3%	0.2%	0.2%
6 to 10 Years	0.8%	0.2%	1.3%	0.7%	0.8%	0.8%
11 to 13 Years	1.8%	1.8%	4.9%	2.1%	4.0%	1.5%
≥ 14 Years	8.5%	4.2%	10.6%	4.9%	11.1%	6.3%
Sex						
Male	2.5%	1.3%	3.3%	2.1%	2.9%	1.8%
Female	3.1%	1.7%	4.5%	1.5%	4.7%	2.5%
Race						
Black or African American	1.7%	0.6%	2.6%	1.7%	3.2%	1.9%
White	3.4%	2.0%	4.3%	1.9%	4.1%	2.3%
Other	2.4%	1.2%	8.2%	1.2%	3.0%	1.0%
Region						
Central	2.4%	0.9%	3.5%	1.7%	3.8%	2.2%
Charlottesville/Western	3.5%	1.7%	4.0%	1.7%	3.5%	2.1%
Northern & Winchester	3.1%	2.2%	5.3%	2.5%	4.2%	2.9%
Roanoke/Alleghany	3.8%	2.1%	4.7%	2.4%	5.4%	2.0%
Southwest	1.8%	1.8%	3.1%	1.0%	2.4%	2.1%
Tidewater	2.0%	0.6%	3.0%	1.7%	3.0%	1.6%
MCO						
Aetna	2.0%	0.3%	3.9%	1.7%	4.4%	1.4%
HealthKeepers	2.8%	1.4%	4.6%	1.9%	4.1%	2.0%
Molina	1.8%	1.8%	1.5%	1.0%	2.8%	2.1%
Sentara*	2.9%	1.6%	3.8%	1.9%	3.5%	2.1%
United	3.0%	2.6%	2.7%	1.8%	4.1%	2.6%
More Than One MCO	7.2%	2.4%	3.8%	2.5%	2.0%	7.8%

Blue shading indicates that a disparity was identified (i.e., had a p-value less than 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 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.

* HSAG combined Optima and VA Premier for MY 2022 in this year's report and displayed the rates as Sentara. For MY 2023, HSAG included members with enrollment in Optima or VA Premier prior to July 2023 in the rate for Sentara.

Table 3-22 shows 3.7 percent of children in foster care and 2.1 percent of controls had a behavioral health encounter with ARTS during MY 2024, and the difference was statistically significant ($p < 0.001$).

The rates for children in foster care were notably lower than controls for members enrolled with More Than One MCO (by 5.8 percentage points).

Rates could not be compared to a national Medicaid benchmark since this indicator is a custom indicator developed for this analysis. The rate for children in foster care decreased from MY 2023 to MY 2024 by 0.2 percentage points, while the rate for controls increased by 0.3 percentage points. For both children in foster care and controls, members 3 to 5 years of age and 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 2024, while members 14 years of age and older were significantly more likely. The disparities identified for children in foster care members 6 to 10 years of age and 14 years of age and older also existed during MY 2022 and MY 2023. For children in foster care only, male members were significantly less likely to have a behavioral health encounter with ARTS during MY 2024, while female members were significantly more likely. For children in foster care only, members in the Roanoke/Alleghany region were significantly more likely to have a behavioral health encounter with ARTS during MY 2024 compared to other regions.

Behavioral Health Encounters—CMH Services

Table 3-23 displays the MY 2022, MY 2023, and MY 2024 Behavioral Health Encounters—CMH Services rates among children in foster care and controls stratified by member characteristics. Additionally, 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 2022		MY 2023		MY 2024	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
All Eligible Members	35.3% ⁺	20.0%	33.1% ⁺	19.3%	34.9% ⁺	20.1%
Age Category						
≤ 2 Years	9.2%	2.9%	9.0%	3.4%	10.3%	3.1%
3 to 5 Years	30.0%	16.7%	27.7%	16.1%	33.7%	17.6%
6 to 10 Years	40.9%	24.0%	38.6%	25.0%	45.0%	26.4%
11 to 13 Years	47.4%	30.6%	44.4%	27.4%	41.4%	26.3%
≥ 14 Years	45.3%	25.0%	42.1%	22.6%	39.4%	24.3%
Sex						
Male	34.5%	20.7%	32.8%	20.2%	36.3%	21.5%
Female	36.2%	19.2%	33.5%	18.3%	33.3%	18.7%
Race						
Black or African American	37.2%	19.7%	35.3%	21.1%	36.5%	22.9%
White	34.7%	20.4%	32.3%	18.8%	34.4%	19.2%
Other	23.2%	12.2%	24.7%	8.2%	25.7%	8.9%
Region						
Central	39.2%	17.9%	33.9%	15.8%	36.4%	19.7%

Category	MY 2022		MY 2023		MY 2024	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
Charlottesville/Western	33.0%	20.3%	33.3%	19.1%	35.2%	22.1%
Northern & Winchester	26.1%	11.1%	27.9%	10.4%	28.3%	9.4%
Roanoke/Alleghany	44.2%	27.2%	37.4%	26.9%	40.0%	22.9%
Southwest	33.2%	29.4%	34.8%	28.1%	34.8%	29.9%
Tidewater	34.2%	16.6%	30.8%	16.6%	32.9%	17.2%
MCO						
Aetna	35.2%	16.6%	30.1%	18.5%	27.6%	15.7%
HealthKeepers	34.0%	15.3%	32.4%	15.4%	33.5%	16.9%
Molina	32.9%	12.3%	26.3%	14.9%	25.9%	13.3%
Sentara*	35.7%	24.7%	34.9%	23.0%	38.4%	24.9%
United	35.5%	20.1%	30.6%	16.9%	28.5%	14.5%
More Than One MCO	50.6%	19.3%	45.6%	15.2%	54.9%	15.7%

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

+ 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.

** HSAG combined Optima and VA Premier for MY 2022 in this year's report and displayed the rates as Sentara. For MY 2023, HSAG included members with enrollment in Optima or VA Premier prior to July 2023 in the rate for Sentara.*

Table 3-23 shows that 34.9 percent of children in foster care and 20.1 percent of controls had a behavioral health encounter with CMH services during MY 2024, 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 3 to 5, 6 to 10, 11 to 13, and 14 years of age and older (by 16.1, 18.6, 15.1, and 15.1 percentage points, respectively); White members and members in the Other racial group (by 15.2 and 16.8 percentage points, respectively); members in the Central, Northern & Winchester, Roanoke/Alleghany, and Tidewater regions (by 16.7, 18.9, 17.1, and 15.7 percentage points, respectively); and members enrolled with HealthKeepers and More Than One MCO (by 16.6 and 39.2 percentage points, respectively).

Rates could not be compared to a national Medicaid benchmark since this indicator is a custom indicator developed for this analysis. The rates for both children in foster care and controls increased from MY 2023 to MY 2024 by 1.8 and 0.8 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 CMH services compared to members in other age groups during MY 2024, while members 6 to 10, 11 to 13, and 14 years of age and older were significantly more likely. These disparities also existed during MY 2022 and MY 2023. For children in foster care, members 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 2023; however, this disparity no longer existed during MY 2024 due to an increase in rate for members 3 to 5 years of age (by 6.0 percentage points). 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 CMH services compared to members

in other regions during MY 2024. This disparity also existed during MY 2022 and MY 2023. For children in foster care only, members in the Roanoke/Alleghany region were significantly more likely to have a behavioral health encounter with CMH services compared to members enrolled in other regions during MY 2024. This disparity also existed during MY 2022 and MY 2023. For both children in foster care and controls, members enrolled with Aetna and Molina were significantly less likely to have a behavioral health encounter with CMH services compared to members enrolled with other MCOs during MY 2024, while members enrolled with Sentara were significantly more likely. 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 2024.

Behavioral Health Encounters—RTC Services

Table 3-24 displays the MY 2022, MY 2023, and MY 2024 Behavioral Health Encounters—RTC Services rates among children in foster care and controls stratified by member characteristics. Additionally, 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. Please note, starting in July 2025, RTC placement and services became a carved-out service rather than an excluded service.

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

Category	MY 2022		MY 2023		MY 2024	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
All Eligible Members	5.5% ⁺	4.1%	9.2% ⁺	4.6%	11.7% ⁺	5.1%
Age Category						
≤ 2 Years	1.0%	1.9%	1.2%	2.7%	2.3%	2.3%
3 to 5 Years	4.9%	6.2%	5.1%	5.7%	10.7%	8.1%
6 to 10 Years	5.2%	2.6%	6.4%	3.2%	9.8%	4.0%
11 to 13 Years	5.8%	4.4%	11.7%	4.9%	14.1%	5.5%
≥ 14 Years	8.9%	5.2%	19.0%	6.3%	19.1%	5.6%
Sex						
Male	5.1%	4.1%	9.0%	4.9%	12.1%	5.7%
Female	5.9%	4.0%	9.5%	4.2%	11.2%	4.4%
Race						
Black or African American	5.5%	4.1%	8.7%	4.7%	12.4%	4.8%
White	5.4%	4.2%	9.3%	4.7%	11.4%	5.3%
Other	7.3%	0.0%	15.3%	2.4%	9.9%	3.0%
Region						
Central	5.8%	4.6%	10.0%	4.9%	14.0%	5.6%
Charlottesville/Western	7.0%	4.2%	9.2%	5.7%	9.0%	5.5%
Northern & Winchester	5.1%	4.9%	7.6%	4.6%	11.4%	6.8%
Roanoke/Alleghany	7.1%	4.3%	12.8%	5.6%	14.3%	4.3%
Southwest	2.0%	2.0%	4.2%	1.5%	5.6%	3.5%

Category	MY 2022		MY 2023		MY 2024	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
Tidewater	4.7%	3.8%	10.4%	4.8%	14.0%	4.4%
MCO						
Aetna	5.3%	4.8%	9.4%	4.1%	10.9%	3.8%
HealthKeepers	5.4%	4.0%	8.9%	4.0%	13.1%	6.9%
Molina	4.6%	3.2%	6.7%	3.1%	12.6%	1.4%
Sentara*	5.9%	4.2%	9.6%	5.1%	10.7%	4.9%
United	2.6%	2.1%	8.7%	4.1%	10.9%	1.0%
More Than One MCO	8.4%	6.0%	12.7%	8.9%	17.6%	9.8%

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

+ 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.

** HSAG combined Optima and VA Premier for MY 2022 in this year's report and displayed the rates as Sentara. For MY 2023, HSAG included members with enrollment in Optima or VA Premier prior to July 2023 in the rate for Sentara.*

Table 3-24 shows that 11.7 percent of children in foster care and 5.1 percent of controls had a behavioral health encounter with RTC services during MY 2024, and the difference was statistically significant ($p < 0.001$). The rates for children in foster care were notably higher than controls for members 11 to 13 years of age and 14 years of age and older (by 8.6 and 13.5 percentage points, respectively); female members (by 6.8 percentage points); Black or African American members and members in the Other racial group (by 7.6 and 6.9 percentage points, respectively); members in the Central, Roanoke/Alleghany, and Tidewater regions (by 8.4, 10.0, and 9.6 percentage points, respectively); and members enrolled with Aetna, Molina, United, and More Than One MCO (by 7.1, 11.2, 9.9, and 7.8 percentage points, respectively).

Rates could not be compared to a national Medicaid benchmark since this indicator is a custom indicator developed for this analysis. The rates for children in foster care and controls increased from MY 2023 to MY 2024 by 2.5 and 0.5 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 2024. This disparity also existed during MY 2022 and MY 2023. For children in foster care only, members 14 years of age and older were significantly more likely to have a behavioral health encounter with RTC services compared to members in other age groups during MY 2024. This disparity also existed during MY 2022 and MY 2023. For children in foster care, members 3 to 5 and 6 to 10 years of age were significantly less likely to have a behavioral health encounter with RTC services compared to members enrolled with other MCOs during MY 2023; however, this disparity no longer existed during MY 2024 due to increases in the rates for these groups (by 5.6 and 3.4 percentage points, respectively). For children in foster care only, members in the Charlottesville/Western and Southwest regions were significantly less likely to have a behavioral health encounter with RTC services compared to members in other regions during MY 2024, while members in the Central region were significantly more likely. The disparity for members in the Southwest region also existed during MY 2022 and MY 2023.

Behavioral Health Encounters—Therapeutic Services

Table 3-25 displays the MY 2022, MY 2023, and MY 2024 Behavioral Health Encounters—Therapeutic Services rates among children in foster care and controls stratified by member characteristics. Additionally, 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 2022		MY 2023		MY 2024	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
All Eligible Members	10.9% ⁺	6.0%	2.2%	1.5%	6.1% ⁺	1.8%
Age Category						
≤ 2 Years	1.0%	1.9%	0.0% [^]	0.0% [^]	0.0% [^]	0.0% [^]
3 to 5 Years	8.8%	9.1%	2.1%	1.3%	1.4%	0.8%
6 to 10 Years	12.6%	8.3%	4.4%	2.0%	5.1%	4.0%
11 to 13 Years	14.1%	7.3%	2.8%	3.0%	7.4%	2.7%
≥ 14 Years	15.8%	4.2%	1.2%	1.6%	13.6%	1.0%
Sex						
Male	12.3%	7.7%	2.5%	1.7%	6.6%	2.4%
Female	9.3%	4.0%	1.8%	1.3%	5.6%	1.1%
Race						
Black or African American	10.0%	6.1%	2.8%	1.7%	6.8%	1.8%
White	11.5%	6.2%	1.9%	1.5%	5.8%	1.8%
Other	6.1%	0.0%	1.2%	1.2%	5.0% [^]	0.0% [^]
Region						
Central	10.6%	4.9%	2.1%	0.6%	7.6%	2.2%
Charlottesville/Western	11.9%	9.3%	3.4%	2.8%	6.2%	2.8%
Northern & Winchester	6.5%	3.3%	0.7% [^]	0.0% [^]	3.4%	0.3%
Roanoke/Alleghany	12.0%	5.9%	3.4%	3.2%	8.8%	2.9%
Southwest	16.0%	9.4%	1.3%	0.4%	2.4%	0.3%
Tidewater	9.2%	3.9%	1.7%	2.0%	6.4%	1.2%
MCO						
Aetna	8.5%	7.5%	1.9%	1.1%	4.4%	1.7%
HealthKeepers	9.7%	4.2%	2.1%	0.8%	5.8%	1.5%
Molina	7.8%	3.2%	1.0%	2.1%	5.6%	2.8%
Sentara*	12.4%	7.2%	2.6%	1.9%	6.9%	1.9%
United	10.7%	4.7%	0.9%	2.7%	5.7%	1.6%
More Than One MCO	14.5%	7.2%	1.3%	1.3%	2.0%	2.0%

Blue shading indicates that a disparity was identified (i.e., had a p-value less than 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 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.
- * HSAG combined Optima and VA Premier for MY 2022 in this year's report and displayed the rates as Sentara. For MY 2023, HSAG included members with enrollment in Optima or VA Premier prior to July 2023 in the rate for Sentara.

Table 3-25 shows that 6.1 percent of children in foster care and 1.8 percent of controls had a behavioral health encounter with therapeutic services during MY 2024, and the difference was statistically significant ($p < 0.001$). The rates for children in foster care were notably higher than controls for members 14 years of age and older (by 12.6 percentage points) and members in the Central, Roanoke/Alleghany, and Tidewater regions (by 5.4, 5.9, and 5.2 percentage points, respectively).

Rates could not be compared to a national Medicaid benchmark since this indicator is a custom indicator developed for this analysis. The rates for both children in foster care and controls increased from MY 2023 to MY 2024 by 3.9 and 0.3 percentage points, respectively. For children in foster care only, members 3 to 5 years of age were significantly less likely to have a behavioral health encounter with therapeutic services compared to members in other age groups during MY 2024, while members 14 years of age and older were significantly more likely. For children in foster care, members 14 years of age and older were significantly less likely to have a behavioral health encounter with therapeutic services compared to members in other age groups during MY 2023; however, this disparity no longer existed during MY 2024 due to an increase in the rate for this group (by 12.4 percentage points). However, MY 2023 rates were impacted by the removal of the Healthcare Common Procedure Coding System (HCPCS) code H2020 from the code set, which was added back to the code set for the MY 2024 analysis. This code set change predominantly impacted results for members 11 to 13 years of age and members 14 years of age and older. For both children in foster care and controls, members in the Northern & Winchester region and the Southwest region were significantly less likely to have a behavioral health encounter with therapeutic services compared to members in other regions during MY 2024, while members in the Roanoke/Alleghany region were significantly more likely.

Behavioral Health Encounters—Traditional Services

Table 3-26 displays the MY 2022, MY 2023, and MY 2024 Behavioral Health Encounters—Traditional Services rates among children in foster care and controls stratified by member characteristics. Additionally, 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 2022		MY 2023		MY 2024	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
All Eligible Members	61.2% ⁺	47.9%	65.8% ⁺	53.8%	71.9% ⁺	57.6%

Category	MY 2022		MY 2023		MY 2024	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
Age Category						
≤ 2 Years	43.3%	33.7%	47.6%	37.0%	50.0%	38.9%
3 to 5 Years	44.8%	30.5%	52.0%	37.0%	61.2%	42.4%
6 to 10 Years	64.7%	48.3%	71.4%	59.2%	80.8%	61.7%
11 to 13 Years	76.4%	61.1%	80.0%	67.9%	79.4%	70.5%
≥ 14 Years	72.9%	61.4%	74.9%	64.4%	81.6%	69.8%
Sex						
Male	60.0%	48.3%	66.4%	54.5%	73.6%	59.7%
Female	62.6%	47.4%	65.2%	53.1%	70.0%	55.5%
Race						
Black or African American	59.5%	47.0%	64.7%	50.6%	71.5%	55.0%
White	62.4%	48.6%	66.2%	55.8%	72.2%	59.4%
Other	51.2%	42.7%	71.8%	45.9%	70.3%	52.5%
Region						
Central	60.8%	48.0%	62.5%	51.1%	71.5%	60.2%
Charlottesville/Western	59.6%	49.4%	65.4% [^]	53.8% [^]	69.4%	59.5%
Northern & Winchester	54.6%	39.9%	60.8%	47.2%	66.5%	50.6%
Roanoke/Alleghany	64.6%	49.8%	70.5%	54.3%	74.7%	57.0%
Southwest	68.6%	49.9%	72.3%	61.0%	76.2%	63.9%
Tidewater	60.8%	49.9%	64.4%	55.6%	73.9%	53.3%
MCO						
Aetna	57.0%	44.7%	60.8%	48.9%	66.9%	48.5%
HealthKeepers	63.0%	49.1%	67.8%	55.6%	72.5%	60.1%
Molina	56.6%	39.7%	55.2%	38.7%	64.3%	41.3%
Sentara*	60.5%	48.5%	66.4%	56.4%	73.9%	60.7%
United	60.3%	47.4%	64.8%	47.9%	63.7%	49.7%
More Than One MCO	88.0%	59.0%	81.0%	55.7%	88.2%	60.8%

Blue shading indicates that a disparity was identified (i.e., had a p-value less than 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 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.

* HSAG combined Optima and VA Premier for MY 2022 in this year's report and displayed the rates as Sentara. For MY 2023, HSAG included members with enrollment in Optima or VA Premier prior to July 2023 in the rate for Sentara.

Table 3-26 shows that 71.9 percent of children in foster care and 57.6 percent of controls had a behavioral health encounter with traditional services during MY 2024, 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 being for members 3 to 5 and 6 to 10 years of age (by 18.8 and 19.1 percentage points, respectively); female members (by 14.5 percentage points); Black or African American members and members in the Other racial group (by 16.5 and 17.8 percentage points, respectively); members in the Northern & Winchester, Roanoke/Alleghany, and Tidewater regions (by 15.9, 17.7, and 20.6 percentage points, respectively); and members enrolled with Aetna, Molina, and More Than One MCO (by 18.4, 23.0, and 27.4 percentage points, respectively).

Rates could not be compared to a national Medicaid benchmark since this indicator is a custom indicator developed for this analysis. The rates for both children in foster care and controls increased from MY 2023 to MY 2024 by 6.1 and 3.8 percentage points, respectively. For both children in foster care 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 traditional services compared to members in other age groups during MY 2024, while members 6 to 10 years of age, 11 to 13 years of age, and 14 years of age and older were significantly more likely. Most of these disparities also existed during MY 2022 and MY 2023. For both children in foster care and controls, male members were significantly more likely to have a behavioral health visit with traditional services during MY 2024, while female members were significantly less likely. 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 2024, while members in the Southwest region were significantly more likely. Most of these disparities also existed during MY 2022 and MY 2023. For children in foster care only, members in the Central region were significantly less likely to have a behavioral health visit with traditional services compared to members in other regions during MY 2023; however, this disparity no longer existed during MY 2024 due to an increase in the rate for members in the Central region (by 9.0 percentage points). For both children in foster care and controls, members enrolled with Aetna, Molina, and United were significantly less likely to have a behavioral health encounter with traditional services compared to members enrolled with other MCOs during MY 2024, while members enrolled with Sentara were significantly more likely. For children in foster care only, members enrolled with More Than One MCO were significantly more likely to have a behavioral health encounter with traditional services during MY 2024. This disparity also existed during MY 2022 and MY 2023.

Overall Service Utilization

Table 3-27 displays the MY 2022, MY 2023, and MY 2024 *Overall Service Utilization* rates among children in foster care and controls stratified by member characteristics. Additionally, 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 2022		MY 2023		MY 2024	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
All Eligible Members	89.7% ⁻	91.6%	89.7% ⁻	91.8%	93.8%	93.5%
Age Category						
≤ 2 Years	92.4%	93.8%	93.9%	94.8%	96.4%	96.0%

Category	MY 2022		MY 2023		MY 2024	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
3 to 5 Years	88.5%	91.2%	88.6%	91.3%	91.7%	92.8%
6 to 10 Years	88.0%	90.9%	88.5%	92.3%	93.8%	93.1%
11 to 13 Years	91.3%	92.5%	88.5%	90.9%	93.8%	93.8%
≥ 14 Years	89.3%	90.6%	89.5%	90.0%	93.5%	92.6%
Sex						
Male	89.8%	92.0%	88.2%	91.5%	93.5%	92.7%
Female	89.6%	91.2%	91.4%	92.1%	94.1%	94.4%
Race						
Black or African American	88.3%	90.1%	88.7%	90.1%	93.8%	92.5%
White	90.6%	92.5%	90.0%	92.8%	93.5%	94.2%
Other	85.4%	89.0%	95.3%	85.9%	98.0%	92.1%
Region						
Central	87.0%	90.4%	86.8%	90.0%	94.1%	93.8%
Charlottesville/Western	91.1%	92.7%	91.1%	91.9%	93.3%	94.2%
Northern & Winchester	86.6%	92.0%	87.6%	90.3%	90.4%	92.5%
Roanoke/Alleghany	93.9%	93.2%	94.4%	92.3%	95.0%	93.0%
Southwest	94.0%	95.3%	93.7%	95.4%	96.8%	96.5%
Tidewater	87.2%	87.6%	85.9%	91.4%	93.2%	91.4%
MCO						
Aetna	85.9%	89.7%	85.4%	89.8%	92.2%	90.1%
HealthKeepers	90.4%	91.5%	89.8%	92.9%	92.9%	95.1%
Molina	86.3%	86.8%	83.5%	88.7%	86.7%	83.2%
Sentara*	90.2%	92.2%	91.1%	91.8%	95.4%	95.2%
United	89.7%	92.7%	89.0%	90.9%	92.2%	87.0%
More Than One MCO	97.6%	100.0%	98.7%	96.2%	100.0%	94.1%

Blue shading indicates that a disparity was identified (i.e., had a p-value less than 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 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.

* HSAG combined Optima and VA Premier for MY 2022 in this year's report and displayed the rates as Sentara. For MY 2023, HSAG included members with enrollment in Optima or VA Premier prior to July 2023 in the rate for Sentara.

Table 3-27 shows that 93.8 percent of children in foster care and 93.5 percent of controls had an ambulatory care visit, ED visit, inpatient visit, or behavioral health encounter (i.e., any service) during MY 2024, and the difference was not statistically significant ($p=0.67$). The rate for children in foster care was notably higher than controls for members in the Other racial group (by 5.9 percentage points) and

members enrolled with United and More Than One MCO (by 5.2 and 5.9 percentage points, respectively).

Rates could not be compared to a national Medicaid benchmark since this indicator is a custom indicator developed for this analysis. The rates for both children in foster care and controls increased from MY 2023 to MY 2024 by 4.1 and 1.7 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 2024. This disparity also existed during MY 2022 and MY 2023. For children in foster care only, members 3 to 5 years of age were significantly less likely to utilize any service during MY 2024. For children in foster care, male members were significantly less likely to utilize any service during MY 2023; however, this disparity no longer existed during MY 2024 due to an increase in rate for male members (by 5.3 percentage points).

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 during MY 2024. This disparity also existed during MY 2022 and MY 2023. For children in foster care only, members in the Northern & Winchester region were significantly less likely to utilize any service compared to members in other regions during MY 2024. For children in foster care, members in the Central region and Tidewater region were significantly less likely to utilize any service during MY 2023; however, these disparities no longer existed during MY 2024 due to an increase in the rate for these regions (by 7.3 percentage points). For both children in foster care and controls, members enrolled with Molina were significantly less likely to utilize any service compared to members enrolled with other MCOs during MY 2024, while members enrolled with Sentara were significantly more likely. For children in foster care, members enrolled with Aetna were significantly less likely to utilize any service during MY 2023; however, this disparity no longer existed during MY 2024 due to an increase in the rate for this region (by 6.8 percentage points).

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 8,654 members and the 6,973 members in the children receiving adoption assistance eligible population and study population, respectively. The eligible population consisted of children in the adoption assistance program younger than 18 years of age as of January 1, 2024, and receiving healthcare coverage from DMAS at any time during MY 2024. Table 4-1 displays the distribution of the children receiving adoption assistance eligible population by age category, sex, race, region, MCO, and Medicaid population.

Table 4-1—Distribution of Children Receiving Adoption Assistance (n=8,654)

Category	Number	Percent
Age Category		
≤ 2 years	320	3.7%
3 to 5 years	941	10.9%
6 to 10 years	2,586	29.9%
11 to 13 years	1,899	21.9%
≥ 14 years	2,908	33.6%
Sex		
Male	4,713	54.5%
Female	3,941	45.5%
Race		
Black or African American	2,484	28.7%
White	5,939	68.6%
Other	231	2.7%
Region		
Central	1,788	20.7%
Charlottesville/Western	1,421	16.4%
Northern & Winchester	1,328	15.3%
Roanoke & Alleghany	1,488	17.2%
Southwest	1,136	13.1%
Tidewater	1,488	17.2%
Latest MCO in the Measurement Year		
Aetna	849	9.8%
HealthKeepers	2,566	29.7%
Molina	452	5.2%
Sentara	3,904	45.1%
United	759	8.8%
Other*	124	1.4%

Category	Number	Percent
Latest Medicaid Population in the Measurement Year		
MLTSS	273	3.2%
Acute	8,257	95.4%
Other*	124	1.4%

[†] Members with Unknown Region are included in the Eligible Population but are not displayed in this table.

* Includes members only enrolled in FFS.

While children receiving adoption assistance were disproportionately male (54.5 percent) compared to the general population in Virginia, which was 49.4 percent male in 2023, children receiving adoption assistance were proportionately White (68.6 percent) compared to the general population in Virginia, which was 68.3 percent White in 2023.^{43,44} Children receiving adoption assistance resided mostly in the Central (20.7 percent), Roanoke & Alleghany (17.2 percent), and Tidewater (17.2 percent) regions. Children receiving adoption assistance were most likely to be enrolled with HealthKeepers (29.7 percent) or Sentara (45.1 percent). Children receiving adoption assistance were most likely to be in the Acute population (95.4 percent). Only 1.4 percent of children receiving adoption assistance were only enrolled in FFS during MY 2024.⁴⁵

The study population consisted of members in the children receiving adoption assistance eligible population who were continuously enrolled in Medicaid managed care with any MCO or a combination of MCOs during the study period and who could be matched to a control (i.e., a member not in a child welfare program). Continuous enrollment was defined as no more than 45 days of enrollment gaps during MY 2024. Among the adoption assistance eligible population, 80.6 percent (n=6,973) of children met the requirements for the study population, compared to 39.5 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.⁴⁶ Demographic characteristics of the study population did not differ substantially from the eligible population, except that there were 2.1 percentage points more children 2 years of age and younger and 2.2 percentage points fewer children enrolled with Sentara. The disproportionate exclusion of infants can be attributed to the inability of children born more than 45 days into the measurement year to meet the continuous enrollment criteria, since these children would have an enrollment gap greater than 45 days.

Table B-2 and Table B-5 present the demographic and health characteristics of continuously enrolled children receiving adoption assistance and the continuously enrolled controls prior to matching (n=6,998). Continuously enrolled children receiving adoption assistance were more likely to be older, male, and White, more likely to be enrolled with Sentara, and less likely to be in the MLTSS population 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

⁴³ United States Census Bureau. Virginia QuickFacts. Available at: <https://www.census.gov/quickfacts/VA>. Accessed on: Nov 18, 2025.

⁴⁴ MY 2024 census data were not available as of October 2025.

⁴⁵ Adoption assistance children may temporarily move to FFS and may not be enrolled with an MCO during the measurement year.

⁴⁶ Virginia Department of Social Services. Adoptive Assistance Screening Tool. Available at: https://www.dss.virginia.gov/files/division/dfs/ap/intro_page/forms/032-04-0091-09-eng.pdf. Accessed on: Nov 18, 2025.

regions. In terms of health characteristics, continuously enrolled children receiving adoption assistance were more likely to have diagnoses for several health conditions, notably ADHD, anxiety, developmental disorders, and mood disorders. Additionally, children receiving adoption assistance were more likely to have ED 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 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 the child welfare program.

HSAG was able to match 99.6 percent (n=6,973) 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 2024. 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 MY 2024 rates for All Eligible Members to the national Medicaid 50th percentile, discusses the change in the rates for All Eligible Members from MY 2023 to MY 2024, and discusses health disparities identified in MY 2024.

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 2022 and MY 2023 may also be

impacted by the COVID-19 pandemic; however, rate comparisons within MY 2022 and MY 2023 (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 2022, MY 2023, and MY 2024 *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. Additionally, 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 2022		MY 2023		MY 2024	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
All Eligible Members	0.0%	55.3%	0.0%	47.6%	50.0%	74.3%
Sex						
Male	0.0%^	46.7%^	—	63.6%^	66.7%^	80.0%^
Female	0.0%^	60.9%^	0.0%	30.0%^	0.0%^	66.7%^
Race						
Black or African American	0.0%^	50.0%^	—	42.9%^	100.0%^	72.7%^
White	0.0%^	56.7%^	0.0%	50.0%^	33.3%^	75.0%^
Other	—	—	—	—	—	—
Region						
Central	—	66.7%^	—	40.0%^	—	75.0%
Charlottesville/Western	0.0%^	33.3%^	—	0.0%^	—	100.0%^
Northern & Winchester	—	83.3%^	—	66.7%^	100.0%^	50.0%^
Roanoke/Alleghany	0.0%^	22.2%^	—	71.4%^	0.0%^	60.0%^
Southwest	—	60.0%^	0.0%	0.0%^	—	75.0%
Tidewater	—	75.0%^	—	100.0%^	100.0%^	100.0%^

Category	MY 2022		MY 2023		MY 2024	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
MCO						
Aetna	—	100.0%^	—	100.0%^	—	66.7%
HealthKeepers	0.0%^	57.1%^	0.0%	100.0%^	100.0%^	85.7%^
Molina	—	25.0%^	—	0.0%^	0.0%^	50.0%^
Sentara*	0.0%^	62.5%^	—	41.7%^	100.0%^	80.0%^
United	—	42.9%^	—	0.0%^	—	75.0%
More Than One MCO	—	0.0%^	—	—	—	—

Blue shading indicates that a disparity was identified (i.e., had a p-value less than 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 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.

* HSAG combined Optima and VA Premier for MY 2022 in this year's report and displayed the rates as Sentara. For MY 2023, HSAG included members with enrollment in Optima or VA Premier prior to July 2023 in the rate for Sentara.

Table 4-2 shows that 50.0 percent of children receiving adoption assistance and 74.3 percent of controls who turned 15 months old during MY 2024 received six or more well-child visits with a PCP, and the difference was not statistically significant ($p=0.56$). 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 2024 rate for children receiving adoption assistance was below the national Medicaid 50th percentile, while controls were above the national Medicaid 50th percentile. The rate of well-child visits for children receiving adoption assistance and controls increased from MY 2023 to MY 2024 by 50.0 and 26.7 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 2022, MY 2023, and MY 2024 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. Additionally, 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 2022		MY 2023		MY 2024	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
All Eligible Members	79.2%	65.7%	78.6%	60.0%	85.7%	78.1%
Sex						
Male	86.4%	66.7%	78.9%	61.9%	74.1% ⁺	75.0% ⁺
Female	73.1%	64.7%	78.3%	57.1%	100.0% ⁺	87.5% ⁺
Race						
Black or African American	91.7%	64.3%	68.8%	55.6%	92.9%	57.1%
White	74.3%	70.0%	84.6%	64.0%	87.9%	82.6%
Other	100.0% ⁺	0.0% ⁺	—	0.0% ⁺	0.0% ⁺	100.0% ⁺
Region						
Central	80.0%	58.3%	87.5%	75.0%	66.7%	33.3%
Charlottesville/Western	100.0% ⁺	40.0% ⁺	50.0%	50.0%	100.0% ⁺	100.0% ⁺
Northern & Winchester	60.0%	80.0%	55.6%	57.1%	71.4% ⁺	100.0% ⁺
Roanoke/Alleghany	75.0%	87.5%	90.9%	60.0%	88.2%	84.6%
Southwest	72.7%	50.0%	87.5%	33.3%	100.0% ⁺	50.0% ⁺
Tidewater	100.0% ⁺	66.7% ⁺	75.0% ⁺	100.0% ⁺	88.9%	71.4%
MCO						
Aetna	100.0% ⁺	50.0% ⁺	100.0% ⁺	75.0% ⁺	50.0%	66.7%
HealthKeepers	71.4% ⁺	100.0% ⁺	71.4%	36.4%	100.0% ⁺	80.0% ⁺
Molina	66.7%	80.0%	100.0% ⁺	80.0% ⁺	66.7% ⁺	100.0% ⁺
Sentara*	87.0%	57.1%	73.3%	61.5%	88.2%	60.0%
United	57.1% ⁺	100.0% ⁺	100.0% ⁺	100.0% ⁺	85.7% ⁺	100.0% ⁺
More Than One MCO	100.0% ⁺	0.0% ⁺	50.0% ⁺	100.0% ⁺	—	—

Blue shading indicates that a disparity was identified (i.e., had a p-value less than 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 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.

* HSAG combined Optima and VA Premier for MY 2022 in this year's report and displayed the rates as Sentara. For MY 2023, HSAG included members with enrollment in Optima or VA Premier prior to July 2023 in the rate for Sentara.

Table 4-3 shows that 85.7 percent of children receiving adoption assistance and 78.1 percent of controls who turned 30 months old during MY 2024 received two or more well-child visits with a PCP, and the difference was not statistically significant ($p=0.38$). 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 2024 rates for children receiving adoption assistance and controls were above the national Medicaid 50th percentile. The rate of well-child visits for children receiving adoption assistance and controls increased from MY 2023 to MY 2024 by 7.1 and 18.1 percentage points, respectively. There were no disparities identified for children receiving adoption assistance.

Child and Adolescent Well-Care Visits (WCV)

Table 4-4 displays the MY 2022, MY 2023, and MY 2024 *Child and Adolescent Well-Care Visits* rates among children receiving adoption assistance and controls stratified by member characteristics. Additionally, 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 children receiving adoption assistance population includes members 18 years of age and younger, this indicator has been modified to include the corresponding ages.

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

Category	MY 2022		MY 2023		MY 2024	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
All Eligible Members	45.9%	47.3%	48.3%	50.4%	51.8%	52.1%
Age Category						
3 to 11 Years	48.8%	50.5%	52.6%	54.5%	56.9%	55.2%
12 to 17 Years	45.4%	47.5%	46.1%	49.1%	50.0%	51.4%
18 to 21 Years	34.0%	30.0%	38.8%	35.9%	34.7%	39.1%
Sex						
Male	45.6%	47.6%	47.0%	51.1%	51.3%	51.9%
Female	46.2%	47.0%	49.8%	49.5%	52.4%	52.4%
Race						
Black or African American	50.6%	48.7%	54.8%	51.9%	56.3%	53.0%
White	43.7%	46.7%	45.4%	50.0%	49.8%	51.4%
Other	48.3%	49.2%	47.9%	42.2%	54.3%	60.2%
Region						
Central	41.9%	47.0%	45.0%	48.2%	49.2%	48.8%

Category	MY 2022		MY 2023		MY 2024	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
Charlottesville/Western	51.5%	46.2%	52.1%	51.7%	54.8%	53.4%
Northern & Winchester	35.8%	55.3%	35.5%	56.3%	41.4%	61.0%
Roanoke/Alleghany	48.0%	44.0%	45.9%	48.6%	51.2%	48.4%
Southwest	45.2%	39.9%	51.2%	40.7%	51.2%	47.0%
Tidewater	52.5%	50.4%	59.8%	55.5%	62.3%	54.9%
MCO						
Aetna	38.6%	48.6%	41.8%	45.0%	45.0%	49.1%
HealthKeepers	46.9%	51.5%	50.0%	54.7%	53.6%	55.7%
Molina	30.8%	36.0%	38.9%	42.3%	43.6%	46.1%
Sentara*	48.2%	45.4%	49.8%	49.0%	53.4%	50.8%
United	40.2%	46.7%	44.7%	51.8%	48.4%	53.0%
More Than One MCO	61.8%	52.2%	42.7%	56.8%	52.8%	51.9%

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

+ 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.

* HSAG combined Optima and VA Premier for MY 2022 in this year's report and displayed the rates as Sentara. For MY 2023, HSAG included members with enrollment in Optima or VA Premier prior to July 2023 in the rate for Sentara.

Table 4-4 shows that 51.8 percent of children receiving adoption assistance and 52.1 percent of controls had a well-care visit with a PCP or an OB/GYN during MY 2024, and the difference was not statistically significant ($p=0.72$). The rates for children receiving adoption assistance were notably higher than controls for members in the Tidewater region (by 7.4 percentage points). Conversely, the rates for children receiving adoption assistance were notably lower than controls for members in the Other racial group (by 5.9 percentage points) and members in the Northern & Winchester region (by 19.6 percentage points).

MY 2024 rates for children receiving adoption assistance and controls were below the national Medicaid 50th percentile for members 3 to 11 and 12 to 17 years of age. The rate for the 18 to 21 years age group was not comparable to the national Medicaid 50th percentile, since members 19 to 21 years of age are excluded from this study population, and older members are less likely to have well-care visits. The rates of well-care visits for both children receiving adoption assistance and controls increased from MY 2023 to MY 2024 by 3.5 and 1.7 percentage points, respectively. For both children receiving adoption assistance and controls, members 18 to 21 years of age were significantly less likely to have a well-care visit compared to members in other age groups during MY 2024, while members 3 to 11 years of age were significantly more likely. These disparities also existed during MY 2022 and MY 2023. For children receiving adoption assistance only, members 12 to 17 years of age were significantly less likely to have a well-care visit compared to members in other age groups during MY

2024. This disparity also existed during MY 2023. For children receiving adoption assistance, male members were significantly less likely to have a well-care visit during MY 2023; however, this disparity no longer existed during MY 2024 due to an increase in the rate for male members (by 4.3 percentage points). For children receiving adoption assistance only, White members were significantly less likely to have a well-care visit compared to members in other racial groups during MY 2024, while Black or African American members were significantly more likely. These disparities also existed during MY 2022 and MY 2023. For both children receiving adoption assistance and controls, members in the Central region were significantly less likely to have a well-care visit compared to members in other regions during MY 2024, while members in the Tidewater region were significantly more likely. Most of these disparities also existed during MY 2022 and MY 2023. For children receiving adoption assistance only, members in the Northern & Winchester region were significantly less likely to have a well-care visit compared to members in other regions during MY 2024, while members in the Charlottesville/Western region were significantly more likely. These disparities also existed during MY 2022 and MY 2023. 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 2024. These disparities also existed during MY 2022 and MY 2023. For children receiving adoption assistance only, members enrolled with Aetna were significantly less likely to have a well-care visit compared to members enrolled with other MCOs during MY 2024, while members enrolled with Sentara were significantly more likely. These disparities also existed during MY 2022 and MY 2023.

Oral Health

Annual Dental Visit (ADV)

Table 4-5 displays the MY 2022, MY 2023, and MY 2024 *Annual Dental Visit* rates among children receiving adoption assistance and controls stratified by member characteristics. Additionally, 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.⁴⁷ 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 2022		MY 2023		MY 2024	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
All Eligible Members	57.3% ⁺	54.3%	59.7% ⁺	57.9%	62.6%	61.5%

⁴⁷ HSAG modified the specifications for this measure in MY 2023 to allow visits with any provider authorized to provide dental services but restricted visits to those with a CDT code to ensure only visits for dental services were counted. Please see the Healthcare Utilization Analysis section in the Overview and Methodology for more details regarding these updates.

Category	MY 2022		MY 2023		MY 2024	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
Age Category						
≤ 2 Years	47.3%	35.3%	45.9%	45.7%	64.3%	59.2%
3 to 5 Years	58.0%	55.0%	64.3%	62.2%	67.9%	64.6%
6 to 10 Years	60.7%	60.5%	64.1%	63.5%	68.2%	67.1%
11 to 13 Years	61.7%	56.6%	63.3%	59.4%	63.5%	60.1%
≥ 14 Years	52.0%	48.0%	52.7%	51.1%	55.4%	56.6%
Sex						
Male	56.4%	53.4%	58.9%	57.2%	61.3%	60.8%
Female	58.4%	55.4%	60.6%	58.8%	64.2%	62.3%
Race						
Black or African American	58.6%	51.8%	61.9%	56.2%	64.5%	59.2%
White	56.7%	55.3%	58.6%	58.8%	61.7%	62.4%
Other	59.1%	55.6%	61.2%	54.1%	67.2%	62.8%
Region						
Central	59.5%	54.5%	60.4%	61.3%	63.2%	64.3%
Charlottesville/Western	59.7%	54.8%	62.1%	56.3%	61.9%	59.4%
Northern & Winchester	51.7%	65.4%	54.7%	67.8%	58.8%	68.3%
Roanoke/Alleghany	52.7%	51.2%	57.0%	54.5%	61.8%	61.5%
Southwest	67.6%	50.4%	66.0%	52.3%	68.5%	57.2%
Tidewater	54.3%	50.3%	58.7%	54.4%	62.6%	57.5%
MCO						
Aetna	48.9%	49.7%	52.8%	55.5%	53.9%	62.2%
HealthKeepers	59.2%	57.8%	62.6%	62.2%	65.1%	64.4%
Molina	43.4%	44.6%	45.7%	50.7%	55.4%	58.1%
Sentara*	59.1%	53.9%	60.4%	56.5%	63.4%	60.2%
United	53.8%	51.8%	57.8%	55.4%	62.5%	59.9%
More Than One MCO	64.7%	65.7%	64.5%	65.8%	71.7%	63.5%

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

+ 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.

* HSAG combined Optima and VA Premier for MY 2022 in this year's report and displayed the rates as Sentara. For MY 2023, HSAG included members with enrollment in Optima or VA Premier prior to July 2023 in the rate for Sentara.

Table 4-5 shows that 62.6 percent of children receiving adoption assistance and 61.5 percent of controls had a dental visit during MY 2024, and the difference was not statistically significant ($p=0.17$).

The rates for children receiving adoption assistance were notably higher than controls for members 2 years of age and younger (by 5.1 percentage points), Black or African American members (by 5.3 percentage points), members in the Southwest and Tidewater regions (by 11.3 and 5.1 percentage points, respectively), and members enrolled with More Than One MCO (by 8.2 percentage points). Conversely, the rates for children receiving adoption assistance were notably lower than controls for members in the Northern & Winchester region (by 9.5 percentage points) and members enrolled with Aetna (by 8.3 percentage points).

Rates could not be compared to a benchmark for this indicator since national Medicaid benchmarks were not available after MY 2021. The rates for both children receiving adoption assistance and controls increased from MY 2023 to MY 2024 by 2.9 and 3.6 percentage points, respectively. For both children receiving adoption assistance and controls, members 14 years of age and older were significantly less likely to have a dental visit compared to members in other age groups during MY 2024, while members 6 to 10 years of age were significantly more likely. These disparities also existed during MY 2022 and MY 2023. For children receiving adoption assistance, members 2 years of age and younger were significantly less likely to have a dental visit compared to members in other age groups during MY 2023; however, this disparity no longer existed during MY 2024 due to an increase in the rate for members 2 years of age and younger (by 18.4 percentage points). For children receiving adoption assistance only, members 3 to 5 years of age were significantly more likely to have a dental visit compared to members in other age groups during MY 2024. This disparity also existed during MY 2023. For children receiving adoption assistance only, male members were significantly less likely to have a dental visit during MY 2024, while female members were significantly more likely. For children receiving adoption assistance only, White members were significantly less likely to have a dental visit compared to members in other racial groups during MY 2024, while Black or African American members were significantly more likely. These disparities also existed during MY 2023. For children receiving adoption assistance only, members in the Northern & Winchester region were significantly less likely to have a dental visit compared to members in other regions during MY 2024, while members in the Southwest region were significantly more likely. These disparities also existed during MY 2022 and MY 2023. For children receiving adoption assistance, members in the Roanoke/Alleghany region were significantly less likely to have a dental visit during MY 2023; however, this disparity no longer existed during MY 2024 due to an increase in the rate for the Roanoke/Alleghany region (by 4.8 percentage points). 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 2024. This disparity also existed during MY 2022 and MY 2023. For children receiving adoption assistance only, members enrolled with Aetna and Molina were significantly less likely to have a dental visit compared to members enrolled with other MCOs during MY 2024. These disparities also existed during MY 2022 and MY 2023.

Preventive Dental Services (PDENT-CH)

Table 4-6 displays the MY 2022, MY 2023, and MY 2024 *Preventive Dental Services* rates among children receiving adoption assistance and controls stratified by member characteristics. Additionally, member characteristics with identified health disparities are indicated with shading. The *Preventive Dental Services* indicator measures the percentage of members 1 to 20 years of age eligible for EPSDT services who received at least one preventive dental service during the measurement year. Since the children receiving adoption assistance population includes members 18 years of age and younger, this indicator has been modified to include the corresponding ages.

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

Category	MY 2022		MY 2023		MY 2024	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
All Eligible Members	53.2% ⁺	49.5%	55.3% ⁺	53.2%	58.1%	56.5%
Age Category						
≤ 2 Years	46.2%	29.0%	42.3%	38.3%	60.5%	42.9%
3 to 5 Years	57.0%	52.3%	62.0%	59.0%	65.2%	62.8%
6 to 10 Years	58.0%	58.0%	61.5%	60.9%	65.5%	64.3%
11 to 13 Years	57.3%	51.7%	58.8%	54.9%	59.4%	55.1%
≥ 14 Years	45.7%	41.0%	46.4%	44.4%	48.3%	49.1%
Sex						
Male	52.9%	49.1%	55.2%	53.0%	57.1%	56.3%
Female	53.5%	49.9%	55.5%	53.5%	59.3%	56.7%
Race						
Black or African American	54.4%	47.3%	58.5%	52.0%	60.4%	54.4%
White	52.6%	50.4%	54.0%	54.0%	57.0%	57.4%
Other	55.8%	50.8%	52.9%	49.7%	61.3%	55.4%
Region						
Central	56.0%	50.8%	57.2%	58.1%	58.3%	59.5%
Charlottesville/Western	54.6%	49.3%	57.4%	51.6%	57.1%	53.9%
Northern & Winchester	47.6%	60.7%	50.8%	63.5%	55.5%	63.7%
Roanoke/Alleghany	47.5%	44.4%	51.2%	48.7%	56.4%	55.4%
Southwest	65.0%	46.2%	62.0%	47.2%	63.4%	52.2%
Tidewater	50.2%	46.0%	54.5%	49.1%	58.9%	53.4%
MCO						
Aetna	45.0%	45.0%	48.8%	50.2%	51.0%	55.7%
HealthKeepers	55.0%	53.1%	58.3%	57.6%	60.8%	59.8%
Molina	37.1%	37.5%	41.1%	46.2%	51.4%	52.1%
Sentara*	55.2%	49.1%	56.1%	51.8%	58.1%	55.2%
United	49.3%	47.4%	54.2%	50.9%	58.9%	55.2%
More Than One MCO	61.8%	58.8%	56.6%	63.2%	66.7%	59.3%

Blue shading indicates that a disparity was identified (i.e., had a p-value less than 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 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.

* HSAG combined Optima and VA Premier for MY 2022 in this year's report and displayed the rates as Sentara. For MY 2023, HSAG included members with enrollment in Optima or VA Premier prior to July 2023 in the rate for Sentara.

Table 4-6 shows that 58.1 percent of children receiving adoption assistance and 56.5 percent of controls had at least one preventive dental service during MY 2024, and the difference was not statistically significant ($p=0.05$). The rates for children receiving adoption assistance were notably higher than controls for members 2 years of age and younger (by 17.6 percentage points), Black or African American members and members in the Other racial group (by 6.0 and 5.9 percentage points, respectively), members in the Southwest and Tidewater regions (by 11.2 and 5.5 percentage points, respectively), and members enrolled with More Than One MCO (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 8.2 percentage points).

Rates could not be compared to a benchmark since national Medicaid benchmarks were not available for this indicator. The rates for both children receiving adoption assistance and controls increased from MY 2023 to MY 2024 by 2.8 and 3.3 percentage points, respectively. For both children receiving adoption assistance and controls, members 14 years of age and older were significantly less likely to have a preventive dental service compared to members in other age groups during MY 2024, while members 3 to 5 and 6 to 10 years of age were significantly more likely. Most of these disparities also existed during MY 2022 and MY 2023. For children receiving adoption assistance, members 2 years of age and younger were significantly less likely to have a preventive dental service during MY 2023; however, this disparity no longer existed during MY 2024 due to an increase in the rate for members 2 years of age and younger (by 18.2 percentage points). For children receiving adoption assistance only, White members were significantly less likely to have a preventive dental service compared to members in other racial groups during MY 2024, while Black or African American members were significantly more likely. These disparities also existed during MY 2023. For children receiving adoption assistance only, members in the Southwest region were significantly more likely to have a preventive dental service compared to members in other regions during MY 2024. This disparity also existed during MY 2022 and MY 2023. For children receiving adoption assistance, members in the Northern & Winchester region and the Roanoke/Alleghany region were significantly less likely to have a preventive dental service compared to members in other regions during MY 2023; however, these disparities no longer existed during MY 2024 due to increases in the rates for the Northern & Winchester region and Roanoke/Alleghany region (by 4.7 and 5.2 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 2024. These disparities also existed during MY 2022 and MY 2023. For children receiving adoption assistance only, members enrolled with Aetna and Molina were significantly less likely to have a preventive dental service compared to members enrolled with other MCOs during MY 2024. These disparities also existed during MY 2022 and MY 2023.

Oral Evaluation, Dental Services (OEV-CH)

Table 4-7 displays the MY 2022, MY 2023, and MY 2024 *Oral Evaluation, Dental Services* rates among children receiving adoption assistance and controls stratified by member characteristics. Additionally, 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 2022		MY 2023		MY 2024	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
All Eligible Members	52.1% ⁺	48.1%	54.1% ⁺	51.9%	56.9%	55.6%
Age Category						
≤ 2 Years	46.2%	26.9%	42.9%	37.5%	60.5%	41.2%
3 to 5 Years	56.4%	50.7%	61.2%	57.4%	64.9%	61.6%
6 to 10 Years	56.7%	56.2%	59.5%	58.8%	64.3%	62.8%
11 to 13 Years	56.2%	49.1%	57.5%	52.7%	57.8%	54.3%
≥ 14 Years	44.7%	40.8%	45.7%	44.3%	47.3%	48.9%
Sex						
Male	51.7%	47.7%	54.2%	51.6%	55.7%	55.2%
Female	52.6%	48.6%	54.1%	52.2%	58.4%	56.0%
Race						
Black or African American	53.9%	46.4%	57.3%	51.0%	59.5%	54.0%
White	51.3%	48.9%	52.8%	52.4%	55.7%	56.3%
Other	53.0%	48.1%	52.4%	48.7%	60.2%	55.9%
Region						
Central	53.8%	49.1%	55.6%	56.8%	57.9%	59.1%
Charlottesville/Western	54.4%	48.0%	56.3%	50.0%	56.3%	53.6%
Northern & Winchester	47.1%	59.3%	50.3%	62.3%	55.0%	63.6%
Roanoke/Alleghany	46.6%	42.6%	50.5%	47.6%	54.5%	54.1%
Southwest	62.3%	44.9%	58.9%	43.9%	60.2%	48.9%
Tidewater	50.2%	45.5%	53.7%	49.0%	58.2%	53.3%
MCO						
Aetna	43.2%	43.5%	47.8%	48.6%	49.8%	55.1%
HealthKeepers	54.4%	52.1%	57.2%	56.2%	60.1%	59.3%
Molina	37.5%	36.5%	39.7%	44.9%	49.8%	51.4%
Sentara*	53.8%	47.7%	54.6%	50.4%	56.8%	54.1%
United	48.9%	45.2%	52.7%	50.5%	57.6%	54.1%
More Than One MCO	57.4%	54.4%	60.5%	60.5%	63.0%	57.4%

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

+ 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.

* HSAG combined Optima and VA Premier for MY 2022 in this year's report and displayed the rates as Sentara. For MY 2023, HSAG included members with enrollment in Optima or VA Premier prior to July 2023 in the rate for Sentara.

Table 4-7 shows that 56.9 percent of children receiving adoption assistance and 55.6 percent of controls received a comprehensive or periodic oral evaluation during MY 2024, and the difference was not statistically significant ($p=0.11$). The rates for children receiving adoption assistance were notably higher than controls for members 2 years of age and younger (by 19.3 percentage points), Black or African American members (by 5.5 percentage points), members in the Southwest region (by 11.3 percentage points), and members enrolled with More Than One MCO (by 5.6 percentage points). Conversely, the rates for children receiving adoption assistance were notably lower than controls for members in the Northern & Winchester region (by 8.6 percentage points) and members enrolled with Aetna (by 5.3 percentage points).

For all eligible members, the MY 2024 rates for children receiving adoption assistance and controls were above the national Medicaid 50th percentile for members under 21 years of age. However, members 19 to 20 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 rates for both children receiving adoption assistance and controls increased from MY 2023 to MY 2024 by 2.8 and 3.7 percentage points, respectively. For both children receiving adoption assistance and controls, members 14 years of age and older were significantly less likely to have an oral evaluation compared to members in other age groups during MY 2024, while members 3 to 5 and 6 to 10 years of age were significantly more likely. Most of these disparities also existed during MY 2022 and MY 2023. For children receiving adoption assistance, members 2 years of age and younger were significantly less likely to have an oral evaluation compared to members in other age groups during MY 2023; however, this disparity no longer existed during MY 2024 due to an increase in the rate for members 2 years of age and younger (by 17.6 percentage points). For children receiving adoption assistance only, male members were significantly less likely to have an oral evaluation during MY 2024, while female members were significantly more likely. For children receiving adoption assistance only, White members were significantly less likely to have an oral evaluation compared to members in other racial groups during MY 2024, while Black or African Americans members were significantly more likely. These disparities also existed during MY 2022 and MY 2023. For children receiving adoption assistance, members in the Southwest region were significantly more likely to have an oral evaluation compared to members in other regions during MY 2024. This disparity also existed during MY 2022 and MY 2023. For children receiving adoption assistance, members in the Northern & Winchester region and the Roanoke/Alleghany region were significantly less likely to have an oral evaluation compared to members in other regions during MY 2023; however, these disparities no longer existed during MY 2024 due to increases in the rates for members in the Northern & Winchester region and the Roanoke/Alleghany region (by 4.7 and 4.0 percentage points, respectively). For both children receiving adoption assistance and controls, members enrolled with HealthKeepers were significantly more likely to have an oral evaluation compared to members enrolled with other MCOs during MY 2024. This disparity also existed during MY 2022 and MY 2023. For children receiving adoption assistance only, members enrolled with Aetna and Molina were significantly less likely to have an oral evaluation compared to members enrolled with other MCOs during MY 2024. These disparities also existed during MY 2022 and MY 2023.

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

Table 4-8 displays the MY 2022, MY 2023, and MY 2024 *Topical Fluoride for Children—Dental or Oral Health Services* rates among children receiving adoption assistance and controls stratified by member characteristics. Additionally, 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 2022		MY 2023		MY 2024	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
All Eligible Members	23.3% ⁺	19.5%	25.6% ⁺	22.7%	26.8% ⁺	24.5%
Age Category						
≤ 2 Years	18.6%	17.9%	25.7%	18.7%	26.3%	24.3%
3 to 5 Years	26.4%	21.7%	31.7%	25.2%	29.8%	29.0%
6 to 10 Years	26.8%	24.0%	30.1%	28.1%	33.0%	29.3%
11 to 13 Years	25.5%	20.2%	26.3%	24.3%	27.6%	24.5%
≥ 14 Years	18.1%	14.7%	19.4%	16.3%	19.6%	18.7%
Sex						
Male	22.9%	19.4%	25.7%	23.0%	25.8%	24.9%
Female	23.7%	19.6%	25.5%	22.4%	27.9%	24.0%
Race						
Black or African American	23.6%	17.0%	28.0%	21.1%	28.2%	21.8%
White	23.1%	20.4%	24.4%	23.4%	26.3%	25.4%
Other	23.8%	24.9%	28.7%	22.7%	23.7%	29.9%
Region						
Central	24.4%	21.3%	26.2%	24.2%	30.4%	26.7%
Charlottesville/Western	22.4%	17.8%	27.7%	23.2%	25.2%	23.3%
Northern & Winchester	22.7%	29.4%	25.5%	30.6%	27.6%	32.6%
Roanoke/Alleghany	19.3%	14.2%	21.7%	19.3%	21.2%	22.8%
Southwest	30.9%	16.9%	28.9%	18.4%	27.3%	17.1%
Tidewater	21.3%	17.6%	24.4%	20.2%	28.7%	23.3%
MCO						
Aetna	16.6%	17.6%	21.2%	22.8%	19.7% [^]	24.5% [^]
HealthKeepers	24.1%	23.8%	26.9%	24.8%	31.6%	26.7%
Molina	16.8%	13.7%	18.7%	20.1%	21.0%	25.2%
Sentara*	24.4%	17.9%	26.3%	21.7%	25.9%	23.0%
United	23.7%	18.1%	25.0%	21.1%	26.3%	24.4%
More Than One MCO	20.6%	16.2%	22.4%	28.9%	15.1%	25.0%

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

+ 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.

* HSAG combined Optima and VA Premier for MY 2022 in this year's report and displayed the rates as Sentara. For MY 2023, HSAG included members with enrollment in Optima or VA Premier prior to July 2023 in the rate for Sentara.

Table 4-8 shows that 26.8 percent of children receiving adoption assistance and 24.5 percent of controls received at least two topical fluoride applications as dental or oral health services during MY 2024, and the difference was statistically significant ($p=0.002$). The rates for children receiving adoption assistance were notably higher than controls for Black or African American members (by 6.4 percentage points) and members in the Southwest and Tidewater regions (by 10.2 and 5.4 percentage points, respectively). Conversely, the rates for children receiving adoption assistance were notably lower than controls for members in the Other racial group (by 6.2 percentage points) and members enrolled with More Than One MCO (by 9.9 percentage points).

For all eligible members, the MY 2024 rates for both children receiving adoption assistance and controls were above the national Medicaid 50th percentile for members under 21 years of age. However, members 19 to 20 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 rates for both children receiving adoption assistance and controls increased from MY 2023 to MY 2024 by 1.2 and 1.8 percentage points, respectively. For both children receiving adoption assistance and controls, members 14 years of age and older were significantly less likely to have at least two topical fluoride applications compared to members in other age groups during MY 2024, while members 6 to 10 years of age were significantly more likely. These disparities also existed during MY 2022 and MY 2023. For both children receiving adoption assistance and controls, members in the Central region were significantly more likely to have at least two topical fluoride applications compared to members in other regions during MY 2024. For children receiving adoption assistance only, 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 2024. This disparity also existed during MY 2022 and MY 2023. For both children receiving adoption assistance and controls, members enrolled with HealthKeepers were significantly more likely to have at least two topical fluoride applications compared to members enrolled with other MCOs during MY 2024. For children receiving adoption assistance only, 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 2024. This disparity also existed during MY 2022 and MY 2023.

Behavioral Health

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

Table 4-9 displays the MY 2022, MY 2023, and MY 2024 *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* rates among children receiving adoption assistance and controls stratified by member characteristics. Additionally, 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 2022		MY 2023		MY 2024	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
All Eligible Members	53.7%	59.7%	60.7%	50.9%	61.1%	57.8%
Age Category						
3 to 5 Years	—	—	—	—	100.0% [^]	—
6 to 10 Years	75.0%	83.3%	46.2%	70.0%	73.9%	58.3%
11 to 13 Years	43.8%	65.4%	69.2%	40.6%	80.0%	64.3%
≥ 14 Years	54.3%	52.5%	59.5%	53.0%	50.8%	53.2%
Sex						
Male	60.3%	55.2%	59.7%	54.3%	63.8%	51.2%
Female	49.5%	62.8%	61.5%	49.3%	58.3%	61.6%
Race						
Black or African American	54.9%	51.9%	49.1%	40.0%	56.3%	55.3%
White	52.7%	64.4%	67.9%	54.7%	63.6%	59.0%
Other	100.0%	—	0.0% [^]	66.7% [^]	100.0%	—
Region						
Central	50.9%	63.6%	52.8%	70.8%	58.8%	52.2%
Charlottesville/Western	60.9%	54.5%	51.4%	60.9%	50.0%	46.7%
Northern & Winchester	50.0%	50.0%	73.1%	53.8%	59.1%	50.0%
Roanoke/Alleghany	65.4%	53.8%	60.0%	33.3%	75.0%	76.5%
Southwest	58.3% [^]	100.0% [^]	80.0%	25.0%	57.1%	53.3%
Tidewater	43.8%	61.9%	67.6%	40.0%	64.7%	61.1%
MCO						
Aetna	50.0%	66.7%	87.5%	45.5%	58.8%	60.0%
HealthKeepers	53.2%	71.4%	58.5%	48.1%	62.5%	65.0%
Molina	55.6%	50.0%	71.4%	62.5%	83.3%	50.0%
Sentara*	54.1%	57.5%	59.8%	49.1%	60.0%	55.6%
United	0.0% [^]	42.9% [^]	50.0%	75.0%	50.0% [^]	0.0% [^]
More Than One MCO	100.0% [^]	100.0% [^]	50.0% [^]	100.0% [^]	—	—

Blue shading indicates that a disparity was identified (i.e., had a p-value less than 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 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.

* HSAG combined Optima and VA Premier for MY 2022 in this year's report and displayed the rates as Sentara. For MY 2023, HSAG included members with enrollment in Optima or VA Premier prior to July 2023 in the rate for Sentara.

Table 4-9 shows that 61.1 percent of children receiving adoption assistance and 57.8 percent of controls had a follow-up visit with a mental health provider within seven days after discharge during MY 2024, and the difference was not statistically significant ($p=0.57$). The rates for children receiving adoption assistance were notably higher than controls for members 11 to 13 years of age (by 15.7 percentage points) and male members (by 12.6 percentage points). While there were large rate differences between children receiving adoption assistance and controls for members 6 to 10 years of age, members in the Central and Northern/Winchester regions, and members enrolled with Molina and United, these rates had small denominators, so the rates may be less reliable.

For all eligible members, the MY 2024 rates for both children receiving adoption assistance and controls were above the national Medicaid 50th percentile for members 6 to 17 years of age. The rates for both children receiving adoption assistance and controls increased from MY 2023 to MY 2024 by 0.4 and 6.9 percentage points, respectively. For children receiving adoption assistance only, members 14 years of age and older were significantly less likely to have a follow-up visit within seven days after discharge with a mental health provider compared to members in other age groups during MY 2024, while members 11 to 13 years of age were significantly more likely. For children receiving adoption assistance, Black or African American members were significantly less likely to have a follow-up visit within seven days after discharge with a mental health provider compared to members in other racial groups during MY 2023; however, this disparity no longer existed during MY 2024 due to an increase in the rate for Black or African American members (by 7.2 percentage points).

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

Table 4-10 displays the MY 2022, MY 2023, and MY 2024 *Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up* rates among children receiving adoption assistance and controls stratified by member characteristics. Additionally, 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 2022		MY 2023		MY 2024	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
All Eligible Members	84.4%	79.3%	71.2%	77.8%	79.3%	85.1%
Age Category						
3 to 5 Years	100.0% [^]	—	100.0% [^]	100.0% [^]	100.0% [^]	—
6 to 10 Years	100.0% [^]	75.0% [^]	72.7%	66.7%	85.7%	72.7%
11 to 13 Years	94.7%	79.2%	90.9%	66.7%	77.3%	93.3%
≥ 14 Years	71.0%	81.8%	59.0%	84.2%	77.8%	85.7%
Sex						
Male	84.8%	80.0%	71.8%	80.8%	73.5%	86.4%
Female	83.9%	78.6%	70.6%	75.7%	87.9%	84.0%
Race						
Black or African American	85.7%	76.9%	66.7%	85.7%	71.4%	92.9%
White	85.7%	80.0%	73.3%	73.2%	83.3%	80.0%
Other	0.0% [^]	—	100.0% [^]	100.0% [^]	—	100.0% [^]
Region						
Central	92.9%	61.5%	57.1%	78.9%	85.7%	90.0%
Charlottesville/Western	66.7%	85.7%	77.8%	77.8%	100.0% [^]	85.7% [^]
Northern & Winchester	88.9%	55.6%	60.0%	85.7%	72.7% [^]	100.0% [^]
Roanoke/Alleghany	91.7%	90.9%	92.3%	64.3%	83.3%	70.0%
Southwest	87.5% [^]	100.0% [^]	80.0% [^]	100.0% [^]	66.7%	60.0%
Tidewater	72.2%	91.7%	80.0%	77.8%	63.2% [^]	100.0% [^]
MCO						
Aetna	75.0%	66.7%	87.5%	87.5%	100.0% [^]	—
HealthKeepers	88.9%	63.6%	73.9%	61.9%	65.6%	90.9%
Molina	80.0% [^]	100.0% [^]	50.0% [^]	100.0% [^]	100.0% [^]	50.0% [^]
Sentara*	81.8%	88.9%	68.8%	84.0%	86.1%	85.7%
United	100.0% [^]	100.0% [^]	66.7%	83.3%	75.0%	50.0%
More Than One MCO	100.0% [^]	—	—	100.0% [^]	100.0% [^]	—

Blue shading indicates that a disparity was identified (i.e., had a p-value less than 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 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.

* HSAG combined Optima and VA Premier for MY 2022 in this year's report and displayed the rates as Sentara. For MY 2023, HSAG included members with enrollment in Optima or VA Premier prior to July 2023 in the rate for Sentara.

Table 4-10 shows that 79.3 percent of children receiving adoption assistance and 85.1 percent of controls had a follow-up visit for mental illness within 30 days of an ED visit during MY 2024, and the difference was not statistically significant ($p=0.41$). 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 2024 rates for both children receiving adoption assistance and controls were above the national Medicaid 50th percentile for members 6 to 17 years of age. The rates for both children receiving adoption assistance and controls increased from MY 2023 to MY 2024 by 8.1 and 7.3 percentage points, respectively. For children receiving adoption assistance, members 14 years of age and older were significantly less likely to have a follow-up visit for mental illness within 30 days of an ED visit compared to members in other age groups during MY 2023; however, this disparity no longer existed during MY 2024 due to an increase in the rate for members 14 years of age and older (by 18.8 percentage points). For children receiving adoption assistance only, members enrolled with HealthKeepers were significantly less likely to have a follow-up visit for mental illness within 30 days of an ED visit compared to members enrolled with other MCOs.

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

Table 4-11 displays the MY 2022, MY 2023, and MY 2024 *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. Additionally, 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.

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 2022		MY 2023		MY 2024	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
All Eligible Members	37.6%	33.2%	34.9%	31.9%	34.5%	38.3%
Age Category						
3 to 5 Years	50.0%	60.0%	16.7%	50.0%	40.0%	100.0%
6 to 10 Years	36.2%	25.0%	30.1%	25.4%	34.0%	34.0%
11 to 13 Years	39.0%	26.5%	32.9%	36.8%	34.6%	35.0%
≥ 14 Years	37.1%	41.2%	40.9%	32.1%	34.1%	42.3%

Category	MY 2022		MY 2023		MY 2024	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
Sex						
Male	36.7%	31.4%	32.5%	26.8%	33.1%	42.0%
Female	39.1%	35.8%	39.4%	42.3%	37.0%	32.4%
Race						
Black or African American	33.8%	24.4%	37.3%	33.3%	35.0%	42.9%
White	39.7%	35.5%	34.2%	31.7%	34.3%	36.2%
Other	25.0%	50.0%	0.0%	25.0%	33.3%	50.0%
Region						
Central	32.0%	27.0%	30.5%	33.3%	33.9%	30.4%
Charlottesville/Western	29.5%	31.3%	36.1%	32.1%	29.2%	45.5%
Northern & Winchester	29.3%	37.0%	37.5%	43.5%	35.4%	37.5%
Roanoke/Alleghany	43.1%	38.9%	31.5%	24.1%	37.4%	18.8%
Southwest	58.7%	41.4%	44.4%	37.5%	48.9%	78.3%
Tidewater	36.7%	26.3%	36.2%	31.0%	27.7%	34.3%
MCO						
Aetna	43.5%	25.0%	33.3%	26.7%	40.6%	45.5%
HealthKeepers	28.7%	25.0%	28.3%	23.8%	29.4%	33.3%
Molina	30.0%	20.0%	22.2%	42.9%	40.0%	28.6%
Sentara*	43.4%	40.2%	39.5%	34.8%	37.3%	41.2%
United	42.1%	37.5%	38.5%	50.0%	34.5%	40.0%
More Than One MCO	33.3%	0.0%	30.0%	40.0%	11.1%	—

Blue shading indicates that a disparity was identified (i.e., had a p-value less than 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 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.

* HSAG combined Optima and VA Premier for MY 2022 in this year's report and displayed the rates as Sentara. For MY 2023, HSAG included members with enrollment in Optima or VA Premier prior to July 2023 in the rate for Sentara.

Table 4-11 shows that 34.5 percent of children receiving adoption assistance and 38.3 percent of controls with two or more antipsychotic prescriptions received blood glucose and cholesterol testing during MY 2024, and the difference was not statistically significant ($p=0.34$). The rate for children receiving adoption assistance was notably higher than controls for members in the Roanoke/Alleghany region (by 18.6 percentage points). Conversely, the rates for children receiving adoption assistance were notably lower than controls for members 14 years of age and older (by 8.2 percentage points), male members (by 8.9 percentage points), Black or African American members (by 7.9 percentage

points), and members in the Charlottesville/Western and Tidewater regions (by 16.3 and 6.6 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 in the Other racial group, members in the Southwest region, and members enrolled with Molina and United, these rates had small denominators, so the rates may be less reliable.

For all eligible members, the MY 2024 rate for children receiving adoption assistance was below the national Medicaid 50th percentile, while the rate for controls was above the national Medicaid 50th percentile. The rate for children receiving adoption assistance decreased from MY 2023 to MY 2024 by 0.4 percentage points, while the rate for controls increased by 6.4 percentage points. For both children receiving adoption assistance and controls, members in the Southwest region were significantly more likely to receive blood glucose and cholesterol testing compared to members in other regions during MY 2024.

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

Table 4-12 displays the MY 2022, MY 2023, and MY 2024 Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics rates among children receiving adoption assistance and controls stratified by member characteristics. Additionally, 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.

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 2022		MY 2023		MY 2024	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
All Eligible Members	58.9%	53.3%	54.2%	61.7%	63.2%	70.9%
Age Category						
3 to 5 Years	50.0%	50.0%	55.6%	—	60.0%	—
6 to 10 Years	66.7%	30.8%	55.6%	57.9%	66.7%	85.7%
11 to 13 Years	48.6%	66.7%	57.1%	64.7%	63.2%	64.7%
≥ 14 Years	59.6%	57.1%	50.9%	62.5%	61.7%	66.7%
Sex						
Male	56.7%	35.5%	51.2%	55.6%	62.5%	66.7%
Female	62.5%	72.4%	58.6%	70.8%	63.9%	75.0%
Race						
Black or African American	57.4%	55.6%	55.0%	65.0%	70.8%	77.8%
White	59.3%	52.4%	53.9%	61.5%	59.2%	67.6%
Other	100.0%	—	—	0.0% [^]	100.0%	—

Category	MY 2022		MY 2023		MY 2024	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
Region						
Central	50.0%	58.3%	53.1%	50.0%	52.8%	70.0%
Charlottesville/Western	70.0%	66.7%	42.9%	80.0%	68.2%	72.7%
Northern & Winchester	52.9%	50.0%	41.7%	50.0%	52.6%	62.5%
Roanoke/Alleghany	67.5%	50.0%	61.1%	73.3%	74.4%	66.7%
Southwest	60.0%	50.0%	83.3%	20.0%	42.9%	87.5%
Tidewater	56.8%	44.4%	50.0%	66.7%	68.0%	66.7%
MCO						
Aetna	66.7%	50.0%	72.7%^	100.0%^	85.7%	75.0%
HealthKeepers	63.0%	56.3%	61.7%	55.6%	63.0%	70.6%
Molina	66.7%^	100.0%^	75.0%^	100.0%^	66.7%	50.0%
Sentara*	53.9%	46.7%	46.4%	60.6%	61.0%	69.0%
United	66.7%	71.4%	28.6%^	100.0%^	66.7%^	100.0%^
More Than One MCO	66.7%	—	75.0%	60.0%	50.0%	—

Blue shading indicates that a disparity was identified (i.e., had a p-value less than 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 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.

* HSAG combined Optima and VA Premier for MY 2022 in this year's report and displayed the rates as Sentara. For MY 2023, HSAG included members with enrollment in Optima or VA Premier prior to July 2023 in the rate for Sentara.

Table 4-12 shows that 63.2 percent of children receiving adoption assistance and 70.9 percent of controls with a new prescription for an antipsychotic medication had documentation of psychosocial care as first-line treatment during MY 2024, and the difference was not statistically significant ($p=0.30$). The rates for children receiving adoption assistance were notably lower than controls for White members (by 8.4 percentage points). 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 2024 rates for both children receiving adoption assistance and controls were above the national Medicaid 50th percentile. The rates for both children receiving adoption assistance and controls increased from MY 2023 to MY 2024 by 9.0 and 9.2 percentage points, respectively. There were no disparities identified for children receiving adoption assistance during MY 2024.

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

Table 4-13 displays the MY 2022, MY 2023, and MY 2024 *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 2022, MY 2023, and MY 2024 *Follow-Up Care for Children Prescribed ADHD Medication—One-Month Follow-Up* rates among children receiving adoption assistance and controls stratified by member characteristics. Additionally, 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 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 2022		MY 2023		MY 2024	
	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate	Children in Foster Care Rate	Control Rate
One-Month	52.9%	62.9%	51.7%	58.9%	51.6%	55.8%
Two-Months	68.9%	80.6%	69.3%	77.2%	75.8%	75.8%
Three-Months	80.9%	87.0%	78.3%	83.9%	82.8%	83.2%
Six-Months	91.4%	94.6%	84.7%	92.4%	91.9%	92.0%
Nine-Months	94.6%	96.5%	91.3%	95.6%	94.7%	95.0%

Table 4-13 shows that 51.6 percent of children receiving adoption assistance had a follow-up visit within one month of when their first ADHD medication was dispensed, and 94.7 percent of children receiving adoption assistance had a follow-up visit within nine months. Additionally, the rates for children receiving adoption assistance were 4.2, 0.4, 0.1, and 0.3 percentage points lower than controls for a follow-up visit within one month, 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 than controls within one month of when their first ADHD medication was dispensed, but had similar rates of follow-up compared to controls for all other follow-up periods.

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 2022		MY 2023		MY 2024	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
All Eligible Members	52.9%	62.9%	51.7%	58.9%	51.6%	55.8%

Category	MY 2022		MY 2023		MY 2024	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
Age Category						
6 to 10 Years	53.6%	67.3%	53.7%	60.8%	55.4%	60.6%
11 to 13 Years	51.3%	55.5%	47.4%	54.8%	44.4%	46.0%
Sex						
Male	51.3%	59.5%	53.0%	60.1%	51.2%	57.8%
Female	55.4%	69.5%	50.0%	56.3%	52.1%	52.3%
Race						
Black or African American	47.6%	58.5%	48.2%	51.4%	53.3%	44.0%
White	55.6%	65.4%	52.7%	62.7%	51.1%	59.9%
Other	50.0%	75.0%	57.1%	57.1%	44.4%	100.0%
Region						
Central	48.0%	60.8%	57.7%	55.4%	51.5%	61.4%
Charlottesville/Western	57.1%	65.9%	50.9%	64.4%	58.5%	58.3%
Northern & Winchester	40.0%	67.7%	51.2%	62.5%	40.0%	63.3%
Roanoke/Alleghany	63.0%	55.4%	41.8%	57.4%	44.7%	41.1%
Southwest	65.7%	79.4%	55.2%	63.2%	51.2%	78.6%
Tidewater	43.4%	59.7%	53.2%	56.0%	58.0%	45.3%
MCO						
Aetna	36.8%	61.1%	62.5%	58.3%	45.2%	60.9%
HealthKeepers	48.8%	56.6%	51.7%	63.2%	58.6%	54.3%
Molina	83.3%	35.7%	50.0%	33.3%	50.0%	33.3%
Sentara*	57.4%	69.6%	51.5%	58.3%	48.8%	58.6%
United	45.5%	69.2%	42.9%	51.9%	52.4%	50.0%
More Than One MCO	40.0%	33.3%	33.3%	80.0%	33.3%	50.0%

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

+ 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.

* HSAG combined Optima and VA Premier for MY 2022 in this year's report and displayed the rates as Sentara. For MY 2023, HSAG included members with enrollment in Optima or VA Premier prior to July 2023 in the rate for Sentara.

Table 4-14 shows that 51.6 percent of children receiving adoption assistance and 55.8 percent of controls had a follow-up visit within one month after the first ADHD medication was dispensed during MY 2024, and the difference was not statistically significant ($p=0.30$). The rates for children receiving adoption assistance were notably higher than controls for Black or African American members (by 9.3 percentage points) and members in the Tidewater region (by 12.7 percentage points). Conversely, the

rates for children receiving adoption assistance were notably lower than controls for members 6 to 10 years of age (by 5.2 percentage points); male members (by 6.6 percentage points); White members (by 8.8 percentage points); members in the Central, Northern & Winchester, and Southwest regions (by 9.9, 23.3, and 27.4 percentage points, respectively); and members enrolled with Sentara (by 9.8 percentage points). While there were also large rate differences for members in the Other racial group and members enrolled with Aetna, Molina, and More Than One MCO, these rates had small denominators, so the rates may be less reliable.

For all eligible members, the MY 2024 rates for both children receiving adoption assistance and controls were above the national Medicaid 50th percentile. The rates for both children receiving adoption assistance and controls decreased from MY 2023 to MY 2024 by 0.1 and 3.1 percentage points, respectively. There were no disparities identified for children receiving adoption assistance during MY 2024.

Substance Use

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

Table 4-15 displays the MY 2022, MY 2023, and MY 2024 *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. Additionally, 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. 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 4-15—Rates of Initiation and Engagement of SUD Treatment—Initiation of SUD Treatment Among Children Receiving Adoption Assistance and Controls

Category	MY 2022		MY 2023		MY 2024	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
All Eligible Members	42.3%	37.5%	45.1%	33.8%	50.0%	43.6%
Age Category						
11 to 13 Years	33.3%	50.0%	25.0%	12.5%	75.0%	71.4%
≥ 14 Years	43.5%	36.2%	46.8%	36.4%	48.1%	39.6%
Sex						
Male	44.0%	43.8%	43.3%	27.5%	31.3%	46.4%
Female	40.7%	31.3%	47.6%	41.2%	75.0%	40.7%
Race						
Black or African American	38.5%	61.9%	27.3%	56.3%	61.5%	31.8%

Category	MY 2022		MY 2023		MY 2024	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
White	41.7%	27.5%	50.0%	29.6%	50.0%	51.5%
Other	66.7%^	0.0%^	50.0%^	0.0%^	0.0%^	—
Region						
Central	63.6%	33.3%	62.5%	33.3%	58.3%	60.0%
Charlottesville/Western	36.4%	42.9%	45.5%	75.0%	75.0%	40.0%
Northern & Winchester	45.5%	16.7%	45.5%	30.0%	25.0%	18.2%
Roanoke/Alleghany	40.0%	41.2%	33.3%	8.3%	88.9%	62.5%
Southwest	37.5%	12.5%	25.0%^	0.0%^	22.2%	44.4%
Tidewater	16.7%	64.3%	100.0%^	50.0%^	50.0%	28.6%
MCO						
Aetna	100.0%^	25.0%^	100.0%^	40.0%^	33.3%^	100.0%^
HealthKeepers	43.5%	40.0%	56.0%	16.0%	31.8%	34.8%
Molina	0.0%^	25.0%^	66.7%	33.3%	100.0%^	33.3%^
Sentara*	41.7%	38.2%	27.3%	47.1%	66.7%	57.1%
United	50.0%^	0.0%^	—	33.3%	0.0%^	16.7%^
More Than One MCO	—	100.0%^	—	0.0%^	0.0%^	—

Blue shading indicates that a disparity was identified (i.e., had a p-value less than 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 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.

* HSAG combined Optima and VA Premier for MY 2022 in this year's report and displayed the rates as Sentara. For MY 2023, HSAG included members with enrollment in Optima or VA Premier prior to July 2023 in the rate for Sentara.

Table 4-15 shows that 50.0 percent of new SUD episodes among children receiving adoption assistance and 43.6 percent of new SUD episodes among controls resulted in initiation of treatment within 14 days of the diagnosis during MY 2024, and the difference was not statistically significant ($p=0.50$). The rate for children receiving adoption assistance was notably higher than controls for members 14 years of age and older (by 8.5 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 the rates may be less reliable.

For all eligible members, the MY 2024 rates for both children receiving adoption assistance and controls were above the national Medicaid 50th percentile for members 13 to 17 years of age. The rates for both children receiving adoption assistance and controls increased from MY 2023 to MY 2024

by 4.9 and 9.8 percentage points, respectively. For children receiving adoption assistance only, male members were significantly less likely to initiate SUD treatment during MY 2024, while female members were significantly more likely. For children receiving adoption assistance only, members in the Roanoke/Alleghany region were significantly more likely to initiate SUD treatment compared to members in other regions during MY 2024. For children receiving adoption assistance only, members enrolled with HealthKeepers were significantly less likely to initiate SUD treatment compared to members enrolled with other MCOs during MY 2024, while members enrolled with Sentara were significantly more likely. For children receiving adoption assistance, members enrolled with Sentara were significantly less likely to initiate SUD treatment compared to members enrolled with other MCOs during MY 2023; however, this disparity no longer existed during MY 2024 due to an increase in the rate for members enrolled with Sentara (by 39.4 percentage points).

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

Table 4-16 displays the MY 2022, MY 2023, and MY 2024 *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. Additionally, 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. 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 4-16—Rates of Initiation and Engagement of SUD Treatment—Engagement of SUD Treatment Among Children Receiving Adoption Assistance and Controls

Category	MY 2022		MY 2023		MY 2024	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
All Eligible Members	7.7%	6.3%	9.8%	6.8%	5.4%	16.4%
Age Category						
11 to 13 Years	16.7%	16.7%	0.0%^	0.0%^	25.0%	42.9%
≥ 14 Years	6.5%	5.2%	10.6%^	7.6%^	3.8%	12.5%
Sex						
Male	4.0%	6.3%	6.7%	10.0%	6.3%	14.3%
Female	11.1%	6.3%	14.3%	2.9%	4.2%	18.5%
Race						
Black or African American	7.7%	14.3%	0.0%^	12.5%^	0.0%^	13.6%^
White	8.3%	2.5%	10.5%	5.6%	7.5%^	18.2%^
Other	0.0%^	0.0%^	50.0%^	0.0%^	0.0%^	—
Region						
Central	9.1%^	0.0%^	12.5%^	0.0%^	0.0%^	20.0%^
Charlottesville/Western	0.0%^	0.0%^	0.0%^	33.3%^	0.0%^	20.0%^

Category	MY 2022		MY 2023		MY 2024	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
Northern & Winchester	18.2% ⁺	0.0% ⁺	0.0% ⁺	3.3% ⁺	8.3%	18.2%
Roanoke/Alleghany	20.0%	17.6%	20.0% ⁺	0.0% ⁺	11.1%	25.0%
Southwest	0.0% ⁺	0.0% ⁺	25.0% ⁺	0.0% ⁺	0.0% ⁺	0.0% ⁺
Tidewater	0.0% ⁺	7.1% ⁺	0.0% ⁺	0.0% ⁺	10.0%	14.3%
MCO						
Aetna	100.0% ⁺	0.0% ⁺	0.0% ⁺	0.0% ⁺	0.0% ⁺	50.0% ⁺
HealthKeepers	8.7% ⁺	0.0% ⁺	8.0%	4.0%	4.5%	8.7%
Molina	0.0% ⁺	0.0% ⁺	0.0% ⁺	0.0% ⁺	50.0% ⁺	0.0% ⁺
Sentara*	4.2%	8.8%	13.6%	11.8%	3.7%	23.8%
United	0.0% ⁺	0.0% ⁺	—	0.0% ⁺	0.0% ⁺	16.7% ⁺
More Than One MCO	—	100.0%	—	0.0% ⁺	0.0% ⁺	—

Blue shading indicates that a disparity was identified (i.e., had a p-value less than 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 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.

* HSAG combined Optima and VA Premier for MY 2022 in this year's report and displayed the rates as Sentara. For MY 2023, HSAG included members with enrollment in Optima or VA Premier prior to July 2023 in the rate for Sentara.

Table 4-16 shows that 5.4 percent of SUD episodes for children receiving adoption assistance and 16.4 percent of SUD episodes for controls resulted in initiation of treatment within 14 days of the diagnosis and engagement in ongoing SUD treatment during MY 2024, and the difference was not statistically significant ($p=0.07$). 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 2024 rate for children receiving adoption assistance was below the national Medicaid 50th percentile for members 13 to 17 years of age, while the rate for controls was above the national Medicaid 50th percentile. The rate for children receiving adoption assistance decreased from MY 2023 to MY 2024 by 4.4 percentage points, while the rate for controls increased by 9.6 percentage points. There were no disparities identified for children receiving adoption assistance during MY 2024.

Respiratory Health

Asthma Medication Ratio (AMR)

Table 4-17 displays the MY 2022, MY 2023, and MY 2024 *Asthma Medication Ratio* rates among children receiving adoption assistance and controls stratified by member characteristics. Additionally, 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 Asthma Medication Ratio Among Children Receiving Adoption Assistance and Controls

Category	MY 2022		MY 2023		MY 2024	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
All Eligible Members	86.0% ⁺	71.0%	82.4%	75.5%	79.3%	81.7%
Age Category						
5 to 11 Years	88.9%	77.1%	89.1%	90.0%	84.8%	91.9%
12 to 18 Years	84.2%	68.2%	75.5%	65.1%	73.9%	75.0%
Sex						
Male	84.5%	70.0%	80.3%	76.6%	81.7%	78.9%
Female	88.0%	72.3%	85.7%	73.5%	75.0%	86.1%
Race						
Black or African American	78.6%	68.8%	77.6%	67.7%	73.2%	79.1%
White	94.9%	72.5%	87.5%	82.7%	84.0%	82.2%
Other	66.7%	—	66.7%	66.7%	100.0% [^]	100.0% [^]
Region						
Central	87.5%	62.1%	76.0%	63.9%	68.8%	58.8%
Charlottesville/Western	82.4%	77.3%	83.3%	91.3%	90.9% [^]	100.0% [^]
Northern & Winchester	88.9%	77.8%	84.6%	91.7%	66.7%	85.7%
Roanoke/Alleghany	82.6%	75.0%	90.0%	89.5%	70.6%	80.0%
Southwest	100.0% [^]	90.5% [^]	86.7%	85.7%	86.7%	84.6%
Tidewater	80.0%	60.0%	78.3%	61.5%	87.5%	84.2%
MCO						
Aetna	88.9% [^]	100.0% [^]	76.9%	80.0%	80.0% [^]	100.0% [^]
HealthKeepers	87.1%	64.8%	73.3%	66.0%	90.5%	75.0%
Molina	100.0% [^]	100.0% [^]	100.0% [^]	100.0% [^]	80.0%	66.7%
Sentara*	83.1%	72.5%	88.7%	78.0%	75.5%	87.5%
United	100.0% [^]	66.7% [^]	75.0% [^]	100.0% [^]	71.4%	70.0%
More Than One MCO	100.0% [^]	60.0% [^]	100.0% [^]	100.0% [^]	—	100.0% [^]

- Blue shading indicates that a disparity was identified (i.e., had a p-value less than 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 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.
- * HSAG combined Optima and VA Premier for MY 2022 in this year's report and displayed the rates as Sentara. For MY 2023, HSAG included members with enrollment in Optima or VA Premier prior to July 2023 in the rate for Sentara.

Table 4-17 shows that 79.3 percent of children receiving adoption assistance and 81.7 percent of controls who were identified as having persistent asthma had a ratio of controller medications to total asthma medications of 0.50 or greater during MY 2024, and the difference was not statistically significant ($p=0.68$). The rates for children receiving adoption assistance were notably lower than controls for members 5 to 11 years of age (by 7.1 percentage points), female members (by 11.1 percentage points), Black or African American members (by 5.9 percentage points), and members enrolled with Sentara (by 12.0 percentage points). While there were large rate differences for members in most regions and members enrolled with Aetna, HealthKeepers, and Molina, these rates had small denominators, so the rates may be less reliable.

For all eligible members, the MY 2024 rates for both children receiving adoption assistance and controls were above the national Medicaid 50th percentiles for members 5 to 11 years of age and members 12 to 18 years of age. The rate for children receiving adoption assistance decreased from MY 2023 to MY 2024 by 3.1 percentage points, while the rate for controls increased by 6.2 percentage points. There were no disparities identified for children receiving adoption assistance during MY 2024.

Service Utilization

Ambulatory Care Visits

Table 4-18 displays the MY 2022, MY 2023, and MY 2024 *Ambulatory Care Visits* rates among children receiving adoption assistance and controls stratified by member characteristics. Additionally, 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 2022		MY 2023		MY 2024	
	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% ⁻	82.9%	83.0%	84.2%	84.2%	85.1%
Age Category						
≤ 2 Years	87.7%	90.8%	90.2%	94.6%	93.0%	94.7%
3 to 5 Years	84.1%	88.6%	88.1%	88.1%	88.7%	88.4%
6 to 10 Years	81.6%	84.0%	84.8%	84.6%	86.0%	85.7%
11 to 13 Years	81.0%	84.5%	81.9%	84.1%	84.0%	86.2%
≥ 14 Years	80.5%	79.0%	80.2%	82.3%	80.8%	82.5%
Sex						
Male	81.7%	82.9%	82.8%	84.2%	84.0%	84.7%
Female	81.2%	83.0%	83.1%	84.1%	84.3%	85.6%
Race						
Black or African American	81.3%	78.7%	83.2%	80.8%	83.2%	80.8%
White	81.6%	85.0%	82.9%	85.7%	84.5%	87.0%
Other	77.3%	77.9%	80.4%	81.5%	84.4%	85.5%
Region						
Central	80.5%	78.9%	81.1%	82.8%	82.3%	81.9%
Charlottesville/Western	81.6%	85.3%	84.8%	84.9%	86.1%	85.7%
Northern & Winchester	69.4%	81.8%	70.4%	84.0%	72.3%	83.5%
Roanoke/Alleghany	86.9%	87.1%	87.3%	86.3%	88.2%	88.6%
Southwest	91.5%	88.6%	90.9%	87.3%	90.4%	91.3%
Tidewater	80.0%	78.9%	83.9%	80.8%	85.7%	81.5%
MCO						
Aetna	77.3%	79.6%	75.8%	81.0%	79.7%	83.7%
HealthKeepers	82.6%	83.0%	83.2%	86.0%	84.1%	85.5%
Molina	68.9%	76.6%	71.9%	77.1%	78.1%	80.5%
Sentara*	83.3%	84.4%	85.4%	84.2%	85.7%	86.0%
United	74.5%	79.4%	79.1%	82.7%	82.6%	83.3%
More Than One MCO	91.2%	89.7%	92.1%	93.4%	96.3%	85.2%

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

+ 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.

* HSAG combined Optima and VA Premier for MY 2022 in this year's report and displayed the rates as Sentara. For MY 2023, HSAG included members with enrollment in Optima or VA Premier prior to July 2023 in the rate for Sentara.

Table 4-18 shows that 84.2 percent of children receiving adoption assistance and 85.1 percent of controls had an ambulatory care visit during MY 2024, and the difference was not statistically significant ($p=0.11$). The rate for children receiving adoption assistance was notably higher than controls for members enrolled with More Than One MCO (by 11.1 percentage points). Conversely, the rate for children receiving adoption assistance was notably lower than controls for members in the Northern & Winchester region (by 11.2 percentage points).

Rates could not be compared to a national Medicaid benchmark since this indicator is a custom indicator developed for this analysis. The rates for both children receiving adoption assistance and controls increased from MY 2023 to MY 2024 by 1.2 and 0.9 percentage points, respectively. For both children receiving adoption assistance and controls, members 14 years of age and older were significantly less likely to have an ambulatory care visit compared to members in other age groups during MY 2024, while members 2 years of age and younger and members 3 to 5 years of age were significantly more likely. Most of these disparities also existed during MY 2022 and MY 2023. For children receiving adoption assistance only, members 6 to 10 years of age were significantly more likely to have an ambulatory care visit compared to members in other age groups during MY 2024. This disparity also existed during MY 2023. For both children receiving adoption assistance and controls, members in the Central region were significantly less likely to have an ambulatory care visit compared to members in other regions during MY 2024, while members in the Roanoke/Alleghany region and the Southwest region were significantly more likely. Most of these disparities also existed during MY 2022 and MY 2023. 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 2024, while members in the Charlottesville/Western region were significantly more likely. The disparity for the Northern & Winchester region also existed during MY 2022 and MY 2023. For both children receiving adoption assistance 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 2024. These disparities also existed during MY 2022 and MY 2023. For children receiving adoption assistance only, members enrolled with Aetna were significantly less likely to have an ambulatory care visit compared to members enrolled with other MCOs during MY 2024, while members enrolled with Sentara and More Than One MCO were significantly more likely. These disparities also existed during MY 2022 and MY 2023.

ED Visits

Table 4-19 displays the MY 2022, MY 2023, and MY 2024 *ED Visits* rates among children receiving adoption assistance and controls stratified by member characteristics. Additionally, 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 2022		MY 2023		MY 2024	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
All Eligible Members	17.7% ⁻	29.3%	18.5% ⁻	30.7%	19.3% ⁻	29.9%

Category	MY 2022		MY 2023		MY 2024	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
Age Category						
≤ 2 Years	30.8%	41.5%	26.8%	47.3%	28.1%	49.1%
3 to 5 Years	18.2%	34.9%	20.2%	36.6%	19.5%	35.4%
6 to 10 Years	13.6%	27.4%	15.9%	28.6%	16.5%	28.7%
11 to 13 Years	16.1%	27.3%	17.2%	28.3%	16.8%	27.7%
≥ 14 Years	21.5%	30.0%	20.8%	31.7%	23.1%	30.0%
Sex						
Male	17.3%	29.0%	19.2%	29.9%	19.4%	28.8%
Female	18.2%	29.7%	17.7%	31.7%	19.2%	31.2%
Race						
Black or African American	17.5%	30.7%	17.7%	31.4%	18.9%	31.3%
White	18.0%	29.0%	19.0%	30.7%	19.8%	29.7%
Other	14.4%	22.7%	14.3%	22.2%	11.8%	21.5%
Region						
Central	17.5%	30.0%	19.9%	34.4%	21.5%	34.7%
Charlottesville/Western	15.9%	25.8%	16.9%	27.3%	15.5%	25.3%
Northern & Winchester	16.1%	29.4%	15.9%	30.2%	17.1%	26.2%
Roanoke/Alleghany	17.6%	29.4%	18.9%	32.1%	18.3%	32.3%
Southwest	23.5%	34.6%	22.9%	34.9%	25.4%	36.0%
Tidewater	17.1%	27.7%	17.1%	25.6%	18.8%	24.8%
MCO						
Aetna	17.4%	29.6%	16.9%	26.3%	17.3%	30.6%
HealthKeepers	17.7% [^]	29.2% [^]	18.8%	31.6%	19.7%	30.5%
Molina	16.7%	28.8%	19.9%	28.8%	19.5%	29.2%
Sentara*	17.4%	29.1%	18.6%	30.6%	19.4%	29.6%
United	19.6%	31.0%	18.3%	34.3%	18.7%	29.6%
More Than One MCO	29.4%	30.9%	19.7%	27.6%	27.8%	27.8%

Blue shading indicates that a disparity was identified (i.e., had a p-value less than 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 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.

* HSAG combined Optima and VA Premier for MY 2022 in this year's report and displayed the rates as Sentara. For MY 2023, HSAG included members with enrollment in Optima or VA Premier prior to July 2023 in the rate for Sentara.

Table 4-19 shows that 19.3 percent of children receiving adoption assistance and 29.9 percent of controls had an ED visit during MY 2024, 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 apart from members enrolled with More Than One MCO, with the largest differences for members 2 years of age and younger, 3 to 5, 6 to 10, and 11 to 13 years of age (by 21.0, 15.9, 12.2, and 10.9 percentage points, respectively); female members (by 12.0 percentage points); Black or African American members (by 12.4 percentage points); members in the Central region and the Roanoke/Alleghany region (by 13.2 and 14.0 percentage points, respectively); and members enrolled with Aetna, HealthKeepers, and United (by 13.3, 10.8, and 10.9 percentage points, respectively).

Rates could not be compared to a national Medicaid benchmark since this indicator is a custom indicator developed for this analysis. The rate for children receiving adoption assistance increased from MY 2023 to MY 2024 by 0.8 percentage points, while the rate for controls decreased by 0.8 percentage points. For both children receiving adoption assistance and controls, members 11 to 13 years of age were significantly less likely to have an ED visit compared to members in other age groups during MY 2024, while members 2 years of age and younger were significantly more likely. The disparities for members 2 years of age and younger also existed during MY 2022 and MY 2023. For children receiving adoption assistance only, members 6 to 10 years of age were significantly less likely to have an ED visit compared to members in other age groups during MY 2024, while members 14 years of age and older were significantly more likely. These disparities also existed during MY 2022 and MY 2023. For both children receiving adoption assistance 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 2024. This disparity only existed for controls during MY 2022 and MY 2023. For both children receiving adoption assistance and controls, members in the Charlottesville/Western region were significantly less likely to have an ED visit compared to members in other regions during MY 2024, while members in the Central region and the Southwest region were significantly more likely.

Inpatient Visits

Table 4-20 displays the MY 2022, MY 2023, and MY 2024 *Inpatient Visits* rates among children receiving adoption assistance and controls stratified by member characteristics. Additionally, 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 2022		MY 2023		MY 2024	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
All Eligible Members	3.3% ⁺	2.3%	3.1%	2.8%	3.6% ⁺	2.8%
Age Category						
≤ 2 Years	2.3%	4.6%	3.6%	6.3%	3.5%	4.4%
3 to 5 Years	1.3%	1.3%	1.1%	1.3%	2.0%	2.3%
6 to 10 Years	1.5%	1.4%	1.4%	1.4%	1.9%	1.6%

Category	MY 2022		MY 2023		MY 2024	
	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	3.8%	2.5%	3.0%	2.9%	3.3%	3.2%
≥ 14 Years	5.1%	3.3%	5.3%	4.3%	5.9%	3.6%
Sex						
Male	2.6%	1.9%	2.9%	2.4%	3.2%	2.3%
Female	4.0%	2.9%	3.4%	3.3%	4.0%	3.3%
Race						
Black or African American	3.7%	2.3%	3.1%	3.0%	4.3%	2.4%
White	3.2%	2.4%	3.2%	2.8%	3.4%	2.9%
Other	1.1%	1.1%	1.1%	2.1%	2.7%	2.7%
Region						
Central	4.4%	1.8%	3.4%	3.2%	5.0%	2.7%
Charlottesville/Western	3.7%	2.4%	4.0%	3.4%	3.5%	2.4%
Northern & Winchester	2.4%	3.0%	2.6%	2.3%	2.4%	2.8%
Roanoke/Alleghany	2.7%	2.2%	2.6%	2.7%	3.2%	2.2%
Southwest	2.5%	2.4%	1.9%	1.8%	2.8%	3.1%
Tidewater	3.3%	2.5%	3.7%	3.2%	4.2%	3.4%
MCO						
Aetna	2.3%	1.5%	2.3%	2.4%	3.3%	1.7%
HealthKeepers	3.3%	2.4%	3.5%	2.4%	4.3%	2.9%
Molina	2.7%	2.0%	3.1%	3.8%	2.4%	4.3%
Sentara*	3.6%	2.5%	3.2%	3.2%	3.7%	2.9%
United	2.4%	2.4%	1.3%	1.5%	2.1%	1.5%
More Than One MCO	4.4%	1.5%	6.6%	2.6%	0.0%	1.9%

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

+ 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.

* HSAG combined Optima and VA Premier for MY 2022 in this year's report and displayed the rates as Sentara. For MY 2023, HSAG included members with enrollment in Optima or VA Premier prior to July 2023 in the rate for Sentara.

Table 4-20 shows that 3.6 percent of children receiving adoption assistance and 2.8 percent of controls had an inpatient visit during MY 2024, and the difference was statistically significant ($p=0.004$). The rate differences between children receiving adoption assistance and controls were similar across all stratified rates.

Rates could not be compared to a national Medicaid benchmark since this indicator is a custom indicator developed for this analysis. The rate for children receiving adoption assistance increased from

MY 2023 to MY 2024 by 0.5 percentage points, while the rate for controls did not change. For both children receiving adoption assistance and controls, members 6 to 10 years of age were significantly less likely to have an inpatient visit compared to members in other age groups during MY 2024, while members 14 years of age and older were significantly more likely. These disparities also existed during MY 2022 and MY 2023. 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 2024. This disparity also existed during MY 2022 and MY 2023. For children receiving adoption assistance only, members in the Northern & Winchester region were significantly less likely to have an inpatient visit compared to members in other regions during MY 2024, while members in the Central region were significantly more likely. This disparity also existed for members in the Central region during MY 2022. For children receiving adoption assistance only, members enrolled with United were significantly less likely to have an inpatient visit compared to members enrolled with other MCOs during MY 2024, while members enrolled with HealthKeepers were significantly more likely. The disparity for members enrolled with United also existed during MY 2023.

Behavioral Health Encounters—Total

Table 4-21 displays the MY 2022, MY 2023, and MY 2024 *Behavioral Health Encounters—Total* rates among children receiving adoption assistance and controls stratified by member characteristics. Additionally, 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 2022		MY 2023		MY 2024	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
All Eligible Members	45.7% ⁺	40.2%	54.7% ⁺	47.5%	57.0% ⁺	49.9%
Age Category						
≤ 2 Years	29.2%	23.8%	29.5%	25.9%	39.5%	28.9%
3 to 5 Years	28.5%	20.7%	35.6%	27.2%	35.5%	30.5%
6 to 10 Years	40.5%	35.9%	51.9%	42.8%	54.3%	45.8%
11 to 13 Years	51.5%	48.0%	60.5%	54.9%	65.1%	58.1%
≥ 14 Years	52.3%	45.5%	60.1%	53.7%	61.1%	54.8%
Sex						
Male	46.9%	40.2%	56.6%	50.6%	58.8%	52.3%
Female	44.3%	40.3%	52.4%	43.9%	54.9%	47.2%
Race						
Black or African American	49.4%	41.4%	59.2%	47.4%	60.4%	51.3%
White	44.3%	39.9%	52.8%	48.0%	55.6%	49.5%
Other	38.1%	34.8%	51.3%	37.0%	55.4%	45.7%

Category	MY 2022		MY 2023		MY 2024	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
Region						
Central	45.3%	37.2%	54.2%	46.8%	56.8%	49.0%
Charlottesville/Western	46.1%	41.2%	58.6%	47.9%	60.3%	49.8%
Northern & Winchester	34.0%	31.6%	42.4%	38.6%	45.2%	43.1%
Roanoke/Alleghany	51.2%	42.9%	58.0%	48.8%	60.4%	51.6%
Southwest	42.7%	39.3%	50.1%	46.3%	52.0%	48.9%
Tidewater	52.3%	48.2%	62.2%	55.1%	64.7%	56.1%
MCO						
Aetna	38.4%	36.8%	46.2%	43.4%	49.5%	44.8%
HealthKeepers	46.9%	41.5%	55.2%	48.5%	60.1%	51.2%
Molina	39.1%	32.1%	42.1%	39.0%	46.8%	39.5%
Sentara*	47.9%	41.8%	57.6%	48.7%	58.7%	52.5%
United	35.4%	30.3%	49.0%	43.9%	48.3%	42.6%
More Than One MCO	55.9%	57.4%	65.8%	59.2%	77.8%	46.3%

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

+ 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.

* HSAG combined Optima and VA Premier for MY 2022 in this year's report and displayed the rates as Sentara. For MY 2023, HSAG included members with enrollment in Optima or VA Premier prior to July 2023 in the rate for Sentara.

Table 4-21 shows that 57.0 percent of children receiving adoption assistance and 49.9 percent of controls had a behavioral health visit during MY 2024, and the difference was statistically significant ($p < 0.001$). The rates for children receiving adoption assistance were notably higher than controls across all stratified rates, with the largest differences being for members 2 years of age and younger and members 6 to 10 years of age (by 10.6 and 8.5 percentage points, respectively); female members (by 7.7 percentage points); Black or African American members and members in the Other racial group (by 9.1 and 9.7 percentage points, respectively); members in the Central, Charlottesville/Western, Roanoke/Alleghany, and Tidewater regions (by 7.8, 10.5, 8.8, and 8.6 percentage points, respectively); and members enrolled with HealthKeepers, Molina, and More Than One MCO (by 8.9, 7.3, and 31.5 percentage points, respectively).

Rates could not be compared to a national Medicaid benchmark since this indicator is a custom indicator developed for this analysis. The rates for both children receiving adoption assistance and controls increased from MY 2023 to MY 2024 by 2.3 and 2.4 percentage points, respectively. For both children receiving adoption assistance and controls, members 2 years of age and younger and members 3 to 5 and 6 to 10 years of age were significantly less likely to have a behavioral health encounter compared to members in other age groups during MY 2024, while members 11 to 13 years

of age and 14 years of age and older were significantly more likely. These disparities also existed during MY 2022 and MY 2023. For both children receiving adoption assistance and controls, female members were significantly less likely to have a behavioral health encounter during MY 2024, while male members were significantly more likely. Most of these disparities also existed during MY 2022 and MY 2023. For children receiving adoption assistance only, White members were significantly less likely to have a behavioral health encounter compared to members in other racial groups during MY 2024, while Black or African American members were significantly more likely. These disparities also existed during MY 2022 and MY 2023. For both children receiving adoption assistance and controls, members in the Northern & Winchester region were significantly less likely to have a behavioral health encounter compared to members in other regions during MY 2024, while members in the Tidewater region were significantly more likely. For children receiving adoption assistance only, members in the Southwest region were significantly less likely to have a behavioral health encounter compared to members in other regions during MY 2024, while members in the Charlottesville/Western region and the Roanoke/Alleghany region were significantly more likely. Most of these disparities also existed during MY 2022 and MY 2023. For both children receiving adoption assistance and controls, members enrolled with Aetna, Molina, and United were significantly less likely to have a behavioral health encounter compared to members enrolled with other MCOs during MY 2024, while members enrolled with Sentara were significantly more likely. Most of these disparities also existed during MY 2022 and MY 2023. For children receiving adoption assistance only, members enrolled with HealthKeepers and More Than One MCO were significantly more likely to have a behavioral health encounter compared to members enrolled with other MCOs during MY 2024.

Behavioral Health Encounters—ARTS

Table 4-22 displays the MY 2022, MY 2023, and MY 2024 Behavioral Health Encounters—ARTS rates among children receiving adoption assistance and controls stratified by member characteristics. Additionally, 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 2022		MY 2023		MY 2024	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
All Eligible Members	1.0%	0.9%	1.6%	1.4%	1.7%	1.5%
Age Category						
≤ 2 Years	0.8%	0.0%	0.0%	0.9%	0.0%	0.9%
3 to 5 Years	0.0%^	0.0%^	0.1%^	0.0%^	0.3%	0.1%
6 to 10 Years	0.4%	0.1%	0.2%	0.4%	0.3%	0.5%
11 to 13 Years	0.7%	0.9%	1.4%	0.8%	1.3%	1.2%
≥ 14 Years	2.1%	1.9%	3.3%	3.1%	3.8%	2.9%

Category	MY 2022		MY 2023		MY 2024	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
Sex						
Male	1.1%	0.8%	1.6%	1.5%	1.9%	1.2%
Female	1.0%	1.1%	1.6%	1.3%	1.5%	1.8%
Race						
Black or African American	1.1%	0.8%	1.6%	1.3%	1.8%	1.4%
White	1.0%	1.0%	1.6%	1.4%	1.7%	1.5%
Other	0.6%	1.1%	1.1%	2.6%	0.5%	1.1%
Region						
Central	1.3%	0.6%	1.7%	1.0%	2.3%	1.7%
Charlottesville/Western	0.8%	1.0%	1.8%	1.6%	1.0%	1.1%
Northern & Winchester	1.3%	0.8%	2.1%	3.3%	2.3%	2.1%
Roanoke/Alleghany	1.1%	1.2%	1.8%	1.4%	1.5%	1.1%
Southwest	1.0%	1.1%	1.2%	0.6%	1.2%	1.7%
Tidewater	0.8%	1.0%	0.9%	0.7%	1.8%	1.2%
MCO						
Aetna	1.3%	0.8%	0.8%	1.8%	1.0%	1.3%
HealthKeepers	1.2%	0.9%	2.0%	1.7%	2.4%	1.6%
Molina	2.0%^	0.0%^	2.4%	1.4%	1.5%	1.5%
Sentara*	0.9%	1.1%	1.5%	1.1%	1.6%	1.4%
United	0.6%	0.6%	0.8%	1.7%	0.9%	1.7%
More Than One MCO	1.5%	2.9%	1.3%	3.9%	1.9%	1.9%

Blue shading indicates that a disparity was identified (i.e., had a p-value less than 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 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.

* HSAG combined Optima and VA Premier for MY 2022 in this year's report and displayed the rates as Sentara. For MY 2023, HSAG included members with enrollment in Optima or VA Premier prior to July 2023 in the rate for Sentara.

Table 4-22 shows that 1.7 percent of children receiving adoption assistance and 1.5 percent of controls had a behavioral health encounter with ARTS during MY 2024, and the difference was not statistically significant ($p=0.28$). The rate differences between children receiving adoption assistance and controls were similar across all stratified rates.

Rates could not be compared to a national Medicaid benchmark since this indicator is a custom indicator developed for this analysis. The rates for both children receiving adoption assistance and

controls increased from MY 2023 to MY 2024 by 0.1 percentage points each. For both children receiving adoption assistance and controls, members 3 to 5 and 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 2024, while members 14 years of age and older were significantly more likely. The disparities for members 6 to 10 years of age and 14 years of age and older also existed during MY 2023 and MY 2024. For children receiving adoption assistance, members in the Tidewater region were significantly less likely to have a behavioral health encounter with ARTS compared to members in other regions during MY 2023; however, this disparity no longer existed during MY 2024 due to an increase in the rate for members in the Tidewater region (by 0.9 percentage points). For children receiving adoption assistance only, members enrolled with HealthKeepers were significantly more likely to have a behavioral health encounter with ARTS compared to members enrolled with other MCOs during MY 2024.

Behavioral Health Encounters—CMH Services

Table 4-23 displays the MY 2022, MY 2023, and MY 2024 Behavioral Health Encounters—CMH Services rates among children receiving adoption assistance and controls stratified by member characteristics. Additionally, 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 2022		MY 2023		MY 2024	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
All Eligible Members	13.1%	13.4%	14.0%	14.0%	14.7%	14.6%
Age Category						
≤ 2 Years	3.1%	2.3%	2.7%	3.6%	6.1%	3.5%
3 to 5 Years	8.2%	9.0%	10.9%	11.6%	10.7%	9.0%
6 to 10 Years	13.0%	14.8%	13.0%	14.0%	14.1%	16.1%
11 to 13 Years	14.3%	14.5%	15.4%	16.8%	15.8%	17.0%
≥ 14 Years	14.5%	13.5%	15.4%	13.5%	16.0%	13.8%
Sex						
Male	15.0%	14.6%	15.9%	15.8%	16.2%	16.0%
Female	11.0%	12.0%	11.8%	11.9%	12.9%	13.0%
Race						
Black or African American	14.9%	15.4%	15.8%	15.8%	16.4%	17.5%
White	12.6%	12.7%	13.5%	13.5%	14.2%	13.5%
Other	6.6%	10.5%	7.4%	7.9%	8.1%	12.4%
Region						
Central	11.3%	10.6%	12.3%	11.2%	13.5%	12.4%

Category	MY 2022		MY 2023		MY 2024	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
Charlottesville/Western	13.1%	13.0%	14.6%	14.0%	17.4%	14.7%
Northern & Winchester	8.7%	6.2%	7.9%	6.9%	7.9%	6.6%
Roanoke/Alleghany	14.9%	18.6%	16.2%	20.1%	16.6%	19.6%
Southwest	17.5%	19.2%	15.7%	17.6%	14.4%	19.7%
Tidewater	14.2%	14.2%	17.3%	14.9%	17.6%	15.0%
MCO						
Aetna	9.4%	9.9%	11.9%	13.3%	12.9%	13.0%
HealthKeepers	12.6%	11.8%	14.0%	11.7%	14.8%	12.1%
Molina	8.7%	13.0%	12.7%	11.0%	8.8%	8.2%
Sentara*	14.8%	15.2%	14.9%	16.0%	16.1%	17.4%
United	11.2%	11.4%	9.4%	12.6%	11.5%	12.7%
More Than One MCO	14.7%	19.1%	25.0%	17.1%	13.0%	20.4%

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

+ 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.

* HSAG combined Optima and VA Premier for MY 2022 in this year's report and displayed the rates as Sentara. For MY 2023, HSAG included members with enrollment in Optima or VA Premier prior to July 2023 in the rate for Sentara.

Table 4-23 shows that 14.7 percent of children receiving adoption assistance and 14.6 percent of controls had a behavioral health encounter with CMH services during MY 2024, and the difference was not statistically significant ($p=0.90$). The rates for children receiving adoption assistance were notably lower than controls for members in the Southwest region (by 5.3 percentage points) and members enrolled with More Than One MCO (by 7.4 percentage points).

Rates could not be compared to a national Medicaid benchmark since this indicator is a custom indicator developed for this analysis. The rates for both children receiving adoption assistance and controls increased from MY 2023 to MY 2024 by 0.7 and 0.6 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 2024. Most of these disparities also existed during MY 2022 and MY 2023. 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 2024. This disparity also existed during MY 2022 and MY 2023. For both children receiving adoption assistance and controls, female members were significantly less likely to have a behavioral health encounter with CMH services during MY 2024, while male members were significantly more likely. These disparities also existed during MY 2022 and MY 2023. 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 2024. 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 2024. This disparity also existed during MY 2022 and MY 2023. For both children receiving adoption assistance and controls, members in the Northern & Winchester region were significantly less likely to have a behavioral health encounter with CMH services compared to members in other regions during MY 2024, while members in the Roanoke/Alleghany region were significantly more likely. These disparities also existed during MY 2022 and MY 2023. For children receiving adoption assistance, members in the Central region were significantly less likely to have a behavioral health encounter with CMH services compared to members in other regions during MY 2023; however, this disparity no longer existed during MY 2024 due to an increase in the rate for members in the Central region (by 1.2 percentage points). For children receiving adoption assistance only, members in the Charlottesville/Western region and the Tidewater region were significantly more likely to have a behavioral health encounter with CMH services compared to members in other regions during MY 2024. This disparity also existed for members in the Tidewater region during MY 2023. For both children receiving adoption assistance and controls, members enrolled with Molina were significantly less likely to have a behavioral health encounter with CMH services compared to members enrolled with other MCOs during MY 2024, while members enrolled with Sentara were significantly more likely. This disparity also existed for members enrolled with Sentara during MY 2022 and MY 2023. For children receiving adoption assistance only, members enrolled with United were significantly less likely to have a behavioral health encounter with CMH services compared to members enrolled with other MCOs during MY 2024. This disparity also existed during MY 2023.

Behavioral Health Encounters—RTC Services

Table 4-24 displays the MY 2022, MY 2023, and MY 2024 Behavioral Health Encounters—RTC Services rates among children receiving adoption assistance and controls stratified by member characteristics. Additionally, 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. Please note, starting in July 2025, RTC placement and services became a carved-out service rather than an excluded service.

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

Category	MY 2022		MY 2023		MY 2024	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
All Eligible Members	4.3% ⁺	2.6%	4.6% ⁺	3.1%	5.0% ⁺	3.6%
Age Category						
≤ 2 Years	1.5%	1.5%	0.9%	3.6%	5.3%	3.5%
3 to 5 Years	4.6%	3.3%	5.1%	4.0%	6.2%	3.7%
6 to 10 Years	4.1%	2.1%	3.9%	2.4%	4.0%	3.5%
11 to 13 Years	4.4%	2.9%	4.4%	3.5%	4.7%	4.0%

Category	MY 2022		MY 2023		MY 2024	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
≥ 14 Years	4.5%	2.5%	5.3%^	3.1%^	5.9%	3.5%
Sex						
Male	4.6%	2.8%	5.1%	3.0%	5.3%	4.0%
Female	4.0%	2.3%	3.9%	3.1%	4.8%	3.2%
Race						
Black or African American	5.0%	3.1%	5.7%	2.8%	6.5%	3.7%
White	4.0%	2.4%	4.2%	3.3%	4.5%	3.6%
Other	2.2%	1.7%	1.1%	0.5%	3.2%	4.8%
Region						
Central	5.9%	2.8%	4.6%	3.0%	5.9%	3.3%
Charlottesville/Western	3.6%	2.5%	5.6%	3.3%	5.7%	3.1%
Northern & Winchester	3.6%	2.3%	4.3%	2.7%	3.9%	3.7%
Roanoke/Alleghany	4.4%	2.8%	4.6%	3.5%	4.4%	3.7%
Southwest	3.0%	1.0%	2.4%	1.8%	2.7%	3.1%
Tidewater	4.2%	3.4%	5.4%	3.7%	6.8%	4.9%
MCO						
Aetna	3.5%	1.8%	3.3%	2.4%	3.5%	2.5%
HealthKeepers	5.2%	3.0%	5.8%	3.0%	6.1%	4.4%
Molina	3.7%	1.3%	4.1%	3.4%	3.6%	3.0%
Sentara*	4.0%	2.4%	4.1%	3.2%	5.1%	3.6%
United	3.7%	3.1%	4.0%	2.6%	3.8%	3.1%
More Than One MCO	5.9%	4.4%	9.2%	3.9%	0.0%	1.9%

Blue shading indicates that a disparity was identified (i.e., had a p-value less than 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 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.

* HSAG combined Optima and VA Premier for MY 2022 in this year's report and displayed the rates as Sentara. For MY 2023, HSAG included members with enrollment in Optima or VA Premier prior to July 2023 in the rate for Sentara.

Table 4-24 shows that 5.0 percent of children receiving adoption assistance and 3.6 percent of controls had a behavioral health encounter with RTC services during MY 2024, and the difference was statistically significant ($p < 0.001$). The rate differences between children receiving adoption assistance and controls were similar across all stratified rates.

Rates could not be compared to a national Medicaid benchmark since this indicator is a custom indicator developed for this analysis. The rates for both children receiving adoption assistance and controls increased from MY 2023 to MY 2024 by 0.4 and 0.5 percentage points, respectively. For children receiving adoption assistance only, members 6 to 10 years of age were significantly less likely to have a behavioral health encounter with RTC services compared to members in other age groups during MY 2024, while members 14 years of age and older were significantly more likely. For children receiving adoption assistance, female members were significantly less likely to have a behavioral health encounter with RTC services during MY 2023; however, this disparity no longer existed during MY 2024 due to an increase in the rate for female members (by 0.9 percentage points).

For children receiving adoption assistance only, White members were significantly less likely to have a behavioral health encounter with RTC services compared to members in other racial groups during MY 2024, while Black or African American members were significantly more likely. These disparities also existed during MY 2023. For children receiving adoption assistance, members in the Other racial group were significantly less likely to have a behavioral health encounter with RTC services compared to members in other racial groups during MY 2023; however, this disparity no longer existed during MY 2024 due to an increase in the rate for members in the Other racial group (by 2.1 percentage points). For both children receiving adoption assistance and controls, members in the Tidewater region were significantly more likely to have a behavioral health encounter with RTC services compared to members in other regions during MY 2024. For children receiving adoption assistance only, 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 2024. This disparity also existed during MY 2022 and MY 2023. For both children receiving adoption assistance and controls, members enrolled with HealthKeepers were significantly more likely to have a behavioral health encounter with RTC services compared to members enrolled with other MCOs during MY 2024. For children receiving adoption assistance only, this disparity also existed during MY 2022 and MY 2023. For children receiving adoption assistance, members enrolled with Sentara were significantly less likely to have a behavioral health encounter with RTC services compared to members enrolled with other MCOs during MY 2023; however, this disparity no longer existed during MY 2024 due to an increase in the rate for members enrolled with Sentara (by 1.0 percentage points).

Behavioral Health Encounters—Therapeutic Services

Table 4-25 displays the MY 2022, MY 2023, and MY 2024 Behavioral Health Encounters—Therapeutic Services rates among children receiving adoption assistance and controls stratified by member characteristics. Additionally, 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 2022		MY 2023		MY 2024	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
All Eligible Members	5.3% ⁺	4.2%	1.1% ⁻	1.5%	1.4%	1.5%

Category	MY 2022		MY 2023		MY 2024	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
Age Category						
≤ 2 Years	2.3%	1.5%	0.0%	0.0%	0.0%	0.0%
3 to 5 Years	5.6%	5.4%	1.0%	1.7%	1.1%	0.3%
6 to 10 Years	6.9%	6.2%	1.3%	1.9%	1.7%	2.5%
11 to 13 Years	4.9%	3.7%	1.1%	1.5%	1.3%	1.9%
≥ 14 Years	4.4%	2.6%	1.0%	1.1%	1.3%	0.6%
Sex						
Male	6.8%	5.5%	1.3%	1.8%	1.7%	1.8%
Female	3.6%	2.7%	0.9%	1.2%	1.0%	1.0%
Race						
Black or African American	5.8%	4.5%	1.4%	1.9%	1.6%	2.1%
White	5.2%	4.1%	1.0%	1.4%	1.3%	1.2%
Other	4.4%	3.3%	0.0%^	0.0%^	0.0%	1.6%
Region						
Central	4.8%	4.0%	0.9%	1.7%	1.4%	1.2%
Charlottesville/Western	5.4%	4.4%	1.6%	2.3%	1.7%	2.4%
Northern & Winchester	3.6%	2.0%	0.5%	0.7%	0.7%	0.5%
Roanoke/Alleghany	5.7%	4.4%	1.8%	2.6%	2.1%	2.8%
Southwest	7.8%	6.7%	0.0%^	0.0%^	0.2%^	0.0%^
Tidewater	5.2%	4.2%	1.5%	1.2%	1.8%	1.4%
MCO						
Aetna	4.1%	3.3%	0.8%	0.8%	1.1%	1.4%
HealthKeepers	5.8%	4.1%	1.1%	1.3%	1.3%	1.1%
Molina	3.7%	3.7%	0.3%	1.0%	0.6%	0.3%
Sentara*	5.4%	4.3%	1.2%	1.7%	1.6%	1.9%
United	5.7%	4.9%	1.1%	1.5%	0.5%	1.0%
More Than One MCO	2.9%	7.4%	1.3%	2.6%	3.7%	3.7%

Blue shading indicates that a disparity was identified (i.e., had a p-value less than 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 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.

* HSAG combined Optima and VA Premier for MY 2022 in this year's report and displayed the rates as Sentara. For MY 2023, HSAG included members with enrollment in Optima or VA Premier prior to July 2023 in the rate for Sentara.

Table 4-25 shows that 1.4 percent of children receiving adoption assistance and 1.5 percent of controls had a behavioral health visit with therapeutic services during MY 2024, and the difference was not statistically significant ($p=0.67$). The rate differences between children receiving adoption assistance and controls were similar across all stratified rates.

Rates could not be compared to a national Medicaid benchmark since this indicator is a custom indicator developed for this analysis. The rate for children receiving adoption assistance increased from MY 2023 to MY 2024 by 0.3 percentage points, while the rate for controls did not change. For both children receiving adoption assistance and controls, female members were significantly less likely to have a behavioral health encounter with therapeutic services during 2024, while male members were significantly more likely. Most of these disparities also existed during MY 2022 and MY 2023. For both children receiving adoption assistance and controls, members in the Northern & Winchester region were significantly less likely to have a behavioral health encounter with therapeutic services compared to members in other regions during 2024, while members in the Roanoke/Alleghany region were significantly more likely. These disparities also existed during MY 2023.

Behavioral Health Encounters—Traditional Services

Table 4-26 displays the MY 2022, MY 2023, and MY 2024 Behavioral Health Encounters—Traditional Services rates among children receiving adoption assistance and controls stratified by member characteristics. Additionally, 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 2022		MY 2023		MY 2024	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
All Eligible Members	43.2% ⁺	37.2%	53.8% ⁺	45.8%	56.1% ⁺	48.1%
Age Category						
≤ 2 Years	26.9%	23.1%	29.5%	25.9%	38.6%	28.9%
3 to 5 Years	25.4%	17.4%	35.2%	25.9%	35.1%	29.4%
6 to 10 Years	37.5%	31.9%	51.0%	41.0%	53.6%	44.0%
11 to 13 Years	49.6%	45.4%	59.6%	53.1%	64.2%	56.3%
≥ 14 Years	50.0%	42.9%	59.0%	52.1%	60.0%	52.8%
Sex						
Male	43.7%	36.7%	55.6%	48.8%	58.0%	50.6%
Female	42.6%	37.7%	51.6%	42.5%	54.0%	45.4%
Race						
Black or African American	47.1%	37.5%	58.3%	45.0%	59.4%	48.7%
White	41.7%	37.2%	51.9%	46.6%	54.8%	48.0%
Other	35.9%	30.9%	50.8%	35.4%	55.4%	45.7%

Category	MY 2022		MY 2023		MY 2024	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
Region						
Central	42.8%	34.2%	53.3%	45.6%	56.0%	47.7%
Charlottesville/Western	43.3%	38.9%	57.4%	46.9%	59.4%	49.0%
Northern & Winchester	32.2%	29.9%	41.8%	38.2%	44.7%	42.6%
Roanoke/Alleghany	48.2%	37.7%	57.1%	45.3%	58.9%	48.1%
Southwest	39.3%	36.8%	49.3%	45.1%	51.5%	46.9%
Tidewater	50.5%	44.9%	61.2%	52.8%	63.8%	53.7%
MCO						
Aetna	36.8%	34.1%	45.2%	40.8%	48.3%	43.2%
HealthKeepers	44.7%	38.6%	54.3%	47.2%	59.4%	50.1%
Molina	36.8%	28.8%	41.8%	36.6%	46.8%	37.4%
Sentara*	45.3%	38.4%	56.5%	46.9%	57.6%	50.3%
United	31.4%	28.3%	48.6%	42.4%	47.9%	40.7%
More Than One MCO	54.4%	52.9%	65.8%	56.6%	75.9%	44.4%

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

+ 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.

* HSAG combined Optima and VA Premier for MY 2022 in this year's report and displayed the rates as Sentara. For MY 2023, HSAG included members with enrollment in Optima or VA Premier prior to July 2023 in the rate for Sentara.

Table 4-26 shows that 56.1 percent of children receiving adoption assistance and 48.1 percent of controls had a behavioral health visit with traditional services during MY 2024, and the difference was statistically significant ($p < 0.001$). The rate differences for children receiving adoption assistance were notably higher than controls across all stratified rates, with the largest differences being for members 2 years of age and older and members 6 to 10 years of age (by 9.7 and 9.6 percentage points, respectively); female members (by 8.6 percentage points); Black or African American members and members in the Other racial group (by 10.7 and 9.7 percentage points, respectively); members in the Central, Charlottesville/Western, Roanoke/Alleghany, and Tidewater regions (by 8.3, 10.4, 10.8, and 10.1 percentage points, respectively); and members enrolled with HealthKeepers, Molina, and More Than One MCO (by 9.3, 9.4, and 31.5 percentage points, respectively).

Rates could not be compared to a national Medicaid benchmark since this indicator is a custom indicator developed for this analysis. The rates for both children receiving adoption assistance and controls increased from MY 2023 to MY 2024 by 2.3 percentage points each. For both children receiving adoption assistance and controls, members 2 years of age and younger, 3 to 5 years of age, and 6 to 10 years of age were significantly less likely to have a behavioral health encounter with traditional services compared to members in other age groups during MY 2024, while members 11 to

13 years of age and 14 years of age and older were significantly more likely. These disparities also existed during MY 2022 and MY 2023. For both children receiving adoption assistance and controls, female members were significantly less likely to have a behavioral health encounter with traditional services during MY 2024, while male members were significantly more likely. These disparities also existed during MY 2023. For children receiving adoption assistance only, White members were significantly less likely to have a behavioral health encounter with traditional services compared to members in other racial groups during MY 2024, while Black or African American members were significantly more likely. These disparities also existed during MY 2022 and MY 2023. For both children receiving adoption assistance and controls, members in the Northern & Winchester region were significantly less likely to have a behavioral health encounter with traditional services compared to members in other regions during MY 2024, while members in the Tidewater region were significantly more likely. These disparities also existed during MY 2022 and MY 2023. For children receiving adoption assistance only, members in the Southwest region were significantly less likely to have a behavioral health encounter with traditional services compared to members in other regions during MY 2024, while members in the Charlottesville/Western region and the Roanoke/Alleghany region were significantly more likely. Most of these disparities also existed during MY 2022 and MY 2023. For both children receiving adoption assistance and controls, members enrolled with Aetna, Molina, and United were significantly less likely to have a behavioral health encounter with traditional services compared to members enrolled with other MCOs during MY 2024, while members enrolled with HealthKeepers and Sentara were significantly more likely. Most of these disparities also existed during MY 2022 and MY 2023. For children receiving adoption assistance only, members enrolled with More Than One MCO were significantly more likely to have a behavioral health encounter with traditional services compared to members enrolled with other MCOs during MY 2024. This disparity also existed during MY 2023.

Overall Service Utilization

Table 4-27 displays the MY 2022, MY 2023, and MY 2024 *Overall Service Utilization* rates among children receiving adoption assistance and controls stratified by member characteristics. Additionally, 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 2022		MY 2023		MY 2024	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
All Eligible Members	84.0% ⁻	86.9%	85.7% ⁻	87.9%	87.0% ⁻	88.5%
Age Category						
≤ 2 Years	92.3%	91.5%	92.0%	96.4%	94.7%	95.6%
3 to 5 Years	85.4%	90.1%	89.4%	90.0%	89.8%	90.0%
6 to 10 Years	83.5%	87.7%	86.4%	88.1%	87.8%	88.9%
11 to 13 Years	83.9%	88.1%	85.2%	87.6%	86.7%	89.4%
≥ 14 Years	83.7%	84.2%	84.0%	86.9%	85.3%	86.7%

Category	MY 2022		MY 2023		MY 2024	
	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate	Children Receiving Adoption Assistance Rate	Control Rate
Sex						
Male	84.1%	86.9%	85.5%	88.4%	86.9%	88.1%
Female	83.9%	86.9%	85.8%	87.4%	87.1%	88.8%
Race						
Black or African American	83.7%	84.6%	85.9%	86.0%	86.1%	86.1%
White	84.3%	88.1%	85.6%	88.9%	87.4%	89.5%
Other	80.7%	81.2%	84.1%	83.6%	86.0%	87.6%
Region						
Central	83.4%	84.0%	84.8%	87.4%	85.6%	87.2%
Charlottesville/Western	84.5%	87.9%	87.6%	87.6%	89.2%	88.5%
Northern & Winchester	72.9%	85.6%	73.9%	86.9%	75.4%	85.7%
Roanoke/Alleghany	88.8%	90.1%	89.4%	90.5%	91.1%	91.6%
Southwest	92.8%	91.3%	92.1%	90.2%	92.9%	93.4%
Tidewater	82.8%	84.4%	86.6%	85.4%	87.9%	85.2%
MCO						
Aetna	79.8%	84.9%	77.9%	84.7%	82.2%	87.1%
HealthKeepers	85.0%	87.3%	85.3%	89.4%	86.5%	88.8%
Molina	71.2%	81.3%	75.0%	81.5%	81.5%	83.6%
Sentara*	85.7%	87.7%	88.3%	88.0%	88.9%	89.4%
United	78.8%	83.9%	83.6%	87.4%	85.2%	86.3%
More Than One MCO	95.6%	95.6%	94.7%	97.4%	100.0%	87.0%

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

+ 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.

* HSAG combined Optima and VA Premier for MY 2022 in this year's report and displayed the rates as Sentara. For MY 2023, HSAG included members with enrollment in Optima or VA Premier prior to July 2023 in the rate for Sentara.

Table 4-27 shows that 87.0 percent of children receiving adoption assistance and 88.5 percent of controls had an ambulatory care visit, ED visit, inpatient visit, or behavioral health encounter (i.e., any service) during MY 2024, and the difference was statistically significant ($p=0.01$). The rate for children receiving adoption assistance was notably higher than controls for members enrolled with More Than One MCO (by 13.0 percentage points). Conversely, the rate for children receiving adoption assistance was notably lower than controls for members in the Northern & Winchester region (by 10.3 percentage points).

Rates could not be compared to a national Medicaid benchmark since this indicator is a custom indicator developed for this analysis. The rates for both children receiving adoption assistance and controls increased from MY 2022 to MY 2023 by 1.3 and 0.6 percentage points, respectively. For both children receiving adoption assistance and controls, members 14 years of age and older were significantly less likely to utilize any service compared to members in other age groups during MY 2024, while members 2 years of age and younger were significantly more likely. Most of these disparities also existed during MY 2022 and MY 2023. For children receiving adoption assistance only, members 3 to 5 years of age were significantly more likely to utilize any service compared to members in other age groups during MY 2024. This disparity also existed during MY 2023. For both children receiving adoption assistance and controls, members in the Northern & Winchester region were significantly less likely to utilize any service compared to members in other regions during MY 2024, while members in the Roanoke/Alleghany region and the Southwest region were significantly more likely. Most of these disparities also existed during MY 2022 and MY 2023. For children receiving adoption assistance only, members in the Charlottesville/Western region were significantly more likely to utilize any service compared to members in other regions during MY 2024. This disparity also existed during MY 2023. For both children receiving adoption assistance and controls, members enrolled with Molina were significantly less likely to utilize any service compared to members enrolled with other MCOs during MY 2024, while members enrolled with Sentara were significantly more likely. Most of these disparities also existed during MY 2022 and MY 2023. 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 2024. This disparity also existed during MY 2022 and MY 2023.

5. Healthcare Utilization: Former Foster Care Members Findings

Characteristics of Former Foster Care Members Eligible Population and Study Population

This section provides findings describing the demographic characteristics of the 2,455 members and 1,365 members in the former foster care eligible population and study population, respectively. The eligible population consisted of former foster care members from 19 to 26 years of age as of January 1, 2024, and receiving healthcare coverage from DMAS at any time during MY 2024. Table 5-1 displays the distribution of the former foster care members eligible population by age category, sex, race, region, MCO, and Medicaid population.

Table 5-1—Distribution of Former Foster Care Members (n=2,455)

Category	Number	Percent
Age Category		
19 to 22 years	1,355	55.2%
23 to 26 years	1,100	44.8%
Sex		
Male	1,253	51.0%
Female	1,202	49.0%
Race		
Black or African American	882	35.9%
White	1,496	60.9%
Other	77	3.1%
Region		
Central	649	26.4%
Charlottesville/Western	428	17.4%
Northern & Winchester	286	11.6%
Roanoke & Alleghany	366	14.9%
Southwest	269	11.0%
Tidewater	457	18.6%
Latest MCO in the Measurement Year		
Aetna	233	9.5%
HealthKeepers	708	28.8%
Molina	147	6.0%
Sentara	1,138	46.4%
United	207	8.4%
Other*	22	0.9%
Latest Medicaid Population in the Measurement Year		
MLTSS	142	5.8%
Acute	2,291	93.3%
Other*	22	0.9%

* Includes members only enrolled in FFS.

Members in the former foster care population were disproportionately Black or African American (35.9 percent) compared to the general population in Virginia, which was 20.0 percent Black or African American in 2023.^{48,49} Former foster care members were mostly from the Central (26.4 percent), Charlottesville/Western (17.4 percent), or Tidewater (18.6 percent) regions. Former foster care members were most likely to be enrolled with HealthKeepers (28.8 percent) and Sentara (46.4 percent). They were also most likely to be in the Acute population (93.3 percent). Only 0.9 percent of former foster care members were only enrolled in FFS during MY 2024.⁵⁰

The study population consisted of members in the former foster care eligible population who were continuously enrolled in Medicaid managed care with any MCO or a combination of MCOs during the study period and who could be matched to a control (i.e., a member not in a child welfare program). Continuous enrollment was defined as no more than 45 days of enrollment gaps during MY 2024. Among the former foster care eligible population, 55.6 percent (n=1,365) of members met the requirements for the study population. The demographic makeup of the study population closely mirrored the demographic makeup of the former foster care eligible population, except that there were 4.2 percentage points more members 19 to 22 years of age and 2.8 percentage points more male members.

Table B-3 and Table B-6 present the demographic and health characteristics of continuously enrolled former foster care members (n=1,368) and the continuously enrolled comparison group (n=160,211) prior to matching. Continuously enrolled former foster care members were more likely to be younger, male, and White; less likely to be enrolled with Aetna; more likely to be enrolled with Sentara; and less likely to be in the MLTSS population 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. Additionally, former foster care members were more likely to have ED visits for mental health than the controls, which may indicate greater severity of mental illness among former foster care members.

HSAG was able to match 99.8 percent (n=1,365) of continuously enrolled former foster care members to members in the comparison group with similar demographic and health characteristics. Table B-9 and Table B-12 present the demographic and health characteristics of the final study population and their matched controls. Matching successfully balanced all demographic and health characteristics between the study population and the controls.

Appendix B: 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.

⁴⁸ United States Census Bureau. Virginia QuickFacts. Available at: <https://www.census.gov/quickfacts/VA>. Accessed on: Nov 18, 2025.

⁴⁹ MY 2024 census data were not available as of October 2025.

⁵⁰ Former foster care members may temporarily move to FFS and may not be enrolled with an MCO during the measurement year.

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 2024. 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 MY 2024 rates for All Eligible Members to the national Medicaid 50th percentile, discusses the change in the rates for All Eligible Members from MY 2023 to MY 2024, and discusses health disparities identified in MY 2024.

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 2022 and MY 2023 may also be impacted by the COVID-19 pandemic; however, rate comparisons within MY 2022 and MY 2023 (i.e., to controls) are still reliable.

Primary Care

Child and Adolescent Well-Care Visits (WCV)

Table 5-2 displays the MY 2022, MY 2023, and MY 2024 *Child and Adolescent Well-Care Visits* rates among former foster care members and controls stratified by member characteristics. Additionally, 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 2022		MY 2023		MY 2024	
	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate
All Eligible Members	17.8%	16.6%	21.1%	20.1%	21.9%	21.6%
Sex						
Male	7.8%	9.1%	15.8%	13.4%	15.6%	13.2%
Female	28.6%	25.3%	27.3%	29.3%	28.3%	32.0%
Race						
Black or African American	19.0%	15.4%	19.8%	20.0%	20.7%	19.7%
White	17.1%	17.5%	21.5%	19.9%	22.0%	23.2%
Other	17.6%	11.8%	28.6%	27.3%	33.3%	10.0%
Region						
Central	20.8%	15.6%	24.0%	18.9%	22.0%	30.0%
Charlottesville/Western	23.1%	15.8%	23.1%	27.8%	23.1%	10.3%
Northern & Winchester	15.6%	22.5%	25.8%	19.1%	25.0%	16.7%
Roanoke/Alleghany	18.3%	17.2%	17.5%	13.6%	22.9%	17.6%
Southwest	11.8%	9.1%	14.3%	21.7%	17.9%	31.8%
Tidewater	14.3%	18.2%	17.9%	20.0%	16.7%	20.3%
MCO						
Aetna	26.5%	9.5%	18.5%	21.6%	25.0%	8.8%
HealthKeepers	17.7%	18.8%	17.4%	19.9%	19.8%	21.4%
Molina	11.1%	10.0%	27.8%	6.7%	28.6%	26.1%
Sentara*	17.4%	16.0%	23.8%	21.2%	20.0%	23.5%
United	13.3%	26.5%	10.0%	12.5%	27.5%	20.5%
More Than One MCO	50.0%	0.0%	50.0%	50.0%	20.0%	—

Blue shading indicates that a disparity was identified (i.e., had a p-value less than 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 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.

* HSAG combined Optima and VA Premier for MY 2022 in this year's report and displayed the rates as Sentara. For MY 2023, HSAG included members with enrollment in Optima or VA Premier prior to July 2023 in the rate for Sentara.

Table 5-2 shows that 21.9 percent of former foster care members and 21.6 percent of controls had a well-care visit with a PCP or an OB/GYN during MY 2024, and the difference was not statistically significant ($p=0.92$). The rates for former foster care members were notably higher than controls for

members in the Charlottesville/Western, Northern & Winchester, and Roanoke/Alleghany regions (by 12.8, 8.3, and 5.3 percentage points, respectively) and members enrolled with United (by 7.0 percentage points, respectively). Conversely, the rates for former foster care members were notably lower than controls for members in the Central and Southwest regions (by 8.0 and 13.9 percentage points, respectively). While there were large rate differences between former foster care members and controls for members for members in the Other racial group and members enrolled with Aetna, these rates had small denominators, so the rates may be less reliable.

For all eligible members, the MY 2024 rates for both former foster care members and controls were below the 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 and controls increased from MY 2023 to MY 2024 by 0.8 percentage points and 1.5 percentage points, respectively. For both former foster care members and controls, male members were significantly less likely to have a well-care visit during MY 2024, while female members were significantly more likely. These disparities also existed during MY 2022 and MY 2023.

Oral Health

Annual Dental Visit (ADV)

Table 5-3 displays the MY 2022, MY 2023, and MY 2024 *Annual Dental Visit* rates among former foster care members and controls stratified by member characteristics. Additionally, 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.⁵¹ 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 2022		MY 2023		MY 2024	
	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate
All Eligible Members	29.1%	28.0%	44.1% ⁺	26.6%	39.6%	36.8%
Sex						
Male	21.4%	25.3%	43.8%	21.4%	40.8%	29.8%
Female	36.2%	31.3%	44.4%	33.0%	38.6%	46.2%

⁵¹ HSAG modified the specifications for this measure in MY 2023 to allow visits with any provider authorized to provide dental services but restricted visits to those with a Current Dental Terminology (CDT) code to ensure only visits for dental services were counted. Please see the Healthcare Utilization Analysis section in the Overview and Methodology for more details regarding these updates.

Category	MY 2022		MY 2023		MY 2024	
	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate
Race						
Black or African American	25.7%	27.0%	62.1%	28.7%	40.0%	38.6%
White	31.4%	27.2%	38.2%	26.2%	39.1%	35.7%
Other	25.0%	62.5%	—	0.0%^	50.0%	33.3%
Region						
Central	34.3%	27.4%	74.3%	25.0%	53.3%	53.8%
Charlottesville/Western	46.2%	35.6%	30.8%	24.2%	45.2%	29.7%
Northern & Winchester	37.5%	46.2%	58.3%	51.7%	50.0%	65.5%
Roanoke/Alleghany	17.2%	27.1%	20.0%	16.1%	24.4%	21.1%
Southwest	28.6%	15.6%	19.0%	18.2%	38.9%	31.8%
Tidewater	14.6%	20.8%	44.4%	26.3%	12.5%	14.7%
MCO						
Aetna	31.6%	30.8%	63.6%	13.0%	53.3%	47.1%
HealthKeepers	36.4%	32.0%	47.4%	28.2%	44.7%	48.1%
Molina	15.4%	25.0%	33.3%	37.5%	12.5%	18.2%
Sentara*	27.6%	27.9%	38.5%	27.2%	36.4%	33.3%
United	20.0%	11.1%	33.3%	21.4%	42.9%	27.8%
More Than One MCO	33.3%	20.0%	100.0%^	66.7%^	—	—

Blue shading indicates that a disparity was identified (i.e., had a p-value less than 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 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.

* HSAG combined Optima and VA Premier for MY 2022 in this year's report and displayed the rates as Sentara. For MY 2023, HSAG included members with enrollment in Optima or VA Premier prior to July 2023 in the rate for Sentara.

Table 5-3 shows that 39.6 percent of former foster care members and 36.8 percent of controls had a dental visit during MY 2024, and the difference was not statistically significant ($p=0.58$). The rates for former foster care members were notably higher than controls for male members (by 11.0 percentage points) and members in the Charlottesville/Western region (by 15.5 percentage points). The rates for former foster care members were notably lower than controls for female members (by 7.6 percentage points). While there were large rate differences for members in the Other racial group; members in the Northern & Winchester and Southwest regions; and members enrolled with Aetna, Molina, and United, these rates had small denominators, so the rates may be less reliable.

Rates could not be compared to a benchmark for this indicator since national Medicaid benchmarks were not available after MY 2021. The rate for former foster care members decreased by 4.5 percentage points from MY 2023 to MY 2024, while the rate for controls increased by 10.2 percentage points. For former foster care members and controls, members in the Roanoke/Allegheny region were significantly less likely to have a dental visit compared to members in other regions during MY 2024, while members in the Central region were significantly more likely. The disparity for the Central region also existed for former foster care members during MY 2023. For former foster care members, members living in the Southwest region were significantly less likely to have a dental visit during MY 2023; however, this disparity no longer existed during MY 2024 due to an increase in the rate for these members (by 19.9 percentage points).

Preventive Dental Services (PDENT-CH)

Table 5-4 displays the MY 2022, MY 2023, and MY 2024 *Preventive Dental Services* rates among former foster care members and controls stratified by member characteristics. Additionally, 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 2022		MY 2023		MY 2024	
	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate
All Eligible Members	21.7%	21.7%	37.2% ⁺	21.5%	31.1%	27.9%
Sex						
Male	12.2%	18.8%	34.3%	18.0%	30.3%	22.6%
Female	30.5%	25.0%	40.7%	25.7%	31.8%	34.7%
Race						
Black or African American	17.6%	20.7%	46.7%	24.2%	27.5%	25.0%
White	24.0%	21.0%	34.1%	20.3%	31.6%	29.5%
Other	25.0%	50.0%	—	0.0% [^]	50.0%	33.3%
Region						
Central	27.1%	19.2%	66.7%	22.1%	41.3%	39.6%
Charlottesville/Western	30.8%	31.1%	22.2%	20.6%	41.9%	18.9%
Northern & Winchester	31.3%	43.6%	50.0%	41.4%	33.3%	53.3%
Roanoke/Alleghany	10.3%	20.8%	13.3%	9.4%	15.6%	18.4%
Southwest	23.8%	6.3%	19.0%	13.0%	31.6%	24.0%
Tidewater	9.8%	14.3%	30.0%	21.1%	12.5%	11.1%

Category	MY 2022		MY 2023		MY 2024	
	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate
MCO						
Aetna	31.6%	23.1%	36.4%	12.5%	46.7%	31.6%
HealthKeepers	27.3%	26.8%	40.0%	25.3%	33.3%	37.5%
Molina	0.0%^	12.5%^	33.3%	25.0%	0.0%^	16.7%^
Sentara*	21.4%	20.6%	34.0%	21.0%	30.8%	24.6%
United	13.3%	11.1%	33.3%	14.3%	28.6%	22.2%
More Than One MCO	0.0%^	20.0%^	100.0%^	33.3%^	—	—

Blue shading indicates that a disparity was identified (i.e., had a p-value less than 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 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.

* HSAG combined Optima and VA Premier for MY 2022 in this year's report and displayed the rates as Sentara. For MY 2023, HSAG included members with enrollment in Optima or VA Premier prior to July 2023 in the rate for Sentara.

Table 5-4 shows that 31.1 percent of former foster care members and 27.9 percent of controls had a preventive dental service during MY 2024, and the difference was not statistically significant ($p=0.50$). The rates for former foster care members were notably higher than controls for male members (by 7.7 percentage points), members in the Charlottesville/Western region (by 23.0 percentage points), and members enrolled with Sentara (by 6.2 percentage points). While there were large rate differences for members in the Other racial group; members in the Northern & Winchester and Southwest regions; and members enrolled with Aetna, Molina, and United, these rates had small denominators and may be less reliable.

Rates could not be compared to a benchmark since national Medicaid benchmarks were not available for this indicator. The rate for former foster care members decreased by 6.1 percentage points from MY 2023 to MY 2024, while the rate for controls increased by 6.4 percentage points. For former foster care members only, members in the Roanoke/Alleghany region were significantly less likely to have a preventive dental service compared to members in other regions during MY 2024.

Oral Evaluation, Dental Services (OEV-CH)

Table 5-5 displays the MY 2022, MY 2023, and MY 2024 Oral Evaluation, Dental Services rates among former foster care members and controls stratified by member characteristics. Additionally, 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 2022		MY 2023		MY 2024	
	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate
All Eligible Members	22.2%	22.0%	39.7% ⁺	21.0%	32.9%	30.1%
Sex						
Male	14.3%	20.0%	37.3%	17.2%	32.9%	25.0%
Female	29.5%	24.3%	42.6%	25.7%	32.9%	36.8%
Race						
Black or African American	18.9%	20.7%	56.7%	25.3%	30.0%	29.8%
White	24.0%	21.5%	34.1%	18.8%	33.3%	30.3%
Other	25.0%	50.0%	—	0.0% [^]	50.0%	33.3%
Region						
Central	27.1%	20.5%	66.7%	23.4%	45.7%	43.4%
Charlottesville/Western	34.6%	31.1%	25.9%	20.6%	38.7%	18.9%
Northern & Winchester	31.3%	46.2%	50.0%	41.4%	50.0%	60.0%
Roanoke/Alleghany	10.3%	18.8%	20.0%	3.1%	15.6%	21.1%
Southwest	23.8%	6.3%	19.0%	13.0%	31.6%	24.0%
Tidewater	9.8%	14.3%	40.0%	21.1%	12.5%	11.1%
MCO						
Aetna	31.6%	15.4%	54.5%	12.5%	46.7%	36.8%
HealthKeepers	25.5%	27.8%	40.0%	25.3%	35.9%	41.1%
Molina	0.0% [^]	12.5% [^]	33.3%	25.0%	0.0% [^]	16.7% [^]
Sentara*	21.4%	21.2%	35.8%	20.0%	30.8%	26.3%
United	20.0%	11.1%	33.3%	14.3%	38.1%	22.2%
More Than One MCO	33.3%	20.0%	100.0% [^]	33.3% [^]	—	—

Blue shading indicates that a disparity was identified (i.e., had a p-value less than 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 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.

* HSAG combined Optima and VA Premier for MY 2022 in this year's report and displayed the rates as Sentara. For MY 2023, HSAG included members with enrollment in Optima or VA Premier prior to July 2023 in the rate for Sentara.

Table 5-5 shows that 32.9 percent of former foster care members and 30.1 percent of controls had a comprehensive or periodic oral evaluation during MY 2024, and the difference was not statistically significant ($p=0.56$). The rates for former foster care members were notably higher than controls for male members (by 7.9 percentage points) and members in the Charlottesville/Western region (by 19.8 percentage points). Conversely, the rates for former foster care members were notably lower than controls for members in the Roanoke/Alleghany region (by 5.5 percentage points) and members enrolled with HealthKeepers (by 5.2 percentage points). While there were large rate differences for members in the Other racial group; members in the Northern & Winchester and Southwest regions; and members enrolled with Aetna, Molina, and United, these rates had small denominators and may be less reliable.

Rates could not be compared to a benchmark since comparable national Medicaid benchmarks were not available for this indicator for this age group. The rate for former foster care members decreased by 6.8 percentage points from MY 2023 to MY 2024, while the rate for controls increased by 9.1 percentage points. For both former foster care members and controls, members in the Central region were significantly more likely to have an oral evaluation compared to members in other regions during MY 2024, and this disparity also existed for former foster care members during MY 2023. For former foster care members only, members in the Roanoke/Alleghany region were significantly less likely to have an oral evaluation during MY 2024. Additionally, members in the Southwest region were significantly less likely to have an oral evaluation compared to members in other regions during MY 2023; however, this disparity no longer existed during MY 2024 due to an increase in the rate for members in the Southwest region (by 12.6 percentage points).

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

Table 5-6 displays the MY 2022, MY 2023, and MY 2024 *Topical Fluoride for Children—Dental or Oral Health Services* rates among former foster care members and controls stratified by member characteristics. Additionally, 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 Among Former Foster Care Members and Controls

Category	MY 2022		MY 2023		MY 2024	
	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate
All Eligible Members	4.9%	3.5%	8.5%	5.7%	8.2%	8.5%
Sex						
Male	2.0%	2.4%	7.8%	6.3%	9.2%	9.1%
Female	7.6%	4.9%	9.3%	4.9%	7.2%	7.7%
Race						
Black or African American	5.4%	3.6%	13.8%	4.3%	5.0%	7.2%
White	4.1%	3.6%	6.7%	6.9%	7.8%	9.5%
Other	12.5%^	0.0%^	—	0.0%^	50.0%^	0.0%^
Region						
Central	11.4%	4.1%	17.1%	3.9%	15.6%	9.6%
Charlottesville/Western	3.8%	4.4%	3.8%	12.1%	9.7%	8.1%
Northern & Winchester	6.3%	7.7%	8.3%	17.2%	8.3%	13.8%
Roanoke/Alleghany	0.0%^	0.0%^	0.0%^	0.0%^	2.2%^	0.0%^
Southwest	0.0%^	3.1%^	4.8%	4.5%	5.6%	13.6%
Tidewater	0.0%^	2.6%^	11.1%^	0.0%^	0.0%^	8.8%^
MCO						
Aetna	5.3%^	0.0%^	9.1%^	0.0%^	20.0%	5.9%
HealthKeepers	7.3%	4.1%	7.9%	5.1%	13.2%	17.3%
Molina	0.0%^	12.5%^	0.0%^	12.5%^	0.0%^	0.0%^
Sentara*	4.1%	3.0%	9.6%	5.8%	6.5%	5.3%
United	6.7%^	0.0%^	11.1%	14.3%	0.0%^	11.1%^
More Than One MCO	0.0%^	0.0%^	0.0%^	0.0%^	—	—

Blue shading indicates that a disparity was identified (i.e., had a p-value less than 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 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.

* HSAG combined Optima and VA Premier for MY 2022 in this year's report and displayed the rates as Sentara. For MY 2023, HSAG included members with enrollment in Optima or VA Premier prior to July 2023 in the rate for Sentara.

Table 5-6 shows that 8.2 percent of former foster care members and 8.5 percent of controls received at least two topical fluoride applications as dental or oral health services during MY 2024, and the difference was not statistically significant ($p=0.91$). 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.⁵² 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).⁵³ The rate for former foster care members was notably higher than controls for members in the Central region (by 6.0 percentage points). While there were large rate differences for members in the Other racial group; members in the Northern & Winchester, Southwest, and Tidewater regions; and members enrolled with Aetna and United, these rates had small denominators and may be less reliable.

Comparable national Medicaid benchmarks were not available for this indicator for this age group. The rate for former foster care members decreased by 0.3 percentage points from MY 2023 to MY 2024, while the rate for controls increased by 2.8 percentage points. For former foster care members only, members in the Central region were significantly more likely to have at least two topical fluoride applications compared to members in other regions during MY 2024, and this disparity existed during MY 2022 and MY 2023 as well.

Behavioral Health

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

Table 5-7 displays the MY 2022, MY 2023, and MY 2024 *Antidepressant Medication Management—Effective Acute Phase Treatment* rates among former foster care and controls stratified by member characteristics. Additionally, member characteristics with identified health disparities are indicated with shading. The *Antidepressant Medication Management—Effective Acute 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 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.

⁵² American Dental Association. Fluoride: Topical and Systemic Supplements. Available at: <https://www.ada.org/resources/ada-library/oral-health-topics/fluoride-topical-and-systemic-supplements>. Accessed on: Nov 18, 2025.

⁵³ Ibid.

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

Category	MY 2022		MY 2023		MY 2024	
	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate
All Eligible Members	27.8%	36.2%	35.3%	37.8%	33.8%	42.6%
Age Category						
19-22 years	26.2%	38.1%	31.4%	36.0%	34.8%	43.2%
23-26 Years	31.3%	33.3%	41.2%	40.6%	31.6%	41.2%
Sex						
Male	13.5%	32.4%	29.0%	41.4%	28.0%	11.1%
Female	36.7%	38.2%	38.9%	35.8%	37.5%	55.8%
Race						
Black or African American	30.8%	24.0%	21.9%	36.0%	25.0%	52.9%
White	26.5%	39.0%	42.3%	37.5%	37.2%	38.6%
Other	33.3%	66.7%	100.0%^	100.0%^	50.0%	—
Region						
Central	19.2%	22.2%	26.1%	30.4%	36.4%	41.2%
Charlottesville/Western	29.4%	33.3%	29.4%	50.0%	53.3%	55.6%
Northern & Winchester	16.7%	53.8%	60.0%	33.3%	0.0%^	60.0%^
Roanoke/Alleghany	33.3%	40.0%	41.7%	29.4%	30.0%	28.6%
Southwest	29.4%	50.0%	60.0%	42.9%	14.3%	55.6%
Tidewater	38.5%	28.6%	27.8%	46.7%	22.2%	28.6%
MCO						
Aetna	36.4%	25.0%	37.5%^	0.0%^	50.0%	66.7%
HealthKeepers	26.1%	26.7%	26.7%	31.0%	29.4%	44.4%
Molina	50.0%	12.5%	100.0%^	50.0%^	0.0%^	—
Sentara*	26.5%	46.2%	36.2%	47.4%	33.3%	40.6%
United	14.3%	40.0%	33.3%	42.9%	37.5%	37.5%
More Than One MCO	0.0%^	50.0%^	—	—	—	—

Blue shading indicates that a disparity was identified (i.e., had a p-value less than 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 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.

* HSAG combined Optima and VA Premier for MY 2022 in this year’s report and displayed the rates as Sentara. For MY 2023, HSAG included members with enrollment in Optima or VA Premier prior to July 2023 in the rate for Sentara.

Table 5-7 shows that 33.8 percent of former foster care members and 42.6 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 2024, and the difference was not statistically significant ($p=0.31$). The rates for former foster care members were notably lower than controls for female members (by 18.3 percentage points). While there were large rate differences for members 23 to 26 years of age, male members, Black or African American members, members in the Northern & Winchester and Southwest regions, and members enrolled with Aetna and HealthKeepers during MY 2024, the denominators for these rates were small and these rates may be less reliable.

For all eligible members, the MY 2024 rates for both former foster care members and controls were below the national Medicaid 50th percentile. The rate for former foster care members decreased by 1.5 percentage points from MY 2023 to MY 2024, while the rate for controls increased by 4.8 percentage points.

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

Table 5-8 displays the MY 2022, MY 2023, and MY 2024 *Antidepressant Medication Management—Effective Continuation Phase Treatment* rates among former foster care and controls stratified by member characteristics. Additionally, 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 2022		MY 2023		MY 2024	
	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate
All Eligible Members	12.4%	16.2%	15.3%	24.4%	10.8%	23.0%
Age Category						
19-22 years	9.2%	14.3%	15.7%	24.0%	13.0%	29.5%
23-26 Years	18.8%	19.0%	14.7%	25.0%	5.3%	5.9%
Sex						
Male	2.7%	21.6%	9.7%	34.5%	8.0%^	0.0%^
Female	18.3%	13.2%	18.5%	18.9%	12.5%^	32.6%^

Category	MY 2022		MY 2023		MY 2024	
	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate
Race						
Black or African American	11.5%	4.0%	3.1%	20.0%	10.0%	23.5%
White	11.8%	18.2%	23.1%	26.8%	11.6%	22.7%
Other	33.3%	66.7%	0.0%^	0.0%^	0.0%^	—
Region						
Central	7.7%	5.6%	13.0%	13.0%	13.6%	11.8%
Charlottesville/Western	17.6%	19.0%	17.6%	50.0%	20.0%	44.4%
Northern & Winchester	0.0%^	30.8%^	20.0%	33.3%	0.0%^	40.0%^
Roanoke/Alleghany	16.7%	20.0%	16.7%	17.6%	10.0%	21.4%
Southwest	5.9%	16.7%	20.0%	28.6%	0.0%^	11.1%^
Tidewater	23.1%	9.5%	11.1%	20.0%	0.0%^	28.6%^
MCO						
Aetna	9.1%	12.5%	12.5%^	0.0%^	0.0%^	33.3%^
HealthKeepers	13.0%	13.3%	13.3%	20.7%	11.8%	22.2%
Molina	16.7%^	0.0%^	100.0%^	0.0%^	0.0%^	—
Sentara*	14.3%	21.2%	15.5%	34.2%	12.1%	25.0%
United	0.0%^	20.0%^	0.0%^	14.3%^	12.5%	12.5%
More Than One MCO	0.0%^	0.0%^	—	—	—	—

Blue shading indicates that a disparity was identified (i.e., had a p-value less than 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 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.

* HSAG combined Optima and VA Premier for MY 2022 in this year's report and displayed the rates as Sentara. For MY 2023, HSAG included members with enrollment in Optima or VA Premier prior to July 2023 in the rate for Sentara.

Table 5-8 shows that 10.8 percent of former foster care members and 23.0 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 2024, and the difference was not statistically significant ($p=0.07$). The rates for former foster care members were notably lower than controls for members 19 to 22 years of age (by 16.5 percentage points), female members (by 20.1 percentage points), and members enrolled with Sentara (by 12.9 percentage points). While there were large rate differences for Black or African American members; members in the Charlottesville/Western,

Northern & Winchester, and Tidewater regions; and members enrolled with Aetna, these rates had small denominators, so the rates may be less reliable.

For all eligible members, the MY 2024 rates for both former foster care members and controls were below the national Medicaid 50th percentile. The rates for former foster care members and controls decreased from MY 2023 to MY 2024 by 4.5 percentage points and 1.4 percentage points, respectively.

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

Table 5-9 displays the MY 2022, MY 2023, and MY 2024 *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* rates among former foster care members and controls stratified by member characteristics. Additionally, 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 2022		MY 2023		MY 2024	
	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate
All Eligible Members	14.9%	32.1%	25.8%	18.8%	39.7%	44.8%
Age Category						
19-22 years	20.0%	35.3%	22.5%	11.1%	40.6%	34.8%
23-26 Years	4.5%	27.3%	30.8%	28.6%	38.7%	83.3%
Sex						
Male	12.0%	25.0%	28.2%	20.0%	44.7%	45.0%
Female	16.7%	41.7%	22.2%	17.6%	32.0%	44.4%
Race						
Black or African American	21.4%	26.7%	21.4%^	0.0%^	33.3%	36.4%
White	8.1%	41.7%	29.7%^	27.3%^	42.9%	50.0%
Other	50.0%^	0.0%^	0.0%^	0.0%^	—	—
Region						
Central	26.1%	33.3%	30.0%	33.3%	50.0%	55.6%
Charlottesville/Western	12.5%	20.0%	20.0%	20.0%	14.3%	33.3%
Northern & Winchester	33.3%	33.3%	50.0%	25.0%	75.0%	66.7%
Roanoke/Alleghany	9.1%	50.0%	33.3%	12.5%	40.0%	50.0%
Southwest	0.0%^	0.0%^	0.0%^	0.0%^	50.0%^	0.0%^

Category	MY 2022		MY 2023		MY 2024	
	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate
Tidewater	7.1%	25.0%	25.0%^	0.0%^	21.4%	25.0%
MCO						
Aetna	50.0%^	0.0%^	0.0%^	50.0%^	100.0%^	100.0%^
HealthKeepers	10.5%	50.0%	18.8%	9.1%	47.1%	36.4%
Molina	0.0%^	20.0%^	33.3%	50.0%	0.0%^	—
Sentara*	16.7%	30.8%	27.3%	15.4%	25.0%	36.4%
United	0.0%^	50.0%^	28.6%^	0.0%^	33.3%	66.7%
More Than One MCO	0.0%^	—	100.0%^	50.0%^	100.0%^	—

Blue shading indicates that a disparity was identified (i.e., had a p-value less than 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 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.

** HSAG combined Optima and VA Premier for MY 2022 in this year’s report and displayed the rates as Sentara. For MY 2023, HSAG included members with enrollment in Optima or VA Premier prior to July 2023 in the rate for Sentara.*

Table 5-9 shows that 39.7 percent of former foster care members and 44.8 percent of controls had a follow-up visit with a mental health provider within seven days after discharge during MY 2024, and the difference was not statistically significant ($p=0.64$). While there were large rate differences for both age groups, female members; White members; members across all regions; and members enrolled with HealthKeepers, Sentara, and United, these rates had small denominators and may be less reliable.

For all eligible members, the MY 2024 rates for former foster care members and controls were above the national Medicaid 50th percentile for members 18 to 64 years of age. The rates for former foster care members and controls increased from MY 2023 to MY 2024 by 13.9 percentage points and 26.0 percentage points, respectively. For former foster care members only, members enrolled with Sentara were significantly less likely to have a follow-up visit within seven days after discharge compared to members enrolled with other MCOs.

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

Table 5-10 displays the MY 2022, MY 2023, and MY 2024 *Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up* rates among former foster care members and controls stratified by member characteristics. Additionally, 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 18 years of age and older 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 2022		MY 2023		MY 2024	
	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate
All Eligible Members	36.4%	43.8%	48.6%	58.8%	56.0%	44.4%
Age Category						
19-22 years	53.8%	50.0%	56.5%	70.0%	52.9%^	50.0%^
23-26 Years	11.1%	33.3%	33.3%	42.9%	62.5%^	0.0%^
Sex						
Male	40.9%	37.5%	55.0%	71.4%	57.9%	40.0%
Female	31.8%	50.0%	40.0%	50.0%	50.0%	50.0%
Race						
Black or African American	45.8%	20.0%	55.6%	50.0%	33.3%	40.0%
White	26.3%	55.6%	46.2%	61.5%	68.8%	50.0%
Other	0.0%^	50.0%^	—	—	—	—
Region						
Central	42.9%	42.9%	68.8%	25.0%	85.7%	50.0%
Charlottesville/Western	40.0%	33.3%	40.0%	—	33.3%	—
Northern & Winchester	0.0%^	—	100.0%^	100.0%^	33.3%	—
Roanoke/Alleghany	14.3%	33.3%	25.0%^	100.0%^	71.4%	—
Southwest	50.0%^	100.0%^	50.0%	50.0%	0.0%^	—
Tidewater	45.5%	50.0%	14.3%^	100.0%^	25.0%	42.9%
MCO						
Aetna	40.0%	50.0%	71.4%^	100.0%^	50.0%	—
HealthKeepers	33.3%	25.0%	62.5%	57.1%	55.6%	33.3%
Molina	50.0%^	0.0%^	0.0%^	—	—	—
Sentara*	37.5%	62.5%	35.3%	55.6%	58.3%	60.0%
United	0.0%^	0.0%^	100.0%^	—	50.0%^	0.0%^
More Than One MCO	100.0%^	—	—	—	—	—

Blue shading indicates that a disparity was identified (i.e., had a p-value less than 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 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.
- * HSAG combined Optima and VA Premier for MY 2022 in this year's report and displayed the rates as Sentara. For MY 2023, HSAG included members with enrollment in Optima or VA Premier prior to July 2023 in the rate for Sentara.

Table 5-10 shows that 56.0 percent of former foster care members and 44.4 percent of controls had a follow-up visit within 30 days after an ED visit during MY 2024, and the difference was not statistically significant ($p=0.70$). While there were large rate differences between former foster care members and controls for members 23 to 26 years of age, male members, White members, members in the Central and Tidewater regions, and members enrolled with HealthKeepers and United, these rates had small denominators, so the rates may be less reliable.

For all eligible members, the MY 2024 rates for former foster care members were higher than the national Medicaid 50th percentile for members 18 to 64 years of age, while the rate for controls was below the national Medicaid 50th percentile. The rate for former foster care members increased by 7.4 percentage points from MY 2023 to MY 2024, while the rate for controls decreased by 14.4 percentage points, returning to a rate similar to MY 2022. There were no disparities identified for former foster care members during MY 2024.

Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD-AD)

Table 5-11 displays the MY 2023 and MY 2024 *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* rates among former foster care members and controls stratified by member characteristics. Additionally, member characteristics with identified health disparities are indicated with shading. The *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* indicator measures the percentage of members 18 to 64 years of age with schizophrenia, schizoaffective disorder, or bipolar disorder and were dispensed an antipsychotic medication who had a diabetes screening test 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 5-11—Rates of Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications Among Former Foster Care Members and Controls

Category	MY 2022		MY 2023		MY 2024	
	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate
All Eligible Members	—	—	66.7%	58.9%	65.7%	53.3%
Age Category						
19-22 years	—	—	70.0%	58.8%	62.8%	47.8%
23-26 Years	—	—	62.1%	59.1%	70.8%	59.1%

Category	MY 2022		MY 2023		MY 2024	
	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate
Sex						
Male	—	—	58.3%	42.3%	62.2%	47.6%
Female	—	—	75.8%	73.3%	70.0%	58.3%
Race						
Black or African American	—	—	73.5%	70.6%	60.0%	61.5%
White	—	—	61.8%	56.8%	69.0%	50.0%
Other	—	—	0.0%^	0.0%^	—	—
Region						
Central	—	—	57.7%	55.6%	67.9%	18.2%
Charlottesville/Western	—	—	66.7%	40.0%	83.3%	40.0%
Northern & Winchester	—	—	85.7%	42.9%	25.0%	60.0%
Roanoke/Alleghany	—	—	80.0%	77.8%	69.2%	77.8%
Southwest	—	—	33.3%	60.0%	0.0%^	66.7%^
Tidewater	—	—	71.4%	85.7%	66.7%	66.7%
MCO						
Aetna	—	—	57.1%	40.0%	83.3%	66.7%
HealthKeepers	—	—	64.3%	66.7%	60.0%	50.0%
Molina	—	—	50.0%	66.7%	50.0%^	0.0%^
Sentara*	—	—	68.4%	57.7%	72.4%	61.9%
United	—	—	33.3%	60.0%	33.3%	42.9%
More Than One MCO	—	—	100.0%^	50.0%^	100.0%^	50.0%^

Blue shading indicates that a disparity was identified (i.e., had a p-value less than 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 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.

* HSAG combined Optima and VA Premier for MY 2022 in this year's report and displayed the rates as Sentara. For MY 2023, HSAG included members with enrollment in Optima or VA Premier prior to July 2023 in the rate for Sentara.

Table 5-11 shows that that 65.7 percent of former foster care members and 53.3 percent of controls with schizophrenia, schizoaffective disorder, or bipolar disorder and dispensed an antipsychotic medication had a diabetes screening test during MY 2024, and the difference was not statistically significant ($p=0.19$). The rates for former foster care members were notably higher than controls for White members (by 19.0 percentage points). The rate differences between former foster care members

and controls were large for most other stratified rates, but the denominators for these rates were small, and the rates may not be reliable.

For all eligible members, the MY 2024 rates for both former foster care members and controls were below the national Medicaid 50th percentile. The rate for former foster care members and controls decreased from MY 2023 to MY 2024 by 1.0 percentage point and 5.6 percentage points, respectively. There were no disparities identified for former foster care members during MY 2024.

Substance Use

Follow-Up After ED Visit for Substance Use—30-Day Follow-Up (FUA)

Table 5-12 displays the MY 2022, MY 2023, and MY 2024 *Follow-Up After ED Visit for Substance Use—30-Day Follow-Up* rates among former foster care members and controls stratified by member characteristics. Additionally, member characteristics with identified health disparities are indicated with shading. The *Follow-Up After ED Visit for Substance Use—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 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.

Table 5-12—Rates of Follow-Up After ED Visit for Substance Use—30-Day Follow-Up Among Former Foster Care Members and Controls

Category	MY 2022		MY 2023		MY 2024	
	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate
All Eligible Members	18.4%	13.3%	20.0%	32.0%	25.0%	30.0%
Age Category						
19-22 years	20.8%^	0.0%^	33.3%	35.3%	31.3%	28.6%
23-26 Years	14.3%^	25.0%^	7.7%	25.0%	16.7%	33.3%
Sex						
Male	15.0%^	33.3%^	27.8%^	30.8%^	25.0%	20.0%
Female	22.2%^	0.0%^	0.0%^	33.3%^	25.0%	40.0%
Race						
Black or African American	11.1%^	0.0%^	16.7%	25.0%	0.0%^	—
White	20.7%	11.1%	22.2%	33.3%	38.9%^	30.0%
Other	—	25.0%	0.0%^	—	—	—
Region						
Central	0.0%^	—	25.0%	16.7%	25.0%	—
Charlottesville/Western	0.0%^	0.0%^	50.0%	75.0%	40.0%	—
Northern & Winchester	50.0%^	0.0%^	100.0%^	66.7%^	100.0%^	50.0%^
Roanoke/Alleghany	33.3%^	25.0%^	0.0%^	0.0%^	9.1%	28.6%

Category	MY 2022		MY 2023		MY 2024	
	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate
Southwest	20.0%	—	66.7%	16.7%	100.0%^	0.0%^
Tidewater	0.0%^	0.0%^	0.0%^	33.3%^	0.0%^	—
MCO						
Aetna	25.0%^	0.0%^	0.0%^	100.0%^	0.0%^	33.3%^
HealthKeepers	15.4%^	0.0%^	20.0%	40.0%	22.2%	50.0%
Molina	0.0%^	0.0%^	—	0.0%^	0.0%^	—
Sentara*	16.7%	11.1%	30.0%	20.0%	28.6%	20.0%
United	40.0%	—	0.0%^	50.0%^	33.3%	—
More Than One MCO	0.0%^	100.0%^	—	—	—	—

Blue shading indicates that a disparity was identified (i.e., had a p-value less than 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 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.

* HSAG combined Optima and VA Premier for MY 2022 in this year's report and displayed the rates as Sentara. For MY 2023, HSAG included members with enrollment in Optima or VA Premier prior to July 2023 in the rate for Sentara.

Table 5-12 shows that 25.0 percent of former foster care members and 30.0 percent of controls had a follow-up visit within 30 days after an ED visit for substance use during MY 2024, and the difference was not statistically significant ($p=1.00$). While there were large rate differences between former foster care members and controls for most of the stratified rates, these rates had small denominators, so the rates may be less reliable.

For all eligible members, the MY 2024 rates for both former foster care members and controls were below the 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 5.0 percentage points from MY 2023 to MY 2024, while the rate for controls decreased by 2.0 percentage points. There were no disparities identified for former foster care members during MY 2024.

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

Table 5-13 displays the MY 2022, MY 2023, and MY 2024 *Initiation and Engagement of SUD Treatment—Initiation of SUD Treatment* rates among former foster care members and controls stratified by member characteristics. Additionally, 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. 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—Initiation of SUD Treatment Among Former Foster Care Members and Controls

Category	MY 2022		MY 2023		MY 2024	
	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate
All Eligible Members	44.0%	43.3%	51.4%	51.9%	51.3% ⁻	70.1%
Age Category						
19-22 years	44.9%	40.4%	54.1%	56.9%	50.7%	73.0%
23-26 Years	43.0%	47.4%	48.9%	47.2%	52.2%	67.5%
Sex						
Male	47.9%	35.4%	52.6%	57.1%	62.5%	72.7%
Female	41.1%	52.4%	50.0%	45.8%	41.3%	68.2%
Race						
Black or African American	40.9%	57.1%	56.9%	72.7%	45.9%	60.0%
White	44.5%	42.2%	48.2%	46.3%	53.7%	72.7%
Other	60.0% [^]	0.0% [^]	100.0%	—	—	100.0% [^]
Region						
Central	54.1%	65.0%	60.8%	60.7%	60.5%	57.1%
Charlottesville/Western	42.9%	58.8%	48.6%	46.2%	53.8%	60.0%
Northern & Winchester	31.6%	50.0%	44.4%	45.5%	42.9%	77.8%
Roanoke/Alleghany	52.9%	36.8%	46.9%	53.3%	36.7%	61.5%
Southwest	37.5%	22.2%	46.2%	45.5%	100.0% [^]	100.0% [^]
Tidewater	34.6%	17.6%	50.0%	53.3%	36.4%	80.0%
MCO						
Aetna	33.3%	20.0%	43.8%	42.9%	27.3%	71.4%
HealthKeepers	45.8%	45.2%	52.0%	41.4%	43.8%	74.3%
Molina	36.4%	57.1%	50.0%	58.3%	100.0%	33.3%
Sentara*	44.4%	35.9%	53.9%	54.3%	55.0%	72.4%
United	47.1%	71.4%	22.2%	66.7%	66.7%	33.3%
More Than One MCO	60.0% [^]	100.0% [^]	71.4% [^]	100.0% [^]	66.7%	—

Blue shading indicates that a disparity was identified (i.e., had a p-value less than 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 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.

* HSAG combined Optima and VA Premier for MY 2022 in this year's report and displayed the rates as Sentara. For MY 2023, HSAG included members with enrollment in Optima or VA Premier prior to July 2023 in the rate for Sentara.

Table 5-13 shows that 51.3 percent of new SUD episodes among former foster care members and 70.1 percent of new SUD episodes among controls resulted in initiation of treatment within 14 days of diagnosis during MY 2024, and the difference was statistically significant ($p=0.01$). The rates for former foster care members were notably lower than controls for members 19 to 22 years of age (by 22.3 percentage points), female members (by 26.9 percentage points), White members (by 19.0 percentage points), and members enrolled with HealthKeepers (by 30.5 percentage points). While there were large rate differences between former foster care members and controls for members in the Roanoke/Alleghany, Northern & Winchester, and Tidewater regions and members enrolled with Aetna, Molina, and United, the denominators for these rates were small, so the rates may be less reliable.

For all eligible members, the MY 2024 rates for both former foster care members and controls were above the national Medicaid 50th percentile for members 18 to 64 years of age. The rate for former foster care members decreased by 0.1 percentage points from MY 2023 to MY 2024, while the rate for controls increased by 18.2 percentage points. For former foster care members only, female members were significantly less likely to initiate SUD treatment during MY 2024, while male members were significantly more likely.

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

Table 5-14 displays the MY 2022, MY 2023, and MY 2024 *Initiation and Engagement of SUD Treatment—Engagement of SUD Treatment* rates among former foster care members and controls stratified by member characteristics. Additionally, 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. Since the former foster care population includes members 19 to 26 years of age, this indicator has been modified to include the corresponding ages.

Table 5-14—Rates of Initiation and Engagement of SUD Treatment—Engagement of SUD Treatment Among Former Foster Care Members and Controls

Category	MY 2022		MY 2023		MY 2024	
	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate
All Eligible Members	13.7%	12.2%	15.0%	15.4%	20.2% ⁻	35.1%
Age Category						
19-22 years	11.2%	11.5%	12.9%	11.8%	20.5%	43.2%

Category	MY 2022		MY 2023		MY 2024	
	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate
23-26 Years	16.5%	13.2%	17.0%	18.9%	19.6%	27.5%
Sex						
Male	12.3%	10.4%	21.6%	17.9%	26.8%	30.3%
Female	14.7%	14.3%	6.6%	12.5%	14.3%	38.6%
Race						
Black or African American	6.8%	14.3%	12.1%	13.6%	10.8%	30.0%
White	16.0%	12.5%	16.7%	15.9%	24.4%	34.5%
Other	20.0%^	0.0%^	0.0%^	—	—	100.0%^
Region						
Central	18.9%	15.0%	5.9%	21.4%	26.3%	28.6%
Charlottesville/Western	14.3%	17.6%	25.7%	23.1%	23.1%	10.0%
Northern & Winchester	10.5%^	0.0%^	11.1%	9.1%	14.3%	33.3%
Roanoke/Alleghany	14.7%	15.8%	18.8%	20.0%	13.3%	30.8%
Southwest	16.7%	11.1%	23.1%	13.6%	33.3%	44.4%
Tidewater	3.8%	5.9%	5.0%^	0.0%^	13.6%	60.0%
MCO						
Aetna	20.0%^	0.0%^	12.5%	28.6%	9.1%	28.6%
HealthKeepers	10.4%	6.5%	6.0%	6.9%	9.4%	37.1%
Molina	9.1%	14.3%	0.0%^	8.3%^	100.0%^	0.0%^
Sentara*	12.5%	17.9%	20.2%	17.4%	21.7%	37.9%
United	17.6%	14.3%	11.1%	33.3%	41.7%	33.3%
More Than One MCO	40.0%^	0.0%^	28.6%^	0.0%^	33.3%	—

Blue shading indicates that a disparity was identified (i.e., had a p-value less than 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 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.

* HSAG combined Optima and VA Premier for MY 2022 in this year's report and displayed the rates as Sentara. For MY 2023, HSAG included members with enrollment in Optima or VA Premier prior to July 2023 in the rate for Sentara.

Table 5-14 shows that 20.2 percent of new SUD episodes among former foster care members and 35.1 percent of new SUD episodes among controls resulted in initiation of treatment within 14 days of diagnosis and engagement in ongoing SUD treatment during MY 2024, and the difference was

statistically significant ($p=0.02$). The rates for former foster care members were notably lower than controls for members 19 to 22 years of age (by 22.7 percentage points), female members (by 24.3 percentage points), and members enrolled with HealthKeepers (by 27.7 percentage points). While there were large rate differences between former foster care members and controls for Black or African American members; members in the Charlottesville/Western, Northern & Winchester, Roanoke/Alleghany, and Tidewater regions; and members enrolled with Aetna, Molina, and United, the denominators for these rates were small, so they may be less reliable.

For all eligible members, the MY 2024 rates for both former foster care members and controls were above the national Medicaid 50th percentile for members 18 to 64 years of age. The rates for former foster care members and controls increased from MY 2023 to MY 2024 by 5.2 percentage points and 19.7 percentage points, respectively. For former foster care members, female members were significantly less likely to engage in SUD treatment during MY 2023, while male members were significantly more likely; however, these disparities no longer existed during MY 2024 due to an increase in the rate for female members (by 7.7 percentage points). Additionally, members in the Central region and members enrolled with HealthKeepers were significantly less likely to engage in SUD treatment during MY 2023 compared to members enrolled with other MCOs; however, neither disparity existed during MY 2024 due to increases in these rates (by 20.4 percentage points and 3.4 percentage points, respectively).

Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD)

Table 5-15 displays the MY 2023 and MY 2024 *Use of Pharmacotherapy for Opioid Use Disorder* rates among former foster care members and controls stratified by member characteristics. Additionally, member characteristics with identified health disparities are indicated with shading. The *Use of Pharmacotherapy for Opioid Use Disorder* indicator measures the percentage of members 18 to 64 years of age with an opioid use disorder who filled a prescription for or were administered or dispensed a U.S. Food and Drug Administration (FDA)-approved medication for the disorder during the measurement year. Since the former foster care population includes members 19 to 26 years of age, this indicator has been modified to include the corresponding ages.

Table 5-15—Rates of Use of Pharmacotherapy for Opioid Use Disorder Among Former Foster Care Members and Controls

Category	MY 2022		MY 2023		MY 2024	
	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate
All Eligible Members	—	—	65.2%	71.4%	72.5%	78.6%
Age Category						
19-22 years	—	—	58.6%	73.1%	56.0%	66.7%
23-26 Years	—	—	70.3%	70.3%	88.5%	90.5%
Sex						
Male	—	—	58.3%	75.8%	77.8%	70.6%
Female	—	—	73.3%	66.7%	66.7%	84.0%

Category	MY 2022		MY 2023		MY 2024	
	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate
Race						
Black or African American	—	—	54.5%	66.7%	83.3%	87.5%
White	—	—	66.7%	72.2%	70.5%	75.8%
Other	—	—	100.0%^	—	100.0%^	100.0%^
Region						
Central	—	—	50.0%	76.5%	76.9%^	100.0%^
Charlottesville/Western	—	—	71.4%	75.0%	77.8%	75.0%
Northern & Winchester	—	—	71.4%	40.0%	100.0%^	44.4%^
Roanoke/Alleghany	—	—	72.2%	71.4%	71.4%^	100.0%^
Southwest	—	—	57.1%	75.0%	40.0%	77.8%
Tidewater	—	—	60.0%	66.7%	60.0%	75.0%
MCO						
Aetna	—	—	71.4%	77.8%	16.7%^	100.0%^
HealthKeepers	—	—	85.0%	66.7%	93.3%	84.6%
Molina	—	—	0.0%^	80.0%^	100.0%^	75.0%^
Sentara*	—	—	60.7%	75.0%	66.7%	76.5%
United	—	—	50.0%	66.7%	85.7%	60.0%
More Than One MCO	—	—	0.0%^	0.0%^	100.0%^	100.0%^

Blue shading indicates that a disparity was identified (i.e., had a p-value less than 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 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.

* HSAG combined Optima and VA Premier for MY 2022 in this year's report and displayed the rates as Sentara. For MY 2023, HSAG included members with enrollment in Optima or VA Premier prior to July 2023 in the rate for Sentara.

Table 5-15 shows that 72.5 percent of former foster care members with an opioid use disorder and 78.6 percent of controls with an opioid use disorder received pharmacotherapy during MY 2024, and the difference was not statistically significant ($p=0.50$). While there were large rate differences for most stratified rates, these rates had small denominators, so the rates may be less reliable.

For all eligible members, the MY 2024 rates for both former foster care members and controls were above the national Medicaid 50th percentile. The rates for former foster care members and controls increased from MY 2023 to MY 2024 by 7.3 percentage points and 7.2 percentage points, respectively.

For former foster care members only, members 19 to 22 years of age were significantly less likely to receive pharmacotherapy during MY 2024, while members 23 to 26 years of age were significantly more likely.

Respiratory Health

Asthma Medication Ratio (AMR)

Table 5-16 displays the MY 2022, MY 2023, and MY 2024 *Asthma Medication Ratio* rates among former foster care members and controls stratified by member characteristics. Additionally, 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 5-16 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, and there were few former foster care members ages 19 to 26 who met these criteria.

Table 5-16—Rates of Asthma Medication Ratio Among Former Foster Care Members and Controls

Category	MY 2022		MY 2023		MY 2024	
	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate
All Eligible Members	22.2%	60.0%	100.0%	57.9%	83.3%	37.5%
Sex						
Male	0.0%^	58.8%^	100.0%^	63.6%^	0.0%^	40.0%^
Female	28.6%^	61.5%^	100.0%^	50.0%^	100.0%^	33.3%^
Race						
Black or African American	25.0%	42.9%	—	57.1%^	50.0%^	33.3%^
White	20.0%	80.0%	100.0%	58.3%^	100.0%^	50.0%^
Other	—	0.0%^	—	—	—	0.0%^
Region						
Central	0.0%^	50.0%^	—	100.0%^	—	20.0%
Charlottesville/Western	66.7%^	33.3%^	100.0%^	66.7%^	100.0%^	100.0%^
Northern & Winchester	0.0%^	75.0%^	—	0.0%^	50.0%^	—
Roanoke/Alleghany	0.0%^	80.0%^	100.0%^	50.0%^	100.0%^	0.0%^
Southwest	—	100.0%^	—	66.7%^	—	—
Tidewater	0.0%^	60.0%^	—	40.0%^	—	100.0%^

Category	MY 2022		MY 2023		MY 2024	
	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate
MCO						
Aetna	—	100.0%^	—	—	—	0.0%^
HealthKeepers	0.0%^	44.4%^	100.0%^	42.9%^	100.0%^	100.0%^
Molina	—	0.0%^	—	—	0.0%^	—
Sentara*	33.3%^	62.5%^	100.0%^	62.5%^	100.0%^	40.0%^
United	0.0%^	100.0%^	—	66.7%^	—	0.0%^
More Than One MCO	—	—	—	100.0%^	—	—

Blue shading indicates that a disparity was identified (i.e., had a p-value less than 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 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.

** HSAG combined Optima and VA Premier for MY 2022 in this year's report and displayed the rates as Sentara. For MY 2023, HSAG included members with enrollment in Optima or VA Premier prior to July 2023 in the rate for Sentara.*

Table 5-16 shows that 83.3 percent of former foster care members and 37.5 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 2024, and the difference was not statistically significant ($p=0.14$). While there were large rate differences for female members, White members, members in the Roanoke/Alleghany region, and members enrolled with Sentara, these rates had very small denominators, so the rates may be less reliable.

For all eligible members, the MY 2024 rate for former foster care members was above the national Medicaid 50th percentile for members 19 to 50 years of age, while the rate for controls was below the 50th percentile. The rate for former foster care members and controls decreased from MY 2023 to MY 2024 by 16.7 percentage points and 20.4 percentage points, respectively. Since the denominators for the All Eligible Members group are small, a few members can drive large fluctuations in the rates. There were no disparities identified for former foster care members during MY 2024.

Service Utilization

Ambulatory Care Visits

Table 5-17 displays the MY 2022, MY 2023, and MY 2024 *Ambulatory Care Visits* rates among former foster care members and controls stratified by member characteristics. Additionally, 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 5-17—Rates of Ambulatory Care Visits Among Former Foster Care Members and Controls

Category	MY 2022		MY 2023		MY 2024	
	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate
All Eligible Members	60.5% ⁻	66.6%	57.0% ⁻	62.6%	59.9% ⁻	63.7%
Age Category						
19-22 years	61.3%	66.9%	61.0%	65.2%	60.9%	64.4%
23-26 Years	59.4%	66.1%	52.6%	59.8%	58.3%	62.6%
Sex						
Male	47.9%	55.6%	45.2%	50.6%	49.1%	51.8%
Female	74.0%	78.0%	70.8%	76.2%	72.4%	77.4%
Race						
Black or African American	57.2%	63.1%	51.6%	62.3%	55.6%	58.2%
White	62.6%	69.1%	60.9%	63.7%	62.4%	67.2%
Other	59.7%	58.2%	46.2%	49.2%	55.6%	50.0%
Region						
Central	63.2%	64.5%	59.5%	58.4%	62.6%	63.1%
Charlottesville/Western	63.5%	68.9%	63.2%	69.3%	66.2%	64.0%
Northern & Winchester	56.9%	63.6%	52.6%	60.2%	54.3%	61.6%
Roanoke/Alleghany	62.1%	70.5%	62.4%	63.2%	64.0%	65.3%
Southwest	62.1%	68.4%	58.7%	69.3%	60.6%	73.9%
Tidewater	55.1%	65.1%	46.5%	60.0%	49.6%	58.1%
MCO						
Aetna	62.6%	67.7%	55.5%	61.0%	61.7%	69.2%
HealthKeepers	63.4%	68.9%	58.4%	62.3%	59.0%	63.7%
Molina	46.5%	55.9%	40.0%	50.5%	43.0%	48.8%
Sentara*	61.2%	67.5%	58.4%	64.8%	60.2%	62.9%
United	54.6%	59.2%	56.1%	58.5%	68.0%	69.6%
More Than One MCO	84.6%	76.9%	71.4%	81.0%	90.9%	100.0%

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

+ 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.

* HSAG combined Optima and VA Premier for MY 2022 in this year's report and displayed the rates as Sentara. For MY 2023, HSAG included members with enrollment in Optima or VA Premier prior to July 2023 in the rate for Sentara.

Table 5-17 shows that 59.9 percent of former foster care members and 63.7 percent of controls had an ambulatory care visit during MY 2024, and the difference was statistically significant ($p=0.04$). Rates for former foster care members were notably lower than controls for members in the Northern & Winchester, Southwest, and Tidewater regions (by 7.3 percentage points, 13.3 percentage points, and 8.5 percentage points, respectively) and members enrolled with Aetna and Molina (by 7.5 percentage points and 5.8 percentage points, respectively). The rates for former foster care members were notably higher than controls for members in the Other racial group (by 5.6 percentage points). While there was a large rate difference for members enrolled with More Than One MCO, these denominators were small, so the rates may be less reliable.

Rates could not be compared to a national Medicaid benchmark since this indicator is a custom indicator developed for this analysis. The rate for former foster care members and controls increased from MY 2023 to MY 2024 by 2.9 percentage points and 1.1 percentage points, respectively. For former foster care members, members 23 to 26 years of age were significantly less likely to have an ambulatory care visit during MY 2023, while members 19 to 22 years of age were significantly more likely; however, this disparity no longer existed during MY 2024 due to an increase in the rate for members 23 to 26 years of age (by 5.7 percentage points). For both former foster care members and controls, male members were significantly less likely to have an ambulatory care visit during MY 2024, while female members were significantly more likely. These disparities also existed during MY 2022 and MY 2023. For both former foster care members and controls, Black or African American members were significantly less likely to have an ambulatory care visit during MY 2024, while White members were significantly more likely. The disparities for former foster care members also existed during MY 2022 and MY 2023. Additionally, for former foster care members and controls, members in the Tidewater region were significantly less likely to have an ambulatory care visit compared to members in other regions during MY 2024, while former foster care members in the Charlottesville/Western region were significantly more likely. These disparities also existed for former foster care members during MY 2023. For both former foster care members 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 2024. This disparity also existed during MY 2022 and MY 2023.

ED Visits

Table 5-18 displays the MY 2022, MY 2023, and MY 2024 *ED Visits* rates among former foster care members and controls stratified by member characteristics. Additionally, 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 5-18—Rates of ED Visits Among Former Foster Care Members and Controls

Category	MY 2022		MY 2023		MY 2024	
	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate
All Eligible Members	45.4% ⁺	39.1%	43.0% ⁺	37.7%	45.1% ⁺	38.0%
Age Category						
19-22 years	47.9%	39.4%	46.9%	37.2%	46.0%	38.2%
23-26 Years	41.6%	38.5%	38.5%	38.3%	43.9%	37.7%
Sex						
Male	39.1%	30.8%	34.7%	31.5%	38.2%	30.6%
Female	52.1%	47.7%	52.6%	44.7%	53.2%	46.7%
Race						
Black or African American	46.1%	43.1%	45.5%	42.4%	43.9%	41.0%
White	46.2%	37.8%	42.5%	36.3%	46.5%	37.5%
Other	25.4%	20.9%	27.7%	18.5%	27.8%	11.1%
Region						
Central	47.7%	39.9%	46.7%	42.3%	48.9%	41.0%
Charlottesville/Western	43.0%	35.8%	41.2%	29.6%	41.9%	30.2%
Northern & Winchester	45.1%	30.8%	33.7%	34.7%	37.8%	29.3%
Roanoke/Alleghany	49.4%	42.9%	55.1%	39.3%	51.6%	38.7%
Southwest	46.3%	42.6%	39.1%	43.6%	45.1%	46.5%
Tidewater	41.5%	40.4%	38.5%	36.0%	41.5%	41.1%
MCO						
Aetna	47.1%	43.9%	52.1%	37.7%	51.4%	43.0%
HealthKeepers	47.9%	39.3%	41.6%	36.8%	41.7%	36.3%
Molina	38.6%	33.9%	33.7%	32.6%	41.9%	33.7%
Sentara*	44.1%	39.4%	42.7%	38.7%	46.1%	39.8%
United	46.9%	31.5%	43.9%	39.8%	48.0%	31.2%
More Than One MCO	69.2%	76.9%	57.1%	33.3%	45.5%	63.6%

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

+ 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.

* HSAG combined Optima and VA Premier for MY 2022 in this year's report and displayed the rates as Sentara. For MY 2023, HSAG included members with enrollment in Optima or VA Premier prior to July 2023 in the rate for Sentara.

Table 5-18 shows that 45.1 percent of former foster care members and 38.0 percent of controls had an ED visit during MY 2024, and the difference was statistically significant (p<0.001). The rates for former

foster care members were notably higher than controls during MY 2024 for members 19 to 22 years of age (by 7.8 percentage points); male members (by 7.6 percentage points); White members and members in the Other racial group (by 9.0 and 16.7 percentage points, respectively); members in the Central, Charlottesville/Western, Northern & Winchester, and Roanoke/Alleghany regions (by 7.9, 11.7, 8.5, and 12.9 percentage points, respectively); and members enrolled with Aetna, Molina, and United (by 8.4, 8.2, and 16.8 percentage points, respectively). While there was a large rate difference for members enrolled with More Than One MCO, these denominators were small, so the rates may be less reliable.

Rates could not be compared to a national Medicaid benchmark since this indicator is a custom indicator developed for this analysis. The rate for former foster care members increased by 2.1 percentage points from MY 2023 to MY 2024, while the rate for controls decreased by 0.3 percentage points. For former foster care members, members 23 to 26 years of age were significantly less likely to have an ED visit during MY 2023, while members 19 to 22 years of age were significantly more likely; however, this disparity no longer existed during MY 2024 due to an increase in the rate for members 23 to 26 years of age (by 5.4 percentage points). For both former foster care members and controls, male members were significantly less likely to have an ED visit during MY 2024, while female members were significantly more likely. These disparities also existed during MY 2022 and MY 2023. For former foster care members 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 2024. This disparity also existed during MY 2022 and MY 2023. For former foster care members only, members in the Roanoke/Alleghany region were significantly more likely to have an ED visit compared to members in other regions during MY 2024. This disparity also existed for MY 2023. For both former foster care members and controls, members in the Northern & Winchester region were significantly less likely to have an ED visit compared to members in other regions during MY 2024. The disparity for former foster care members in the Northern & Winchester region also existed during MY 2023.

Inpatient Visits

Table 5-19 displays the MY 2022, MY 2023, and MY 2024 *Inpatient Visits* rates among former foster care members and controls stratified by member characteristics. Additionally, 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 5-19—Rates of Inpatient Visits Among Former Foster Care Members and Controls

Category	MY 2022		MY 2023		MY 2024	
	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate
All Eligible Members	9.9%	9.9%	8.2%	9.3%	7.9%	8.8%
Age Category						
19-22 years	10.4%	9.2%	9.2%	8.4%	7.2%	8.4%
23-26 Years	9.3%	11.1%	7.0%	10.3%	9.0%	9.4%

Category	MY 2022		MY 2023		MY 2024	
	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate
Sex						
Male	6.7%	5.1%	5.8%	4.1%	7.3%	4.5%
Female	13.4%	15.1%	11.0%	15.2%	8.6%	13.8%
Race						
Black or African American	10.2%	10.6%	8.2%	9.7%	8.1%	7.4%
White	9.7%	9.7%	8.3%	9.4%	8.2%	9.8%
Other	11.9%	9.0%	6.2%	4.6%	0.0%	2.8%
Region						
Central	10.9%	10.9%	8.8%	8.6%	8.5%	6.3%
Charlottesville/Western	8.2%	10.9%	9.4%	10.5%	6.8%	8.1%
Northern & Winchester	9.7%	6.7%	7.1%	7.1%	6.7%	9.8%
Roanoke/Alleghany	12.3%	11.1%	8.1%	11.5%	8.0%	10.2%
Southwest	8.4%	7.4%	7.8%	7.3%	6.3%	14.8%
Tidewater	9.4%	10.2%	7.1%	10.2%	9.8%	7.7%
MCO						
Aetna	9.7%	9.0%	7.5%	9.6%	8.4%	9.3%
HealthKeepers	10.3%	9.3%	7.1%	8.8%	7.7%	9.1%
Molina	7.1%	13.4%	7.4%	8.4%	2.3%	5.8%
Sentara*	10.3%	10.6%	8.7%	9.4%	8.6%	8.7%
United	8.5%	2.3%	8.1%	9.8%	8.8%	8.8%
More Than One MCO	23.1%	46.2%	19.0%	19.0%	9.1%	18.2%

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

+ 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.

* HSAG combined Optima and VA Premier for MY 2022 in this year's report and displayed the rates as Sentara. For MY 2023, HSAG included members with enrollment in Optima or VA Premier prior to July 2023 in the rate for Sentara.

Table 5-19 shows that 7.9 percent of former foster care members and 8.8 percent of controls had an inpatient visit during MY 2024, and the difference was not statistically significant (p=0.41). Rates for former foster care members were notably lower than controls for female members (by 5.2 percentage points) and members in the Southwest region (by 8.5 percentage points). While there was a large rate difference for members enrolled with More Than One MCO, these denominators were small, so the rates may be less reliable.

Rates could not be compared to a national Medicaid benchmark since this indicator is a custom indicator developed for this analysis. The rates for former foster care members and controls decreased from MY 2023 to MY 2024 by 0.3 and 0.5 percentage points, respectively. There were no disparities identified for former foster care members during MY 2024.

Behavioral Health Encounters—Total

Table 5-20 displays the MY 2022, MY 2023, and MY 2024 Behavioral Health Encounters—Total rates among former foster care members and controls stratified by member characteristics. Additionally, 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 5-20—Rates of Behavioral Health Encounters—Total Among Former Foster Care Members and Controls

Category	MY 2022		MY 2023		MY 2024	
	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate
All Eligible Members	33.6% ⁺	28.3%	36.1% ⁺	31.0%	36.3% ⁺	32.5%
Age Category						
19-22 years	35.7%	28.4%	38.4%	32.1%	37.0%	35.0%
23-26 Years	30.4%	28.1%	33.5%	29.8%	35.2%	28.7%
Sex						
Male	25.9%	21.0%	30.7%	24.6%	31.3%	25.8%
Female	41.7%	35.9%	42.4%	38.2%	42.1%	40.2%
Race						
Black or African American	33.9%	24.4%	32.6%	25.7%	34.2%	25.3%
White	33.5%	30.8%	38.5%	34.7%	37.9%	36.7%
Other	31.3%	23.9%	29.2%	21.5%	25.0%	25.0%
Region						
Central	39.4%	29.4%	40.5%	32.1%	43.2%	34.7%
Charlottesville/Western	34.8%	29.7%	38.6%	34.7%	36.9%	33.3%
Northern & Winchester	26.7%	23.6%	26.5%	27.0%	32.3%	26.8%
Roanoke/Alleghany	35.6%	33.3%	39.3%	36.8%	36.4%	33.8%
Southwest	31.1%	26.3%	36.9%	33.0%	32.4%	39.4%
Tidewater	28.9%	25.7%	31.1%	23.7%	30.1%	26.8%
MCO						
Aetna	40.0%	25.8%	38.4%	28.1%	40.2%	34.6%
HealthKeepers	32.5%	29.8%	37.0%	31.6%	36.0%	33.1%
Molina	24.4%	22.0%	28.4%	32.6%	23.3%	25.6%
Sentara*	33.8%	28.3%	35.2%	30.6%	36.1%	31.7%

Category	MY 2022		MY 2023		MY 2024	
	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate
United	33.8%	26.9%	36.6%	29.3%	40.0%	35.2%
More Than One MCO	69.2%	69.2%	61.9%	57.1%	72.7%	54.5%

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

+ 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.

** HSAG combined Optima and VA Premier for MY 2022 in this year's report and displayed the rates as Sentara. For MY 2023, HSAG included members with enrollment in Optima or VA Premier prior to July 2023 in the rate for Sentara.*

Table 5-20 shows that 36.3 percent of former foster care members and 32.5 percent of controls had a behavioral health encounter during MY 2024, and the difference was statistically significant (p=0.04). The rates for former foster care members were notably higher than controls for members 23 to 26 years of age (by 6.5 percentage points), male members (by 5.5 percentage points), Black or African American members (by 8.9 percentage points), members in the Central and Northern & Winchester regions (by 8.5 and 5.5 percentage points, respectively), and members enrolled with Aetna (by 5.6 percentage points). The rate for former foster care members was notably lower than controls for members in the Southwest region (by 7.0 percentage points). While there was a large rate difference between former foster care members and controls for members enrolled with More Than One MCO, the denominators for these rates were small, so they may be less reliable.

Rates could not be compared to a national Medicaid benchmark since this indicator is a custom indicator developed for this analysis. The rates for former foster care members and controls increased from MY 2023 to MY 2024 by 0.2 and 1.5 percentage points, respectively. For both former foster care members and controls, male members were significantly less likely to have a behavioral health encounter during MY 2024, while female members were significantly more likely. These disparities also existed during MY 2022 and MY 2023. For both former foster care members and controls, members in the Tidewater region were significantly less likely to have a behavioral health encounter compared to members in other regions. This disparity also existed during MY 2023. For former foster care members only, members in the Central region were significantly more likely to have a behavioral health encounter during MY 2024. This disparity also existed during MY 2022 and MY 2023. For former foster care members, members in the Northern & Winchester region were significantly less likely to have a behavioral health encounter during MY 2023 compared to members in other regions; however, this disparity no longer existed during MY 2024 due to an increase in the rate for members in the Northern & Winchester region (by 5.8 percentage points). For former foster care members only, members enrolled with Molina were significantly less likely to have a behavioral health visit compared to members enrolled with other MCOs during MY 2024, while members enrolled with More Than One MCO were significantly more likely. The disparity for members enrolled with More Than One MCO also existed during MY 2022 and MY 2023.

Behavioral Health Encounters—ARTS

Table 5-21 displays the MY 2022, MY 2023, and MY 2024 Behavioral Health Encounters—ARTS rates among former foster care members and controls stratified by member characteristics. Additionally, 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 5-21—Rates of Behavioral Health Encounters—ARTS Among Former Foster Care Members and Controls

Category	MY 2022		MY 2023		MY 2024	
	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate
All Eligible Members	7.3% ⁺	5.5%	9.1%	7.9%	9.3% ⁺	6.4%
Age Category						
19-22 years	7.0%	4.5%	8.4%	8.6%	8.4%	6.2%
23-26 Years	7.7%	6.9%	9.8%	7.1%	10.6%	6.9%
Sex						
Male	5.4%	5.1%	8.0%	7.0%	9.3%	6.1%
Female	9.4%	5.9%	10.3%	8.8%	9.4%	6.8%
Race						
Black or African American	6.3%	3.6%	6.3%	4.5%	6.6%	5.5%
White	8.2%	6.7%	11.0%	10.2%	11.1%	7.1%
Other	3.0%	3.0%	4.6%	1.5%	2.8%	2.8%
Region						
Central	7.4%	4.6%	7.2%	7.4%	9.6%	5.7%
Charlottesville/Western	5.8%	5.8%	11.2%	9.0%	9.9%	5.4%
Northern & Winchester	7.2%	4.6%	6.6%	7.7%	5.5%	7.9%
Roanoke/Alleghany	10.7%	9.2%	12.8%	12.4%	12.9%	7.1%
Southwest	11.1%	7.4%	13.4%	8.9%	10.6%	8.5%
Tidewater	4.2%	3.1%	6.2%	3.7%	6.9%	5.7%
MCO						
Aetna	7.7%	3.9%	11.6%	6.8%	7.5%	4.7%
HealthKeepers	7.6%	4.3%	7.5%	7.5%	9.9%	5.4%
Molina	3.9%	5.5%	4.2%	8.4%	4.7%	8.1%
Sentara*	6.8%	6.1%	9.4%	7.8%	9.4%	6.8%
United	10.0%	6.2%	11.4%	10.6%	9.6%	8.0%
More Than One MCO	30.8%	15.4%	23.8%	4.8%	36.4%	9.1%

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

+ 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.

* HSAG combined Optima and VA Premier for MY 2022 in this year's report and displayed the rates as Sentara. For MY 2023, HSAG included members with enrollment in Optima or VA Premier prior to July 2023 in the rate for Sentara.

Table 5-21 shows that 9.3 percent of former foster care members and 6.4 percent of controls had a behavioral health encounter with ARTS during MY 2024, and the difference was statistically significant (p=0.01). Rates for former foster care members were notably higher for members in the Roanoke/Alleghany region (by 5.8 percentage points). 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.

Rates could not be compared to a national Medicaid benchmark since this indicator is a custom indicator developed for this analysis. The rate for former foster care members increased by 0.2 percentage points from MY 2023 to MY 2024, while the rate for controls decreased by 1.5 percentage points. For former foster care members only, Black or African American members were significantly less likely to have a behavioral health encounter with ARTS compared to other racial groups during MY 2024, while White members were significantly more likely. These disparities also existed during MY 2023. For former foster care members only, members in the Roanoke/Alleghany region were significantly more likely to have a behavioral health encounter with ARTS during MY 2024 compared to members in other regions. This disparity also existed during MY 2022 and MY 2023. For former foster care members only, members enrolled with More Than One MCO during MY 2024 were significantly more likely to have a behavioral health encounter with ARTS compared to members enrolled with other MCOs. This disparity also existed during MY 2022 and MY 2023.

Behavioral Health Encounters—CMH Services

Table 5-22 displays the MY 2022, MY 2023, and MY 2024 Behavioral Health Encounters—CMH Services rates among former foster care members and controls stratified by member characteristics. Additionally, 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 5-22—Rates of Behavioral Health Encounters—CMH Services Among Former Foster Care Members and Controls

Category	MY 2022		MY 2023		MY 2024	
	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate
All Eligible Members	9.8% ⁺	5.1%	8.7% ⁺	5.5%	9.7% ⁺	5.8%
Age Category						
19-22 years	11.0%	5.6%	10.1%	5.4%	9.4%	6.5%

Category	MY 2022		MY 2023		MY 2024	
	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate
23-26 Years	8.0%	4.4%	7.1%	5.5%	10.1%	4.7%
Sex						
Male	8.6%	3.9%	7.5%	4.5%	8.6%	5.5%
Female	11.0%	6.4%	10.0%	6.6%	11.0%	6.2%
Race						
Black or African American	13.7%	7.1%	11.6%	7.6%	12.3%	6.8%
White	7.8%	4.2%	7.4%	4.5%	8.5%	5.5%
Other	4.5%	1.5%	1.5%	1.5%	2.8% ⁺	0.0% ⁺
Region						
Central	17.4%	9.8%	13.0%	10.2%	15.3%	7.1%
Charlottesville/Western	7.8%	4.8%	6.5%	4.7%	6.3%	6.3%
Northern & Winchester	3.6%	0.5%	3.6%	3.1%	4.9%	2.4%
Roanoke/Alleghany	9.6%	5.4%	9.8%	5.1%	8.9%	6.7%
Southwest	8.9%	4.2%	8.9%	5.0%	8.5%	5.6%
Tidewater	5.8%	2.4%	6.8%	1.8%	8.9%	4.9%
MCO						
Aetna	15.5%	3.2%	11.6%	6.8%	13.1%	4.7%
HealthKeepers	9.3%	4.1%	6.7%	3.8%	7.9%	3.2%
Molina	7.9%	3.1%	5.3%	3.2%	7.0%	5.8%
Sentara*	9.7%	6.1%	9.3%	6.4%	10.0%	7.4%
United	5.4%	4.6%	8.1%	5.7%	9.6%	7.2%
More Than One MCO	30.8%	23.1%	28.6%	9.5%	45.5%	0.0%

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

+ 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.

* HSAG combined Optima and VA Premier for MY 2022 in this year's report and displayed the rates as Sentara. For MY 2023, HSAG included members with enrollment in Optima or VA Premier prior to July 2023 in the rate for Sentara.

Table 5-22 shows that 9.7 percent of former foster care members and 5.8 percent of controls had a behavioral health encounter with CMH services during MY 2024, and the difference was statistically significant (p<0.001). The rates for former foster care members were notably higher than controls for members 23 to 26 years of age (by 5.4 percentage points), Black or African American members (by 5.5 percentage points), members in the Central region (by 8.2 percentage points), and members enrolled with Aetna (by 8.4 percentage points). 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.

Rates could not be compared to a national Medicaid benchmark since this indicator is a custom indicator developed for this analysis. The rates for former foster care members and controls increased from MY 2023 to MY 2024 by 1.0 and 0.3 percentage points, respectively. For former foster care members, members 19 to 22 years of age were significantly more likely to have a behavioral health encounter with CMH services during MY 2023, while members 23 to 26 years of age were significantly less likely; however, these disparities no longer existed during MY 2024 due to an increase the rate for members 23 to 26 years of age (by 3.0 percentage points). For former foster care members, White members were significantly less likely to have a behavioral health encounter with CMH services compared to members in other racial groups during MY 2023 and MY 2022; however, during MY 2024, this disparity no longer existed due to an increase in the rate for White members (by 1.1 percentage points). For former foster care members only, 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 2024. This disparity also existed during MY 2022 and MY 2023. For former foster care members only, members in the Northern & Winchester region were significantly less likely to have a behavioral health encounter with CMH services compared to members in other regions during MY 2024, while members in the Central region were significantly more likely. These disparities also existed in MY 2022 and MY 2023. For former foster care members 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 2024. This disparity also existed during MY 2022 and MY 2023.

Behavioral Health Encounters—RTC Services

Table 5-23 displays the MY 2022, MY 2023, and MY 2024 Behavioral Health Encounters—RTC Services rates among former foster care members and controls stratified by member characteristics. Additionally, 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. Please note, starting in July 2025, RTC placement and services became a carved-out service rather than an excluded service.

Table 5-23—Rates of Behavioral Health Encounters—RTC Services Among Former Foster Care Members and Controls

Category	MY 2022		MY 2023		MY 2024	
	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate
All Eligible Members	5.1% ⁺	2.7%	4.4% ⁺	2.8%	5.1% ⁺	2.9%
Age Category						
19-22 years	5.5%	2.7%	4.9%	3.4%	5.2%	3.1%
23-26 Years	4.4%	2.7%	3.9%	2.2%	5.1%	2.7%
Sex						
Male	4.4%	3.1%	4.6%	2.4%	5.9%	3.4%
Female	5.8%	2.3%	4.1%	3.2%	4.3%	2.4%

Category	MY 2022		MY 2023		MY 2024	
	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate
Race						
Black or African American	5.5%	3.0%	4.0%	2.3%	5.1%	3.2%
White	4.9%	2.5%	4.8%	3.2%	5.4%	2.9%
Other	3.0%	3.0%	1.5%	1.5%	0.0%^	0.0%^
Region						
Central	6.1%	3.1%	4.7%	3.3%	6.8%	3.0%
Charlottesville/Western	3.8%	3.8%	5.1%	3.6%	4.5%	1.4%
Northern & Winchester	4.1%	2.6%	4.1%	3.1%	3.7%	4.9%
Roanoke/Alleghany	6.5%	3.4%	3.8%	3.0%	4.4%	2.2%
Southwest	4.7%	1.6%	4.5%	0.6%	3.5%	3.5%
Tidewater	4.5%	1.6%	4.0%	2.5%	5.7%	3.3%
MCO						
Aetna	5.2%	1.3%	3.4%	1.4%	2.8%	0.9%
HealthKeepers	5.1%	2.3%	4.0%	3.1%	5.4%	4.7%
Molina	3.1%	4.7%	4.2%	3.2%	1.2%	2.3%
Sentara*	5.4%	2.8%	4.5%	2.6%	5.5%	2.2%
United	3.8%	2.3%	4.1%	4.1%	6.4%	2.4%
More Than One MCO	7.7%	15.4%	19.0%	4.8%	9.1%	9.1%

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

+ 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.

* HSAG combined Optima and VA Premier for MY 2022 in this year's report and displayed the rates as Sentara. For MY 2023, HSAG included members with enrollment in Optima or VA Premier prior to July 2023 in the rate for Sentara.

Table 5-23 shows that 5.1 percent of former foster care members and 2.9 percent of controls had a behavioral health encounter with RTC services during MY 2024, and the difference was statistically significant (p=0.004). The rate differences between former foster care members and controls were similar across the stratified rates.

Rates could not be compared to a national Medicaid benchmark since this indicator is a custom indicator developed for this analysis. The rates for former foster care members and controls increased from MY 2023 to MY 2024 by 0.7 and 0.1 percentage points, respectively. There were no disparities identified for this study indicator during MY 2024.

Behavioral Health Encounters—Therapeutic Services

Table 5-24 displays the MY 2022, MY 2023, and MY 2024 Behavioral Health Encounters—Therapeutic Services rates among former foster care members and controls stratified by member characteristics. Additionally, 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 5-24—Rates of Behavioral Health Encounters—Therapeutic Services Among Former Foster Care Members and Controls

Category	MY 2022		MY 2023		MY 2024	
	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate
All Eligible Members	2.0% ⁺	0.6%	2.0% ⁺	0.8%	2.1% ⁺	1.0%
Age Category						
19-22 years	1.7%	0.9%	2.2%	0.8%	2.2%	0.9%
23-26 Years	2.4%	0.1%	1.7%	0.8%	2.0%	1.3%
Sex						
Male	1.6%	0.2%	1.8%	0.7%	2.0%	0.7%
Female	2.3%	1.0%	2.1%	0.9%	2.2%	1.4%
Race						
Black or African American	3.5%	0.8%	3.6%	1.0%	3.0%	1.5%
White	1.2%	0.6%	1.0%	0.7%	1.7%	0.8%
Other	0.0% [^]	0.0% [^]	1.5% [^]	0.0% [^]	0.0% [^]	0.0% [^]
Region						
Central	3.9%	0.7%	3.3%	1.2%	2.7%	1.9%
Charlottesville/Western	0.7%	0.3%	0.4%	1.4%	1.4%	0.5%
Northern & Winchester	0.5% [^]	0.0% [^]	1.0%	0.5%	0.6%	0.6%
Roanoke/Alleghany	2.7%	0.8%	3.0%	0.9%	4.0%	1.8%
Southwest	1.1%	0.5%	0.6% [^]	0.0% [^]	1.4% [^]	0.0% [^]
Tidewater	1.3%	1.0%	2.2%	0.3%	1.6%	0.4%
MCO						
Aetna	5.8% [^]	0.0% [^]	1.4%	1.4%	1.9%	2.8%
HealthKeepers	2.1%	0.6%	1.0%	0.2%	1.2%	0.7%
Molina	0.0% [^]	0.8% [^]	1.1% [^]	0.0% [^]	1.2%	1.2%
Sentara*	1.3%	0.7%	2.3%	0.9%	2.1%	1.0%
United	2.3%	0.8%	2.4%	1.6%	4.0%	0.8%
More Than One MCO	15.4% [^]	0.0% [^]	14.3%	4.8%	27.3%	0.0%

Blue shading indicates that a disparity was identified (i.e., had a p-value less than 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 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.

* HSAG combined Optima and VA Premier for MY 2022 in this year's report and displayed the rates as Sentara. For MY 2023, HSAG included members with enrollment in Optima or VA Premier prior to July 2023 in the rate for Sentara.

Table 5-24 shows that 2.1 percent of former foster care members and 1.0 percent of controls had a behavioral health encounter with therapeutic services during MY 2024, and the difference was statistically significant (p=0.02). The rate differences between former foster care members and controls were similar across most stratified rates. While there was a large rate difference for members enrolled with More Than One MCO, these denominators were small, so the rates may be less reliable.

Rates could not be compared to a national Medicaid benchmark since this indicator is a custom indicator developed for this analysis. The rates for former foster care members and controls increased from MY 2023 to MY 2024 by 0.1 and 0.2 percentage points, respectively. For former foster care members only, members in the Roanoke/Alleghany region were significantly more likely to have a behavioral health encounter with therapeutic services during MY 2024 compared to members in other regions, and members enrolled with More Than One MCO were significantly more likely to have a behavioral health encounter with therapeutic services compared to members enrolled with other MCOs.

Behavioral Health Encounters—Traditional Services

Table 5-25 displays the MY 2022, MY 2023, and MY 2024 Behavioral Health Encounters—Traditional Services rates among former foster care members and controls stratified by member characteristics. Additionally, 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 5-25—Rates of Behavioral Health Encounters—Traditional Services Among Former Foster Care Members and Controls

Category	MY 2022		MY 2023		MY 2024	
	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate
All Eligible Members	32.2% ⁺	27.0%	34.8% ⁺	30.2%	34.7%	31.6%
Age Category						
19-22 years	33.9%	27.2%	36.9%	31.6%	35.9%	33.9%
23-26 Years	29.5%	26.7%	32.5%	28.6%	32.9%	28.2%
Sex						
Male	24.7%	20.2%	29.5%	23.6%	29.7%	25.2%
Female	40.0%	34.0%	41.0%	37.6%	40.5%	38.9%

Category	MY 2022		MY 2023		MY 2024	
	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate
Race						
Black or African American	32.4%	22.2%	31.4%	24.3%	32.5%	23.8%
White	32.0%	30.0%	37.2%	34.1%	36.2%	36.1%
Other	31.3%	23.9%	27.7%	21.5%	25.0%	25.0%
Region						
Central	37.7%	25.9%	38.8%	30.7%	41.0%	33.3%
Charlottesville/Western	33.8%	29.0%	37.9%	33.9%	36.9%	32.9%
Northern & Winchester	25.6%	23.6%	26.0%	26.5%	31.7%	26.8%
Roanoke/Alleghany	33.3%	32.6%	35.9%	35.0%	32.0%	33.8%
Southwest	30.5%	25.3%	36.3%	33.0%	31.7%	37.3%
Tidewater	27.6%	25.5%	30.5%	23.4%	29.3%	25.6%
MCO						
Aetna	38.7%	24.5%	37.0%	28.1%	38.3%	33.6%
HealthKeepers	31.5%	28.8%	34.9%	30.5%	35.3%	32.8%
Molina	24.4%	21.3%	28.4%	31.6%	23.3%	24.4%
Sentara*	32.0%	26.6%	34.3%	29.7%	33.9%	30.4%
United	31.5%	26.9%	35.8%	29.3%	38.4%	34.4%
More Than One MCO	69.2%	69.2%	57.1%	52.4%	63.6%	54.5%

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

+ 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.

* HSAG combined Optima and VA Premier for MY 2022 in this year's report and displayed the rates as Sentara. For MY 2023, HSAG included members with enrollment in Optima or VA Premier prior to July 2023 in the rate for Sentara.

Table 5-25 shows that 34.7 percent of former foster care members and 31.6 percent of controls had a behavioral health encounter with traditional services during MY 2024, and the difference was not statistically significant (p=0.09). The rates for former foster care members were notably higher than controls for Black or African American members (by 8.7 percentage points) and members in the Central region (by 7.7 percentage points). The rates for former foster care members were notably lower than controls for members in the Southwest region (by 5.6 percentage points). 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.

Rates could not be compared to a national Medicaid benchmark since this indicator is a custom indicator developed for this analysis. The rate for former foster care members decreased by 0.1

percentage points from MY 2023 to MY 2024, while the rate for controls increased by 1.4 percentage points. For both former foster care members and controls, male members were significantly less likely to have a behavioral health encounter with traditional services during MY 2024, while female members were significantly more likely. These disparities also existed during MY 2022 and MY 2023. For former foster care members, members in the Northern & Winchester region were significantly less likely to have a behavioral health encounter with traditional services compared to members in other regions during MY 2023; however, this disparity did not exist during MY 2024 due to an increase in the rate for members in this region (by 5.7 percentage points). 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 during MY 2024. Former foster care members enrolled with Molina were significantly less likely to have a behavioral health encounter with traditional services compared to members enrolled with other MCOs during MY 2024.

Overall Service Utilization

Table 5-26 displays the MY 2022, MY 2023, and MY 2024 *Overall Service Utilization* rates among former foster care members care and controls stratified by member characteristics. Additionally, 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 5-26—Rates of Overall Service Utilization Among Former Foster Care Members and Controls

Category	MY 2022		MY 2023		MY 2024	
	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate
All Eligible Members	73.7%	75.0%	69.8%	71.2%	74.3%	73.2%
Age Category						
19-22 years	75.7%	75.3%	73.5%	72.7%	75.1%	74.8%
23-26 Years	70.7%	74.5%	65.7%	69.6%	73.1%	70.8%
Sex						
Male	64.4%	65.2%	61.3%	61.2%	66.7%	63.4%
Female	83.6%	85.2%	79.8%	82.5%	83.2%	84.5%
Race						
Black or African American	72.8%	75.7%	68.1%	72.9%	71.1%	69.0%
White	74.7%	75.5%	71.8%	71.5%	76.2%	76.1%
Other	65.7%	59.7%	55.4%	52.3%	69.4%	58.3%
Region						
Central	75.8%	74.9%	73.7%	70.5%	77.9%	74.3%
Charlottesville/Western	77.1%	75.1%	74.7%	74.0%	75.2%	68.9%
Northern & Winchester	70.8%	71.3%	61.7%	68.9%	69.5%	70.7%
Roanoke/Alleghany	76.2%	76.6%	76.5%	71.4%	77.8%	73.8%

Category	MY 2022		MY 2023		MY 2024	
	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate	Former Foster Care Members Rate	Control Rate
Southwest	74.7%	77.4%	69.3%	76.5%	76.8%	83.1%
Tidewater	67.7%	74.5%	60.9%	68.3%	66.7%	70.7%
MCO						
Aetna	73.5%	76.1%	69.9%	68.5%	74.8%	76.6%
HealthKeepers	75.9%	76.5%	71.3%	70.7%	71.9%	73.1%
Molina	62.2%	63.0%	56.8%	60.0%	62.8%	60.5%
Sentara*	74.5%	77.0%	69.3%	72.6%	75.6%	73.1%
United	68.5%	64.6%	74.0%	74.0%	81.6%	77.6%
More Than One MCO	100.0%	92.3%	90.5%	85.7%	90.9%	100.0%

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

+ 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.

* HSAG combined Optima and VA Premier for MY 2022 in this year's report and displayed the rates as Sentara. For MY 2023, HSAG included members with enrollment in Optima or VA Premier prior to July 2023 in the rate for Sentara.

Table 5-26 shows that 74.3 percent of former foster care members and 73.2 percent of controls had an ambulatory care visit, ED visit, inpatient visit, or behavioral health encounter (i.e., any service) during MY 2024, and the difference was not statistically significant (p=0.51). The rates for former foster care members were notably higher than controls for members in the Other racial group (by 11.1 percentage points) and members in the Charlottesville/Western region (by 6.3 percentage points). The rate for former foster care members was notably lower than controls for members in the Southwest region (by 6.3 percentage points). 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.

Rates could not be compared to a national Medicaid benchmark since this indicator is a custom indicator developed for this analysis. The rate for former foster care members and controls increased from MY 2023 to MY 2024 by 4.5 percentage points and 2.0 percentage points, respectively. For former foster care members, members 23 to 26 years of age were significantly less likely to utilize any service during MY 2023, while members 19 to 22 years of age were significantly more likely; however, these disparities did not exist during MY 2024 due to an increase in the rate for members 23 to 26 years of age (by 7.4 percentage points). For both former foster care members and controls, male members were significantly less likely to utilize any service during MY 2024, while female members were significantly more likely. These disparities also existed during MY 2022 and MY 2023. For former foster care members, members in the Other racial group were significantly less likely to utilize any service compared to other racial groups during MY 2023; however, this disparity no longer existed during MY 2024 due to an increase in the rate for members in the Other racial group (by 14.0 percentage points).

For former foster care members and controls, White members were significantly more likely to utilize any service compared to members in other racial groups during MY 2024. This disparity existed for former foster care members during MY 2023. For former foster care members, members in the Northern & Winchester region were significantly less likely to utilize any service during MY 2023 compared to members in other regions; however, this disparity no longer existed during MY 2024 due to an increase in the rate for this group (by 7.8 percentage points). For former foster care members only, members in the Tidewater region were significantly less likely to utilize any service compared to members in other regions during MY 2024. This disparity also existed during MY 2022 and MY 2023. For both former foster care members and controls, members enrolled with Molina were significantly less likely to utilize any service during MY 2024 compared to members enrolled with other MCOs. This disparity also existed during MY 2022 and MY 2023.

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 2024. The tables displayed in this section also include stratified rates and shading to indicate the results of the health disparities analysis. Since the study indicators in this section are custom indicators that were developed for this analysis, national Medicaid benchmarks were not applicable for comparison.

Timely Access to Primary Care

Table 6-1 displays the MY 2022, MY 2023, and MY 2024 rates for the *Timely Access to Primary Care 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 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 2022		MY 2023		MY 2024	
	Denom	Rate	Denom	Rate	Denom	Rate
All Eligible Members†	1,778	86.8%	1,822	85.7%	2,058	84.0%
Age Category						
≤ 2 Years	547	92.3%	559	90.9%	650	91.4%
3 to 5 Years	252	88.5%	271	90.8%	294	85.7%
6 to 10 Years	338	91.1%	353	84.4%	407	82.8%
11 to 13 Years	246	85.8%	245	80.4%	244	78.3%
≥ 14 Years	395	75.2%	394	79.4%	463	76.7%
Sex						
Male	903	83.9%	909	85.7%	1033	83.6%
Female	875	89.8%	913	85.8%	1025	84.4%
Race						
Black or African American	580	87.6%	619	81.6%	698	81.5%
White	1148	86.7%	1135	88.4%	1285	85.5%
Other	50	82.0%	68	79.4%	75	81.3%
Region						
Central	326	85.0%	387	84.5%	422	82.7%
Charlottesville/Western	287	89.2%	306	89.5%	421	82.9%
Northern & Winchester	240	80.8%	245	78.0%	262	78.6%
Roanoke/Alleghany	362	90.6%	298	83.9%	307	86.3%
Southwest	254	87.0%	261	92.7%	261	91.6%

Category	MY 2022		MY 2023		MY 2024	
	Denom	Rate	Denom	Rate	Denom	Rate
Tidewater	301	86.4%	316	85.1%	384	83.3%
MCO						
Aetna	197	87.8%	237	83.1%	231	80.5%
HealthKeepers	434	86.2%	453	84.8%	531	84.4%
Molina	137	80.3%	147	86.4%	163	82.2%
Sentara*	837	88.2%	791	88.1%	913	85.4%
United	170	85.9%	179	82.7%	205	82.0%

[†]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 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 0.05) and the stratified rate was lower than the reference group rate.

* HSAG combined Optima and VA Premier for MY 2022 in this year's report and displayed the rates as Sentara. For MY 2023, HSAG included members with enrollment in Optima or VA Premier prior to July 2023 in the rate for Sentara.

Table 6-1 shows that 84.0 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 2024, and this rate decreased by 1.7 percentage points from MY 2023. Members 2 years of age and younger were significantly more likely to have a PCP visit compared to members in other age groups, while members 11 to 13 years of age and 14 years of age and older were significantly less likely. The disparities for members 2 years of age and younger and 14 years of age and older also existed during MY 2022 and MY 2023. Black or African American members were significantly less likely to have a PCP visit compared to members in other racial groups during MY 2024, while White members were significantly more likely. These disparities also existed during MY 2023. Members in the Southwest region were significantly more likely to have a PCP visit compared to members in other regions, while members in the Northern & Winchester region were significantly less likely. These disparities also existed during MY 2023. Members enrolled with More Than One MCO were significantly less likely to have at least one visit with a PCP compared to members enrolled with other MCOs during MY 2023; however, this disparity no longer existed during MY 2024 due to an increase in the rate for this group (by 28.7 percentage points).

Timely Access to Dental Care

Table 6-2 displays the MY 2022, MY 2023, and MY 2024 rates for the *Timely Access to Dental Care 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 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 2022		MY 2023		MY 2024	
	Denom	Rate	Denom	Rate	Denom	Rate
All Eligible Members†	1,778	47.2%	1,822	48.2%	2,058	44.8%
Age Category						
≤ 2 Years	547	22.7%	559	24.9%	650	20.0%
3 to 5 Years	252	62.7%	271	57.2%	294	54.4%
6 to 10 Years	338	63.9%	353	65.2%	407	62.9%
11 to 13 Years	246	62.2%	245	60.8%	244	56.6%
≥ 14 Years	395	47.8%	394	52.0%	463	51.6%
Sex						
Male	903	46.6%	909	47.9%	1033	43.9%
Female	875	47.9%	913	48.5%	1025	45.8%
Race						
Black or African American	580	50.5%	619	47.7%	698	43.6%
White	1148	46.1%	1135	48.5%	1285	46.3%
Other	50	36.0%	68	47.1%	75	32.0%
Region						
Central	326	48.5%	387	51.9%	422	40.5%
Charlottesville/Western	287	42.9%	306	46.1%	421	48.0%
Northern & Winchester	240	54.6%	245	44.5%	262	52.7%
Roanoke/Alleghany	362	33.1%	298	44.6%	307	39.1%
Southwest	254	55.1%	261	52.1%	261	45.2%
Tidewater	301	54.5%	316	49.1%	384	45.3%
MCO						
Aetna	197	41.6%	237	44.7%	231	42.0%
HealthKeepers	434	51.8%	453	51.9%	531	49.5%
Molina	137	42.3%	147	38.8%	163	35.0%
Sentara*	837	47.2%	791	50.6%	913	45.0%
United	170	45.9%	179	40.2%	205	43.9%

†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 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 0.05) and the stratified rate was lower than the reference group rate.

* HSAG combined Optima and VA Premier for MY 2022 in this year’s report and displayed the rates as Sentara. For MY 2023, HSAG included members with enrollment in Optima or VA Premier prior to July 2023 in the rate for Sentara.

Table 6-2 shows that 44.8 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 2024, and this rate decreased by 3.4 percentage points from MY 2023. Members 2 years of age and younger were significantly less likely to have a dental provider visit compared to members in other age groups during MY 2024, while members in all other age groups were significantly more likely. The disparities for all age groups except members

14 years of age and older also existed during MY 2022 and MY 2023. Members in the Other racial group were significantly less likely to have visit with a dental provider compared to members in other racial groups. Members in the Central and Roanoke/Alleghany regions were significantly less likely to have a visit with a dental provider compared to members in other regions, while members in the Northern & Winchester region were significantly more likely. Members enrolled with Molina were significantly less likely to have a visit with a dental provider compared to members enrolled with other MCOs, while members enrolled with HealthKeepers were significantly more likely. Members enrolled with United were significantly less likely to have a visit with a dental provider during MY 2023; however, this disparity no longer existed during MY 2024 due to an increase in the rate for this group (by 3.7 percentage points).

Timely Access to Primary Care or Dental Care

Table 6-3 displays the MY 2022, MY 2023, and MY 2024 rates for the *Timely Access to Primary Care or Dental Care 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 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 2022		MY 2023		MY 2024	
	Denom	Rate	Denom	Rate	Denom	Rate
All Eligible Members [†]	1,778	91.2%	1,822	90.0%	2,058	89.4%
Age Category						
≤ 2 Years	547	92.7%	559	91.9%	650	92.5%
3 to 5 Years	252	93.3%	271	94.1%	294	89.8%
6 to 10 Years	338	96.4%	353	91.2%	407	91.2%
11 to 13 Years	246	91.5%	245	87.3%	244	86.9%
≥ 14 Years	395	83.0%	394	85.0%	463	84.4%
Sex						
Male	903	89.3%	909	90.0%	1033	89.1%
Female	875	93.1%	913	90.0%	1025	89.7%
Race						
Black or African American	580	92.2%	619	86.4%	698	86.4%
White	1148	90.8%	1135	92.2%	1285	91.4%
Other	50	88.0%	68	85.3%	75	82.7%
Region						
Central	326	90.5%	387	89.1%	422	87.7%
Charlottesville/Western	287	93.0%	306	92.5%	421	87.4%
Northern & Winchester	240	87.1%	245	85.3%	262	87.4%
Roanoke/Alleghany	362	92.5%	298	88.3%	307	92.5%
Southwest	254	92.9%	261	95.4%	261	95.4%
Tidewater	301	90.0%	316	89.2%	384	88.0%

Category	MY 2022		MY 2023		MY 2024	
	Denom	Rate	Denom	Rate	Denom	Rate
MCO						
Aetna	197	92.9%	237	87.8%	231	86.6%
HealthKeepers	434	90.8%	453	90.3%	531	90.0%
Molina	137	86.9%	147	89.1%	163	87.7%
Sentara*	837	91.9%	791	91.9%	913	90.3%
United	170	90.0%	179	86.0%	205	87.3%

†Members with Unknown Region and More Than One MCO are included in the All Eligible Members rate but are not displayed in this table.

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

* HSAG combined Optima and VA Premier for MY 2022 in this year’s report and displayed the rates as Sentara. For MY 2023, HSAG included members with enrollment in Optima or VA Premier prior to July 2023 in the rate for Sentara.

Table 6-3 shows that 89.4 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 2024, and this rate decreased by 0.6 percentage points from MY 2023. Members 14 years of age and older were significantly less likely to have a PCP or dental provider visit compared to members in other age groups during MY 2024, while members 2 years of age and younger were significantly more likely. The disparity for members 14 years of age and older also existed during MY 2022 and MY 2023. Black or African American members were significantly less likely to have a PCP or dental provider visit compared to members in other racial groups during MY 2024, while White members were significantly more likely. These disparities also existed during MY 2023. Members in the Northern & Winchester region were significantly less likely to have a PCP or dental provider visit compared to members in other regions during MY 2022 and MY 2023; however, this disparity no longer existed during MY 2024 due to an increase in the rate for this group (by 2.1 percentage points). Members in the Southwest region were significantly more likely to have a PCP or dental provider visit compared to members in other regions during MY 2024. This disparity also existed during MY 2023. Members enrolled with More Than One MCO were significantly less likely to have a PCP or dental provider visit compared to members enrolled with other MCOs during MY 2023; however, this disparity no longer existed during MY 2024 due to an increase in the rate for this group (by 26.5 percentage points).

Timely Access to Primary Care and Dental Care

Table 6-4 displays the MY 2022, MY 2023, and MY 2024 rates for the *Timely Access to Primary Care and Dental Care 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 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 2022		MY 2023		MY 2024	
	Denom	Rate	Denom	Rate	Denom	Rate
All Eligible Members [†]	1,778	42.9%	1,822	43.9%	2,058	39.5%
Age Category						
≤ 2 Years	547	22.3%	559	23.8%	650	18.9%
3 to 5 Years	252	57.9%	271	53.9%	294	50.3%
6 to 10 Years	338	58.6%	353	58.4%	407	54.5%
11 to 13 Years	246	56.5%	245	53.9%	244	48.0%
≥ 14 Years	395	40.0%	394	46.4%	463	43.8%
Sex						
Male	903	41.3%	909	43.6%	1033	38.5%
Female	875	44.6%	913	44.2%	1025	40.5%
Race						
Black or African American	580	45.9%	619	42.8%	698	38.7%
White	1148	42.0%	1135	44.7%	1285	40.5%
Other	50	30.0%	68	41.2%	75	30.7%
Region						
Central	326	42.9%	387	47.3%	422	35.5%
Charlottesville/Western	287	39.0%	306	43.1%	421	43.5%
Northern & Winchester	240	48.3%	245	37.1%	262	43.9%
Roanoke/Alleghany	362	31.2%	298	40.3%	307	32.9%
Southwest	254	49.2%	261	49.4%	261	41.4%
Tidewater	301	50.8%	316	44.9%	384	40.6%
MCO						
Aetna	197	36.5%	237	40.1%	231	35.9%
HealthKeepers	434	47.2%	453	46.4%	531	43.9%
Molina	137	35.8%	147	36.1%	163	29.4%
Sentara*	837	43.5%	791	46.8%	913	40.2%
United	170	41.8%	179	36.9%	205	38.5%

[†]Members with Unknown Region and More Than One MCO are included in the All Eligible Members rate but are not displayed in this table.

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

* HSAG combined Optima and VA Premier for MY 2022 in this year's report and displayed the rates as Sentara. For MY 2023, HSAG included members with enrollment in Optima or VA Premier prior to July 2023 in the rate for Sentara.

Table 6-4 shows that 39.5 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 2024, and this rate decreased by 4.4 percentage points from MY 2023. Given that the statewide rate for the *Timely Access to Dental Care for New Foster Care Members* indicator was 39.2 percentage points lower than

the rate for the *Timely Access to Primary Care for New Foster Care Members* indicator, the *Timely Access to Primary Care and Dental Care for New Foster Care Members* statewide rate was mostly limited by the low rates of dental provider visits. 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 all other age groups were significantly more likely. The disparities for all age groups except members 14 years of age and older also existed during MY 2022 and MY 2023. Members in the Roanoke/Alleghany region were significantly less likely to have a PCP visit and a dental provider visit compared to members in other regions. Members in the Northern & Winchester region were significantly less likely to have a PCP visit and a dental provider visit compared to members in other regions during MY 2023; however, this disparity no longer existed during MY 2024 due to an increase in the rate for this group (by 6.8 percentage points). Members enrolled with Molina were significantly less likely to have a PCP visit and dental provider visit compared to members enrolled with other MCOs, while members enrolled with HealthKeepers were significantly more likely. Members enrolled with United were significantly less likely to have a PCP visit and a dental provider visit compared to members enrolled with other MCOs during MY 2023; however, this disparity no longer existed during MY 2024 due to an increase in the rate for this group (by 1.6 percentage points).

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 2022, MY 2023, and MY 2024 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 2022		MY 2023		MY 2024	
	Denom	Rate	Denom	Rate	Denom	Rate
All Eligible Members†	1,601	50.5%	1,596	49.3%	1,811	47.7%
Age Category						
≤ 2 Years	484	20.9%	476	21.8%	569	25.5%
3 to 5 Years	232	45.7%	242	39.7%	264	37.1%
6 to 10 Years	304	69.1%	320	65.0%	361	59.3%
11 to 13 Years	222	72.5%	218	69.7%	216	66.7%
≥ 14 Years	359	64.3%	340	66.8%	401	65.3%
Sex						
Male	812	46.8%	796	50.1%	914	44.7%
Female	789	54.4%	800	48.5%	897	50.6%

Category	MY 2022		MY 2023		MY 2024	
	Denom	Rate	Denom	Rate	Denom	Rate
Race						
Black or African American	516	51.2%	538	50.4%	619	43.5%
White	1038	50.1%	1005	49.2%	1121	50.8%
Other	47	53.2%	53	41.5%	71	33.8%
Region						
Central	293	47.1%	327	51.4%	376	45.2%
Charlottesville/Western	257	45.5%	265	48.3%	378	41.0%
Northern & Winchester	212	30.2%	226	28.8%	239	43.1%
Roanoke/Alleghany	334	64.1%	251	59.0%	265	58.5%
Southwest	228	58.3%	239	61.9%	233	56.7%
Tidewater	270	53.0%	281	45.6%	319	46.1%
MCO						
Aetna	178	46.6%	193	41.5%	205	42.9%
HealthKeepers	374	49.7%	393	47.8%	449	45.0%
Molina	123	47.2%	120	37.5%	134	36.6%
Sentara*	738	54.3%	704	57.0%	809	51.4%
United	152	42.8%	159	37.1%	183	51.4%
More Than One MCO	36	44.4%	27	51.9%	31	45.2%

[†]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 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 0.05) and the stratified rate was lower than the reference group rate.

* HSAG combined Optima and VA Premier for MY 2022 in this year's report and displayed the rates as Sentara. For MY 2023, HSAG included members with enrollment in Optima or VA Premier prior to July 2023 in the rate for Sentara.

Table 6-5 shows that 47.7 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 2024, and this rate decreased by 1.6 percentage points from MY 2023. 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, 11 to 13, and 14 years of age and older were significantly more likely. Except for members 3 to 5 years of age, these disparities also existed during MY 2022 and MY 2023. Male members were significantly less likely to have an MHP visit, while female members were significantly more likely, and these disparities also existed during MY 2022. Black or African American members and members in the Other racial group were significantly less likely to have an MHP visit compared to members in other racial groups, while White members were significantly more likely. Members in the Southwest region and the Roanoke/Alleghany region were significantly more likely to have an MHP visit compared to members in other regions, while members in the Charlottesville/Western region were significantly less likely. The disparities for the Southwest region and the Roanoke/Alleghany region also existed during MY 2022 and MY 2023. Members in the Northern & Winchester region were significantly less likely to have a visit with an MHP compared to members in other regions during MY 2023; however, this disparity no longer existed during MY 2024 due to an increase in the rate for this group (by 14.3 percentage points). Members enrolled with Sentara were significantly more likely to have an MHP visit compared to members enrolled with other

MCOs, while members enrolled with Molina were significantly less likely. The disparity for Sentara also existed during MY 2022 and MY 2023. Members enrolled with Aetna and United were significantly less likely to have a visit with an MHP compared to members enrolled with other MCOs during MY 2023; however, these disparities no longer existed during MY 2024 due to increases in the rates for these groups (by 1.4 and 14.3 percentage points, respectively).

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 2022, MY 2023, and MY 2024 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 2022		MY 2023		MY 2024	
	Denom	Rate	Denom	Rate	Denom	Rate
All Eligible Members†	643	79.0%	638	79.5%	629	80.0%
Age Category						
≤ 2 Years	S	S	S	S	S	S
3 to 5 Years	S	S	S	S	S	S
6 to 10 Years	179	86.6%	177	83.6%	166	79.5%
11 to 13 Years	144	80.6%	147	84.4%	136	83.8%
≥ 14 Years	266	75.2%	247	75.3%	277	78.7%
Sex						
Male	303	75.2%	311	80.7%	314	74.8%
Female	340	82.4%	327	78.3%	315	85.1%
Race						
Black or African American	219	74.9%	216	76.4%	207	76.8%
White	405	81.0%	407	80.8%	409	81.7%
Other	19	84.2%	15	86.7%	13	76.9%
Region						
Central	126	75.4%	140	78.6%	116	82.8%
Charlottesville/Western	105	73.3%	109	82.6%	126	73.0%
Northern & Winchester	57	71.9%	59	67.8%	66	75.8%
Roanoke/Alleghany	136	90.4%	104	82.7%	119	83.2%
Southwest	115	83.5%	125	83.2%	99	81.8%
Tidewater	104	73.1%	101	76.2%	103	82.5%

Category	MY 2022		MY 2023		MY 2024	
	Denom	Rate	Denom	Rate	Denom	Rate
MCO						
Aetna	59	74.6%	61	68.9%	54	75.9%
HealthKeepers	144	79.2%	161	78.3%	153	77.1%
Molina	37	75.7%	31	74.2%	30	76.7%
Sentara*	345	80.0%	335	82.4%	322	81.1%
United	51	76.5%	42	81.0%	64	85.9%

†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 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 0.05) and the stratified rate was lower than the reference group rate.

* HSAG combined Optima and VA Premier for MY 2022 in this year’s report and displayed the rates as Sentara. For MY 2023, HSAG included members with enrollment in Optima or VA Premier prior to July 2023 in the rate for Sentara.

Table 6-6 shows that 80.0 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 2024, and this rate increased by 0.5 percentage points from MY 2023. Members 14 years of age and older were significantly less likely to have a visit with an MHP during MY 2023; however, this disparity no longer existed during MY 2024 due to an increase in the rate for this group (by 3.4 percentage points). Male members were significantly less likely to have an MHP visit, while female members were significantly more likely, and these disparities also existed during MY 2022. Members in the Charlottesville/Western region were significantly less likely to have an MHP visit compared to members in other regions. Members in the Northern/Winchester region and members enrolled with Aetna were significantly less likely to have a visit with an MHP during MY 2023; however, these disparities no longer existed during MY 2024 due to increases in the rates for these groups (by 8.0 and 7.0 percentage points, respectively).

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 2022, MY 2023, and MY 2024 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 2022		MY 2023		MY 2024	
	Denom	Rate	Denom	Rate	Denom	Rate
All Eligible Members [†]	1,368	67.1%	1,450	73.1%	1,355	72.8%
Age Category						
≤ 2 Years	419	32.0%	361	43.8%	376	46.3%
3 to 5 Years	207	64.3%	255	68.6%	234	64.5%
6 to 10 Years	252	89.7%	281	86.8%	290	85.9%
11 to 13 Years	138	92.0%	187	89.3%	162	94.4%
≥ 14 Years	352	84.7%	366	86.3%	293	88.7%
Sex						
Male	706	65.7%	733	69.3%	695	75.4%
Female	662	68.6%	717	77.0%	660	70.2%
Race						
Black or African American	414	65.5%	490	72.2%	483	76.2%
White	926	67.9%	916	73.3%	823	71.3%
Other	28	64.3%	44	79.5%	49	65.3%
Region						
Central	223	70.0%	270	67.8%	303	75.6%
Charlottesville/Western	242	64.5%	240	68.3%	226	68.6%
Northern & Winchester	198	52.0%	193	62.2%	191	57.1%
Roanoke/Alleghany	285	67.7%	271	84.5%	218	75.7%
Southwest	188	77.7%	216	81.9%	180	81.1%
Tidewater	226	70.8%	251	72.5%	233	78.5%
MCO						
Aetna	175	71.4%	154	70.8%	161	68.3%
HealthKeepers	344	65.4%	366	70.8%	364	72.0%
Molina	88	61.4%	109	70.6%	85	72.9%
Sentara*	571	66.7%	635	76.1%	583	77.0%
United	119	68.1%	124	71.8%	114	56.1%
More Than One MCO	71	73.2%	62	69.4%	48	83.3%

[†]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 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 0.05) and the stratified rate was lower than the reference group rate.

* HSAG combined Optima and VA Premier for MY 2022 in this year's report and displayed the rates as Sentara. For MY 2023, HSAG included members with enrollment in Optima or VA Premier prior to July 2023 in the rate for Sentara.

Table 6-7 shows that 72.8 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 2024, and this rate decreased by 0.3 percentage points from MY 2023. 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, 11 to 13, and 14 years of age and older were significantly more likely.

Except for the disparity for the 3 to 5 years of age group, these disparities also existed during MY 2022 and MY 2023. Male members were significantly less likely to have an MHP visit during MY 2023; however, for MY 2024, male members were significantly more likely and female members were significantly less likely. Black or African American members were significantly more likely to have an MHP visit compared to members in other racial groups during MY 2024. 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 and Tidewater regions were significantly more likely. The disparities for members in the Northern & Winchester and Southwest regions also existed during MY 2022 and MY 2023. Members in the Central region were significantly less likely to have a visit with an MHP compared to members in other regions during MY 2023; however, this disparity no longer existed during MY 2024 due to an increase in the rate for this group (by 7.8 percentage points). Members enrolled with Sentara were significantly more likely to have an MHP visit compared to members enrolled with other MCOs, while members enrolled with United were significantly less 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 2022, MY 2023, and MY 2024 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 2022		MY 2023		MY 2024	
	Denom	Rate	Denom	Rate	Denom	Rate
All Eligible Members†	520	93.1%	572	92.3%	493	95.3%
Age Category						
≤ 2 Years	—	—	S	S	S	S
3 to 5 Years	33	90.9%	S	S	S	S
6 to 10 Years	137	97.8%	156	93.6%	149	96.0%
11 to 13 Years	96	94.8%	117	94.9%	108	98.1%
≥ 14 Years	254	90.2%	268	90.7%	197	93.4%
Sex						
Male	245	91.8%	257	91.8%	256	96.9%
Female	275	94.2%	315	92.7%	237	93.7%
Race						
Black or African American	158	89.9%	207	88.4%	174	94.8%
White	354	94.6%	345	94.8%	309	95.5%

Category	MY 2022		MY 2023		MY 2024	
	Denom	Rate	Denom	Rate	Denom	Rate
Region						
Central	96	95.8%	113	90.3%	116	94.8%
Charlottesville/Western	96	90.6%	94	88.3%	85	96.5%
Northern & Winchester	45	88.9%	53	90.6%	44	90.9%
Roanoke/Alleghany	133	92.5%	99	96.0%	83	96.4%
Southwest	81	93.8%	110	96.4%	87	94.3%
Tidewater	66	95.5%	101	92.1%	78	97.4%
MCO						
Aetna	63	90.5%	53	83.0%	39	92.3%
HealthKeepers	128	94.5%	143	91.6%	143	96.5%
Molina	19	100.0%^	37	86.5%	19	100.0%^
Sentara*	252	92.9%	281	94.0%	248	94.4%
United	35	88.6%	39	97.4%	24	95.8%
More Than One MCO	23	95.7%	19	100.0%^	20	100.0%^

[†]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 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 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.

* HSAG combined Optima and VA Premier for MY 2022 in this year's report and displayed the rates as Sentara. For MY 2023, HSAG included members with enrollment in Optima or VA Premier prior to July 2023 in the rate for Sentara.

Table 6-8 shows that 95.3 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 2024, and this rate increased by 3.0 percentage points from MY 2023. Black or African American members and members enrolled with Aetna were significantly less likely to have a visit with an MHP during MY 2023; however, these disparities no longer existed during MY 2024 due to increases in the rates for these groups (by 6.4 and 9.3 percentage points, respectively).

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 2022, MY 2023, and MY 2024 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 2022		MY 2023		MY 2024	
	Denom	Rate	Denom	Rate	Denom	Rate
All Eligible Members [†]	812	44.3%	777	46.3%	992	48.5%
Age Category						
≤ 2 Years	90	26.7%	68	35.3%	88	33.0%
3 to 5 Years	187	25.7%	188	36.2%	230	31.7%
6 to 10 Years	262	51.9%	248	52.8%	307	54.4%
11 to 13 Years	130	47.7%	122	48.4%	173	56.6%
≥ 14 Years	143	62.9%	151	51.7%	194	58.8%
Sex						
Male	437	43.7%	402	49.5%	550	49.6%
Female	375	45.1%	375	42.9%	442	47.1%
Race						
Black or African American	230	39.1%	233	45.1%	283	53.7%
White	559	45.8%	525	47.4%	685	46.3%
Region						
Central	168	42.3%	150	47.3%	183	45.4%
Charlottesville/Western	113	41.6%	151	36.4%	151	49.0%
Northern & Winchester	134	27.6%	137	34.3%	171	40.4%
Roanoke/Alleghany	135	62.2%	131	64.9%	169	53.8%
Southwest	113	46.0%	88	51.1%	121	52.9%
Tidewater	148	46.6%	120	47.5%	197	50.8%
MCO						
Aetna	69	33.3%	76	42.1%	119	40.3%
HealthKeepers	234	42.3%	214	49.1%	291	49.8%
Molina	44	29.5%	43	37.2%	101	41.6%
Sentara*	358	48.9%	326	48.2%	333	55.6%
United	69	46.4%	86	41.9%	117	40.2%
More Than One MCO	38	47.4%	32	43.8%	31	45.2%

[†]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 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 0.05) and the stratified rate was lower than the reference group rate.

* HSAG combined Optima and VA Premier for MY 2022 in this year's report and displayed the rates as Sentara. For MY 2023, HSAG included members with enrollment in Optima or VA Premier prior to July 2023 in the rate for Sentara.

Table 6-9 shows that 48.5 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 2024, and this rate increased by 2.2 percentage points from MY 2023. 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, 11 to 13, and 14 years of age and older were significantly more likely. The disparities for members 3 to 5 years of age and 6 to 10 years of age also

existed during MY 2022 and MY 2023. White members were significantly less likely to have an MHP visit compared to members in other racial groups, while Black or African American members were significantly more likely. Members in the Northern & Winchester region were significantly less likely to have an MHP visit compared to members in other regions. This disparity also existed during MY 2022 and MY 2023. Members in the Charlottesville/Western region were significantly less likely to have a visit with an MHP compared to members in other regions during MY 2023; however, this disparity no longer existed during MY 2024 due to an increase in the rate for this group (by 12.6 percentage points). Members enrolled with Sentara were significantly more likely to have an MHP visit compared to members enrolled with other MCOs.

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 2022, MY 2023, and MY 2024 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 2022		MY 2023		MY 2024	
	Denom	Rate	Denom	Rate	Denom	Rate
All Eligible Members†	356	68.3%	321	69.8%	383	73.4%
Age Category						
≤ 2 Years	S	S	—	—	S	S
3 to 5 Years	S	S	34	70.6%	S	S
6 to 10 Years	149	67.8%	136	72.1%	147	71.4%
11 to 13 Years	75	62.7%	62	66.1%	86	72.1%
≥ 14 Years	91	74.7%	89	68.5%	112	79.5%
Sex						
Male	200	67.5%	181	72.4%	210	74.3%
Female	156	69.2%	140	66.4%	173	72.3%
Race						
Black or African American	94	64.9%	107	62.6%	126	77.0%
White	252	68.7%	210	72.9%	249	71.9%
Region						
Central	72	61.1%	58	70.7%	53	77.4%
Charlottesville/Western	49	63.3%	70	58.6%	67	71.6%
Northern & Winchester	41	63.4%	49	61.2%	57	64.9%
Roanoke/Alleghany	76	80.3%	52	78.8%	64	75.0%
Southwest	61	65.6%	40	75.0%	54	72.2%

Category	MY 2022		MY 2023		MY 2024	
	Denom	Rate	Denom	Rate	Denom	Rate
Tidewater	57	71.9%	52	78.8%	88	77.3%
MCO						
Aetna	22	54.5%	S	S	S	S
HealthKeepers	116	65.5%	103	71.8%	124	72.6%
Molina	S	S	S	S	S	S
Sentara*	183	69.4%	147	72.1%	167	75.4%
United	S	S	37	59.5%	24	79.2%

[†]Members with Other Race, Unknown Region, and More Than Once 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 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 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.

* HSAG combined Optima and VA Premier for MY 2022 in this year’s report and displayed the rates as Sentara. For MY 2023, HSAG included members with enrollment in Optima or VA Premier prior to July 2023 in the rate for Sentara.

Table 6-10 shows that 73.4 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 2024, and this rate increased by 3.6 percentage points from MY 2023. Black or African American members and members in the Charlottesville/Western region were significantly less likely to have a visit with an MHP during MY 2023; however, these disparities no longer existed during MY 2024 due to increases in the rates for these groups (by 14.4 and 13.0 percentage points, respectively).

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

Timely Access to Primary Care

Table 6-11 displays the MY 2022, MY 2023, and MY 2024 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 for Members Who Aged Out of Foster Care

Category	MY 2022		MY 2023		MY 2024	
	Denom	Rate	Denom	Rate	Denom	Rate
All Eligible Members [†]	152	67.8%	92	73.9%	114	65.8%
Sex						
Male	75	46.7%	49	61.2%	54	51.9%

Category	MY 2022		MY 2023		MY 2024	
	Denom	Rate	Denom	Rate	Denom	Rate
Female	77	88.3%	43	88.4%	60	78.3%
Race						
Black or African American	51	58.8%	20	70.0%	31	58.1%
White	95	71.6%	72	75.0%	80	68.8%
Region						
Central	55	63.6%	26	73.1%	31	71.0%
Charlottesville/Western	21	61.9%	22	81.8%	17	82.4%
Northern & Winchester	S	S	S	S	S	S
Roanoke/Alleghany	26	69.2%	13	84.6%	35	60.0%
Southwest	20	75.0%	18	66.7%	S	S
Tidewater	S	S	S	S	S	S
MCO						
Aetna	S	S	S	S	S	S
HealthKeepers	42	64.3%	27	70.4%	29	65.5%
Molina	S	S	S	S	S	S
Sentara*	68	72.1%	43	93.0%	56	62.5%
United	S	S	S	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 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 0.05) and the stratified rate was lower than the reference group rate.

* HSAG combined Optima and VA Premier for MY 2022 in this year's report and displayed the rates as Sentara. For MY 2023, HSAG included members with enrollment in Optima or VA Premier prior to July 2023 in the rate for Sentara.

Table 6-11 shows that 65.8 percent of members who aged out of foster care had at least one visit with a PCP during MY 2024, and this rate decreased by 8.1 percentage points from MY 2023. Male members were significantly less likely to have a PCP visit during MY 2024, while female members were significantly more likely. These disparities also existed during MY 2022 and MY 2023.

Timely Access to Dental Care

Table 6-12 displays the MY 2022, MY 2023, and MY 2024 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 2022		MY 2023		MY 2024	
	Denom	Rate	Denom	Rate	Denom	Rate
All Eligible Members†	152	29.6%	92	39.1%	114	40.4%
Sex						
Male	75	20.0%	49	38.8%	54	44.4%
Female	77	39.0%	43	39.5%	60	36.7%
Race						
Black or African American	51	23.5%	20	60.0%	31	41.9%
White	95	32.6%	72	33.3%	80	38.8%
Region						
Central	55	36.4%	26	73.1%	31	61.3%
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	42	33.3%	S	S	29	48.3%
Molina	S	S	S	S	S	S
Sentara*	68	29.4%	43	37.2%	56	37.5%
United	S	S	S	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 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 0.05) and the stratified rate was lower than the reference group rate.

* HSAG combined Optima and VA Premier for MY 2022 in this year's report and displayed the rates as Sentara. For MY 2023, HSAG included members with enrollment in Optima or VA Premier prior to July 2023 in the rate for Sentara.

Table 6-12 shows that 40.4 percent of members who aged out of foster care had at least one visit with a dental provider during MY 2024, and this rate increased by 1.3 percentage points from MY 2023. White members were significantly less likely to have a dental provider visit during MY 2023; however, this disparity no longer existed during MY 2024 due to an increase in the rate for this group (by 5.5 percentage points). Members in the Central region were significantly more likely to have a dental provider visit during MY 2024 and MY 2023.

Timely Access to Primary Care or Dental Care

Table 6-13 displays the MY 2022, MY 2023, and MY 2024 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 2022		MY 2023		MY 2024	
	Denom	Rate	Denom	Rate	Denom	Rate
All Eligible Members†	152	71.7%	92	79.3%	114	71.9%
Sex						
Male	75	52.0%	49	71.4%	54	64.8%
Female	77	90.9%	43	88.4%	60	78.3%
Race						
Black or African American	51	60.8%	20	75.0%	31	67.7%
White	95	76.8%	72	80.6%	80	72.5%
Region						
Central	55	69.1%	26	84.6%	31	80.6%
Charlottesville/Western	S	S	22	86.4%	17	82.4%
Northern & Winchester	S	S	S	S	S	S
Roanoke/Alleghany	26	69.2%	13	84.6%	35	62.9%
Southwest	20	80.0%	18	72.2%	S	S
Tidewater	19	73.7%	S	S	S	S
MCO						
Aetna	14	78.6%	S	S	S	S
HealthKeepers	42	66.7%	27	74.1%	29	69.0%
Molina	S	S	S	S	S	S
Sentara*	68	76.5%	43	95.3%	56	71.4%
United	S	S	S	S	14	78.6%

†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 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 0.05) and the stratified rate was lower than the reference group rate.

* HSAG combined Optima and VA Premier for MY 2022 in this year’s report and displayed the rates as Sentara. For MY 2023, HSAG included members with enrollment in Optima or VA Premier prior to July 2023 in the rate for Sentara.

Table 6-13 shows that 71.9 percent of members who aged out of foster care had at least one visit with a PCP or dental care provider during MY 2024, and this rate decreased by 7.4 percentage points from MY 2023. However, the MY 2024 rate was similar to the MY 2022 rate.

Timely Access to Primary Care and Dental Care

Table 6-14 displays the MY 2022, MY 2023, and MY 2024 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 2022		MY 2023		MY 2024	
	Denom	Rate	Denom	Rate	Denom	Rate
All Eligible Members†	152	25.7%	92	33.7%	114	34.2%
Sex						
Male	75	14.7%	49	28.6%	54	31.5%
Female	77	36.4%	43	39.5%	60	36.7%
Race						
Black or African American	51	21.6%	20	55.0%	S	S
White	95	27.4%	72	27.8%	S	S
Region						
Central	55	30.9%	26	61.5%	31	51.6%
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	42	31.0%	S	S	29	44.8%
Molina	S	S	S	S	S	S
Sentara*	68	25.0%	43	34.9%	56	28.6%
United	S	S	S	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 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 0.05) and the stratified rate was lower than the reference group rate.

* HSAG combined Optima and VA Premier for MY 2022 in this year’s report and displayed the rates as Sentara. For MY 2023, HSAG included members with enrollment in Optima or VA Premier prior to July 2023 in the rate for Sentara.

Table 6-14 shows that 34.2 percent of members who aged out of foster care had at least one PCP visit and at least one visit with a dental care provider during MY 2024, and this rate increased by 0.5 percentage points from MY 2023. Given that the statewide rate for the *Timely Access to Dental Care for Members Who Aged Out of Foster Care* indicator was 31.5 percentage points lower than the rate 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. Members in the Central region were significantly

more likely to have a PCP visit and a dental provider visit compared to members in other regions. The disparity for the Central region also existed during MY 2023. White members were significantly less likely to have a PCP visit and a dental provider visit during MY 2023; however, this disparity no longer existed during MY 2024 due to an increase in the rate for this group (by 7.2 percentage points).

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 2022, MY 2023, and MY 2024 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 2022		MY 2023		MY 2024	
	Denom	Rate	Denom	Rate	Denom	Rate
All Eligible Members†	152	38.8%	92	44.6%	114	41.2%
Sex						
Male	75	26.7%	49	40.8%	54	38.9%
Female	77	50.6%	43	48.8%	60	43.3%
Race						
Black or African American	51	37.3%	S	S	31	48.4%
White	95	38.9%	S	S	80	38.8%
Region						
Central	55	47.3%	26	42.3%	31	58.1%
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	42	38.1%	27	48.1%	29	44.8%
Molina	S	S	S	S	S	S
Sentara*	68	36.8%	43	41.9%	56	39.3%
United	S	S	S	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 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 0.05) and the stratified rate was lower than the reference group rate.

* HSAG combined Optima and VA Premier for MY 2022 in this year's report and displayed the rates as Sentara. For MY 2023, HSAG included members with enrollment in Optima or VA Premier prior to July 2023 in the rate for Sentara.

Table 6-15 shows that 41.2 percent of members who aged out of the foster care program had at least one visit with an MHP during MY 2024, and this rate decreased by 3.4 percentage points from MY 2023. However, the MY 2024 rate was still higher than the MY 2022 rate. Members in the Central region were significantly more likely to have an MHP visit compared to members in other regions.

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 2022, MY 2023, and MY 2024 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 2022		MY 2023		MY 2024	
	Denom	Rate	Denom	Rate	Denom	Rate
All Eligible Members [†]	120	45.8%	73	54.8%	81	49.4%
Sex						
Male	56	33.9%	39	48.7%	36	50.0%
Female	64	56.3%	34	61.8%	45	48.9%
Race						
Black or African American	43	41.9%	S	S	20	60.0%
White	73	47.9%	S	S	59	45.8%
Region						
Central	46	52.2%	21	52.4%	25	64.0%
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	34	44.1%	19	63.2%	S	S
Molina	S	S	S	S	S	S

Category	MY 2022		MY 2023		MY 2024	
	Denom	Rate	Denom	Rate	Denom	Rate
Sentara*	52	46.2%	35	51.4%	43	44.2%
United	S	S	S	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 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 0.05) and the stratified rate was lower than the reference group rate.

* HSAG combined Optima and VA Premier for MY 2022 in this year’s report and displayed the rates as Sentara. For MY 2023, HSAG included members with enrollment in Optima or VA Premier prior to July 2023 in the rate for Sentara.

Table 6-16 shows that 49.4 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 2024, and this rate decreased by 5.4 percentage points from MY 2023. However, the MY 2024 rate was still higher than the MY 2022 rate.

7. Conclusions and Recommendations

SFY 2024–25 is the tenth year of the Child Welfare Focus Study and the seventh 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 members in child welfare programs. Comparing members in child welfare programs 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 population, 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 control groups 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 control groups. Covariate balance between the stratification-limited study populations and the stratification-limited control groups 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 2024–25 study, all characteristics for which rates were stratified were exact-matched except for member sex, and HSAG found that most covariates were balanced within the overall 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, rather than to assess the frequency of service utilization. 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 control groups 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 populations and control groups.
- MY 2022 and MY 2023 findings may be impacted by the COVID-19 PHE, which expired on May 11, 2023.⁵⁴ Therefore, HSAG recommends exercising caution when interpreting these findings, where applicable.
- Each reporting year, the code sets used in the measure specifications to identify services are updated to reflect codes that were billable during the measurement year. Therefore, some rate differences between measurement years may be attributable to changes in code sets and billing practices rather than changes in utilization.

Conclusions and Recommendations

DMAS' Quality Improvement Efforts

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. Additionally, DMAS has taken actions in response to HSAG's recommendations from the prior year's focus study. As context for the current study's conclusions and recommendations, the following section provides an overview of these quality improvement efforts.

Initiatives and Policy Changes

Cardinal Care Managed Care Procurement and Foster Care Specialty Plan

CCMC was launched in January 2023 to enhance Virginia's Medicaid managed care system. Through the initiative, Virginia consolidated the two previous managed care programs (Medallion 4.0 and CCC Plus) into CCMC, defined transformation goals for the program, and reprocured the contracted managed care health plans to improve the delivery system and better serve members.

The managed care procurement, which began in 2023 with a Request for Proposals, included an addendum for one selected MCO to serve as the single statewide FCSP for all members in foster care, adoption assistance, and former foster care Medicaid eligibility groups. DMAS recognizes the unique needs of children and young adults impacted by the child welfare system. The need for timely access to a comprehensive and coordinated array of services is key to improving outcomes. The FCSP Contract Addendum was created with additional requirements for outreach and care management, as well as

⁵⁴ U.S. Department of Health and Human Services. Covid-19 Public Health Emergency. Available at: <https://www.hhs.gov/coronavirus/covid-19-public-health-emergency/index.html>. Accessed on Oct 9, 2025.

staffing requirements to include expertise in trauma-informed care and the Virginia child welfare system.

DMAS issued a Notice of Award for the new CCMC health plans on December 30, 2024, with Anthem HealthKeepers Plus selected to serve as the single statewide FCSP and awarded the FCSP Contract Addendum. DMAS has worked with Anthem HealthKeepers, the Department of Social Services, and other stakeholders to plan for the implementation of the new FCSP beginning July 1, 2025, for all youth in foster care, receiving adoption assistance, and members under 26 years of age who were in foster care until their discharge at 18 years of age or older.

The FCSP will be a single point of accountability for the State; will mitigate access and continuity of care issues; and includes an innovative, trauma-informed care management model to address the unique needs of members and initiatives in Virginia. DMAS anticipates that the implementation of Anthem HealthKeepers' FCSP, to serve all members included in this Child Welfare Focus Study, will lead to an improvement in overall utilization, timeliness of healthcare, and health disparities among these members.

Safe and Sound Task Force

Under the leadership of Virginia's Governor, the Safe and Sound Task Force continued through SFY 2024–25. The objective of the task force is to work collaboratively across state and local agencies serving youth in foster care to address the barriers related to safe and appropriate placements. Through this work, the Task Force has identified that access to appropriate and timely medical and behavioral health services is a priority for ensuring safe and appropriate placements for these children.

The core priorities identified by the Task Force 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. The Task Force will continue beyond the current administration and is now hosted by the VDSS 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 health care services as well as timely access to and utilization of services for child welfare members. DMAS utilizes conclusions and recommendations from the Child Welfare Focus Study to inform its participation and input in the work of the Task Force.

Safe Kids, Strong Families

In May 2025, Virginia's Governor launched a child welfare redesign initiative focused on increasing support for families of youth in foster and kinship care, reducing reliance on congregate (or residential) care, and improving access to services that support youth and families impacted by the child welfare system. The first few months of these efforts began with a study to address systemic challenges faced by youth and families involved in the child welfare system. DMAS has been involved since the launch of this initiative, attending roundtable discussions; design sessions; and serving on the Safe Kids, Strong Families Steering Committee.

DMAS is committed to continuing to work with partners and stakeholders toward improving access to necessary healthcare services for Medicaid members involved in the child welfare system. Additionally, DMAS anticipates that efforts toward these improvements over the next year will result in higher rates

of appropriate and timely health care utilization for individuals in foster care, receiving adoption assistance, and those formerly in foster care through age 26.

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 health care 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 reentry and stabilization when transitioning from a crisis. DMAS is an integral partner and stakeholder within this plan.

In support of the Governor's Right Help, Right Now Behavioral Health Transformation Plan, DMAS in collaboration with other state agencies and stakeholders has completed the first of a two-year initiative to redesign Medicaid legacy CMHRS for youth. The 2024–2026 biennium budget provided DMAS with the authority to replace its CMHRS and case management services. Additionally, a new bill (Senate Bill 403) adds two new professions and scopes of practice for Behavioral Health Technicians and Behavioral Health Technician Assistants. This new scope of practice (to be developed by the Department of Health Professions) will be integrated into the newly designed Medicaid behavioral health services.

During SFY 2024–25, DMAS completed a variety of objectives toward implementing new behavioral health Medicaid services by June 2026. DMAS worked collaboratively with stakeholders and researched evidence-based services in order to develop service requirements and definitions, FFS rates and utilization, cost, and budget impact estimations for the redesigned services. In July 2025, DMAS began operationalizing these new services through licensure and regulatory changes, preparing providers and MCOs to transition to new services, and planning for implementation and go-live by June 2026.

DMAS' goal in implementing these new services 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, including identified disparities and areas of improvement in this year's Child Welfare Focus Study related to behavioral health services, DMAS will continue to work collaboratively with its partners to move Right Help, Right Now forward.

Input on Prior Focus Study Recommendations

Focus Study Measures and Analyses

The 2023–24 Child Welfare Focus Study continued to monitor healthcare utilization among children in foster care. For the fourth year, children receiving adoption assistance and former foster care members were also included as child welfare populations in this study. SFY 2023–24 was the third year analyzing measures related to health disparities and timely access to care for children in foster care, children receiving adoption assistance, and former foster care members. This includes 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.

Based on HSAG's prior focus study recommendations, DMAS has requested that the 2024–25 Child Welfare Focus Study, as well as all future studies, continue to include these additional analyses. This will allow DMAS to continue to monitor impacts of the COVID-19 PHE, to verify or establish new appropriate baseline rates post-pandemic, and to identify areas for improvement and monitor impacts of program changes. 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.

Quality Improvement Recommendations

HSAG provided DMAS with several recommendations related to quality improvement in the areas of healthcare utilization, timeliness of care, and healthcare disparities among children in foster care, children receiving adoption assistance, and former foster care members. This year, DMAS has utilized a variety of methods to collaborate with members and/or their guardians, providers, and other stakeholders, as well as to initiate and continue quality improvement strategies to address HSAG's recommendations.

Community Partnerships and Focus Groups

DMAS continues to facilitate regular virtual statewide Foster Care Partnership meetings with child welfare stakeholders from across the state. These stakeholders included those from the Virginia Department of Social Services, LDSS, the Virginia Commission on Youth, LCPAs, Medicaid contracted 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 are developed based on cross-sector discussions around current needs of youth in foster care, factoring in results and recommendations of the 2023–24 Child Welfare Focus Study.

In addition to utilizing the Foster Care Partnership to solicit feedback in planning for the implementation of the new FCSP, stakeholders involved also share challenges, barriers, and best practices around accessing timely and appropriate services. Each year, the Foster Care Partnership hosts an annual review of the Child Welfare Focus Study results, conclusions, and recommendations for discussion and brainstorming. HSAG shared the 2023–24 outcomes during a Foster Care Partnership meeting on May 28, 2025, with over 450 attendees statewide. Areas of interest during that discussion included follow up measures for SUD.

As previously discussed, as part of the Governor's Right Help, Right Now initiative, DMAS is re-designing Medicaid legacy CMHRS for youth. DMAS hosted workgroups throughout SFY 2024-25 with internal and external stakeholders to begin work on this project. Year 1 of the project concentrated on policy, rate development, and stakeholder engagement with the assistance of the DMAS contractor Mercer. The group also focused on workforce development to reduce disparities in access to services regionally. This provided an opportunity to share input based on Child Welfare Focus Study recommendations and to get feedback from impacted members and stakeholders related to behavioral health-specific measures and disparities.

Member Outreach

DMAS has continued to engage in frequent member and stakeholder outreach. DMAS sends 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. These newsletters now reach over 900 members, guardians, providers, community-based agencies, state agencies, and others statewide interested in keeping up to date with child welfare initiatives.

DMAS and Anthem HealthKeepers worked to create a variety of outreach materials to share information about Medicaid services for youth in foster care, adoption assistance, and former foster care as part of the CCMC procurement and planning for the transition to Anthem HealthKeepers Plus FCSP. These communications included flyers tailored to each FCSP eligibility group; FCSP assignment letters; FCSP welcome packets with thorough coverage and health plan information; and website updates to include resources such as webinar slides, webinar recording, and contact information for support.

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 presentations at the annual Children’s Services Act Conference, the VDSS Permanency Conference, DMAS’ BabySteps Bimonthly meeting, the Virginia League of Social Services Executives Board Meetings, Children’s Welfare Advisory Committee, and the Governor’s Safe & Sound Task Force 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.

Managed Care Oversight Efforts

As previously discussed, as of October 2023 DMAS is operating under one unified health program called Cardinal Care. Cardinal Care is a single brand encompassing all health coverage programs for Virginia’s two million Medicaid members. At the time of this report, there were five MCOs contracted with DMAS serving members in foster care, members in adoption assistance, and former foster care.

DMAS continues to improve efforts to track and analyze a variety of data sources to evaluate Virginia’s foster care Medicaid programs. DMAS MCOs continue to report on a variety of measures monthly, including those related to care coordination and member outreach, service utilization, and efforts to assist members who age out of the child welfare system with transition planning. DMAS continues to utilize a dashboard for easier analysis and tracking of utilization and member outreach over time and by MCO. These monthly reports also allow MCOs to report barriers to member outreach and engagement so that DMAS can assist and address efficient outreach and communication. The data from these

monthly reports are tied to both Cardinal Care contract compliance and program oversight, presenting DMAS with an opportunity to utilize various data sources, including those in the Child Welfare Focus Study, to better understand the status of Medicaid programs serving youth in foster care.

DMAS will monitor the impact of members' transition into the FCSP on all study indicators relative to historic rates as well as controls and national benchmarks. As part of the new FSCP, which began on July 1, 2025, DMAS has implemented additional reporting requirements in a supplemental FCSP Technical Manual. New reporting requirements are related to additional contract requirements in the FCSP Addendum for youth in foster care, to include documentation of care management outreach, level of care management received, triggering events requiring updated assessments or care plans, and support provided to members during transitions of care. DMAS plans to add additional measures to reporting requirements from Anthem HealthKeepers in future years based on outcomes and recommendations from future Child Welfare Focus Studies.

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.⁵⁵ 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.⁵⁶ 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 2023, and MY 2024. During MY 2024, children in foster care had higher rates than controls for two of three indicators in the Primary Care domain, all indicators in the Oral Health domain, nine of 11 indicators in the Behavioral Health domain, and nine of 10 indicators in the Service Utilization domain. Rate differences between children in foster care and controls across study indicators persisted even after matching on many demographic and health characteristics.

During MY 2024, children in foster care had lower rates compared to controls for four study indicators, of which one was statistically significant: *ED Visits*. The lower rate for the *ED Visits* indicator may reflect better management of health conditions for children in foster care compared to controls. Additionally, the rate for the *Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up* indicator for children in foster care was 15.9 percentage points lower than controls during MY 2024; however, this rate difference was mostly driven by a large improvement in the rate for controls from MY 2023 to MY 2024.

The Virginia Foster Care Affinity Group worked on improving timely initial MCO outreach to foster care members to support service initiation efforts through December 2023 and predicted that these efforts may help improve rates of SUD treatment initiation and engagement. Findings show that while historically the rates of SUD treatment initiation and engagement for children in foster care has been lower than controls, the rates for children in foster care were higher than controls during MY 2023 and MY 2024. Additionally, the MY 2024 rates for children in foster care exceeded the national Medicaid

⁵⁵ Virginia Department of Social Services. Foster Care (FC). Available at: <https://www.dss.virginia.gov/family/fc/index.cgi>. Accessed on: Nov 17, 2025.

⁵⁶ 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/09_2024/section_12_identifying_services_to_be_provided.pdf. Accessed on: Oct 2, 2025.

66.67th percentile for the *Initiation and Engagement of SUD Treatment—Initiation of SUD Treatment* indicator and exceeded the national Medicaid 50th percentile for the *Initiation and Engagement of SUD Treatment—Engagement of SUD Treatment* indicator. Therefore, DMAS has achieved meaningful improvement in the rates for these indicators over MY 2023 and MY 2024.

Among children in foster care, 21 study indicator rates increased, while eight study indicator rates decreased from MY 2023 to MY 2024. Therefore, healthcare utilization is generally improving for children in foster care. Of note, all indicator rates in the Oral Health domain increased. The largest increase from MY 2023 to MY 2024 was for the *Initiation and Engagement of SUD Treatment—Initiation of SUD Treatment* indicator (by 16.1 percentage points). The MCOs documented quality improvement efforts related to this indicator in their QAPI Program Evaluation for MY 2023. Three MCOs (i.e., HealthKeepers, Molina, and Sentara) demonstrated substantial improvements in initiation of SUD treatment for children in foster care during MY 2024, though denominators are small and therefore subject to greater year-to-year variability. The largest decline from MY 2023 to MY 2024 was for the *Asthma Medication Ratio* indicator (by 6.1 percentage points). Of note, the measure specifications for the *Asthma Medication Ratio* study indicator changed substantially in MY 2024, and the national Medicaid 50th percentile benchmarks for children also decreased from MY 2023 to MY 2024; therefore, the decrease in the rate for this study indicator is in alignment with national trends.

Several stratifications within the children in foster care population demonstrated significant health disparities, particularly for dental services and behavioral health services. While a majority of measures demonstrated age-based disparities, some of these rate differences are associated with expected differences in healthcare utilization (e.g., members 2 years of age and younger are less likely to utilize behavioral health services). However, members 2 years of age and younger and members 14 years of age and older had significantly lower rates for most study indicators in the Oral Health domain, indicating opportunity for improvement. Additionally, members 12 years of age and older had significantly lower rates of well-care visits. Regional disparities were the most commonly identified disparities for children in foster care, occurring in over 70 percent of indicators. Of note, members in the Charlottesville/Western and Roanoke/Alleghany regions had significantly lower rates for all study indicators in the Oral Health domain, and members in the Northern & Winchester region had significantly lower rates for most of the *Behavioral Health Encounters* indicators. Members in the Southwest region had many indicators with significantly higher rates, including two Oral Health domain indicators. Aetna, Molina, and United had a high percentage of study indicators with significantly lower rates, particularly the *Behavioral Health Encounters* indicators and indicators in the Oral Health domain.

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

- To ensure high rates for the *Initiation and Engagement of SUD Treatment* indicator are sustained, HSAG recommends that DMAS continue to monitor whether indicator rates for children in foster care exceed controls and national benchmarks, particularly during and after the transition to the FCSP administered by HealthKeepers on July 1, 2025. The rate for initiation of SUD treatment for HealthKeepers was lower than the rate for All Eligible Members during MY 2024, though it still exceeded the rate for controls and the national Medicaid 50th percentile. HealthKeepers' rate for engagement in SUD treatment was higher than the rate for All Eligible Members. However, the denominators for HealthKeepers for these study indicators were very small and are therefore subject to greater year-to-year variability. Evaluating these study indicators with a larger HealthKeepers population following the transition will be more indicative of its performance. In the QAPI Program Evaluations for MY 2023, some MCOs identified lack of in-network providers as a

barrier to SUD treatment. DMAS should ensure that HealthKeepers has a sufficient network of SUD treatment providers in all regions, particularly those who were working with children in foster care previously enrolled with other MCOs.

- To address the disparities identified for children in foster care, DMAS may consider focusing quality improvement efforts toward the age and region groups with significantly lower rates, given that all children in foster care have transitioned to a single MCO. For the disparities identified by region, DMAS may consider evaluating whether provider availability and appointment availability align with these findings. Alternatively, DMAS may consider utilizing either stratified surveys or targeted surveys to collect information about the barriers for these groups and identify opportunities for improvement. Under the stratified survey approach, DMAS would conduct a survey on a representative sample of stakeholders (e.g., foster parents) for the entire study population and calculate results stratified by characteristics for which disparities were identified (e.g., region). Under the targeted survey approach, DMAS or HealthKeepers would sample stakeholders for affected members only (e.g., members in need of the service of interest who reside in a region with a significantly lower rate). These surveys could evaluate members' experience of care, including access to care, coverage transparency, and prior authorizations. Alternatively, DMAS could consider utilizing regional focus groups to gather information on these topics.
- Children in foster care transitioned to the statewide FCSP administered by HealthKeepers effective July 2025. Among the 15 indicators presented in the Primary Care, Oral Health, Behavioral Health, Substance Use, and Respiratory Health domains, the rate for children in foster care enrolled with HealthKeepers exceeded the rate for all eligible controls for 12 indicators during MY 2024. High rates on these measures indicate high performance. However, DMAS may still consider monitoring the impact of the transition to the FCSP using surveys or administrative data analyses. For example, a survey could be distributed to foster parents or providers that work with children in foster care. This survey could evaluate topics such as whether the member was able to keep their provider, whether services that were previously covered remained covered, and whether there were disruptions in payment for services and medications. Alternatively, administrative data could be used to assess healthcare utilization for children in foster care enrolled with the FCSP compared to controls and compared to members who opt out into FFS. Administrative data could also be used to calculate measures specific to the FCSP, such as utilization of value-added benefits and the percentage of members for which the FCSP met certain contractual requirements. Additionally, while quality improvement efforts in the existing QAPI programs typically focus on the broader Medicaid population, the transition to a single FCSP presents an opportunity to implement interventions specific to the foster care population consistently across the population. Surveys and administrative data analyses may help inform opportunities for these interventions.
- While the current study design provides insight into utilization of healthcare services, it does not assess health outcomes or member experiences among children in foster care. DMAS may consider implementing a survey evaluating members' experience with the FCSP, including quality of care, access to care, health-related quality of life, coverage transparency, usefulness of the value-added benefits, prior authorizations, and communication with the FCSP. Additionally, DMAS could consider an analysis evaluating the prevalence of pertinent outcomes among members enrolled with the FCSP, such as obesity, type 2 diabetes, teen pregnancy, suicide, and mortality, as well as evaluating causes of ED visits and inpatient visits.

Healthcare Utilization: Children Receiving Adoption Assistance

Children in the adoption assistance program are children with special needs who have been adopted from foster care. The Adoption Assistance program provides medical and financial assistance for the benefit of these children to help facilitate adoption placements and ensure permanency for children with special needs.⁵⁷ 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.⁵⁸ The adoptive parents may also choose to enroll the adoption assistance child in private insurance instead of Medicaid. 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 2023, and MY 2024. During MY 2024, children receiving adoption assistance had higher rates than controls for one of three indicators in the Primary Care domain, all indicators in the Oral Health domain, two of 11 indicators in the Behavioral Health domain, and six of 10 indicators in the Service Utilization domain. Rate differences between children receiving adoption assistance and controls across study indicators persisted even after matching on many demographic and health characteristics.

During MY 2024, children receiving adoption assistance had lower rates compared to controls for 15 study indicators, of which two differences were statistically significant: the *ED Visits* study indicator (by 10.6 percentage points) and the *Overall Service Utilization* indicator (by 1.5 percentage points). However, the lower rate of ED visits may reflect better management of health conditions for children receiving adoption assistance compared to controls, and the lower rate of overall service utilization is attributable to the lower rate of ED visits. Of note, while not statistically significant, the rates for the *Initiation and Engagement of SUD Treatment—Engagement of SUD Treatment* and *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics* study indicators for children receiving adoption assistance were 11.0 and 7.7 percentage points lower than controls during MY 2024, respectively. For eight study indicators, the rates for children receiving adoption assistance were less than 3.0 percentage points lower than the controls.

Among children receiving adoption assistance, 25 study indicator rates increased, while four study indicator rates decreased from MY 2023 to MY 2024. Of note, rates for all study indicators in the Oral Health domain increased. The largest rate decreases from MY 2023 to MY 2024 were for the *Asthma Medication Ratio* study indicator (by 4.8 percentage points) and the *Initiation and Engagement of SUD Treatment—Engagement of SUD Treatment* study indicator (by 4.4 percentage points). Of note, the measure specifications for the *Asthma Medication Ratio* study indicator changed substantially in MY 2024, and the national Medicaid 50th percentile benchmarks for children also decreased from MY 2023 to MY 2024; therefore, the decrease in the rate for this study indicator is in alignment with national trends.

⁵⁷ 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/09_2024/section_12_identifying_services_to_be_provided.pdf. Accessed on: Oct 2, 2025.

⁵⁸ 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/02-01-2022/Section_2_Adoption_Assistance.pdf. Accessed on: Oct 9, 2025.

Since children receiving adoption assistance comprise the largest child welfare population, 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, a large number of disparities were identified in the Oral Health domain and for the *Behavioral Health Encounters* indicators. Within the Oral Health domain, members enrolled with HealthKeepers and members in the Southwest region tended to have significantly higher rates of utilization. Conversely, members 14 years of age and older, White members, and members enrolled with either Aetna or Molina had significantly lower rates. Within the *Behavioral Health Encounters* indicators, male members; Black or African American members; members in the Charlottesville/Western, Roanoke/Alleghany, and Tidewater regions; and members enrolled with HealthKeepers or Sentara had significantly higher rates, while White members; members in the Northern & Winchester and Southwest regions; and members enrolled with Aetna, Molina, or United had significantly lower rates. Additionally, members in the Northern & Winchester region and members enrolled with Aetna or Molina had significantly lower rates for well-care visits and ambulatory care visits.

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

- The SFY 2024–25 study found that children receiving adoption assistance had lower rates than controls for nine of 11 Behavioral Health domain study indicators. Additionally, the rates for children receiving adoption assistance who were enrolled with HealthKeepers were lower than the rates for All Eligible Members and controls for several of these indicators. To address these low rates, DMAS should consider working with the FCSP administered by HealthKeepers to evaluate why rates are low and improve utilization where appropriate. HealthKeepers could collect information from case managers and adoptive parents for members with a triggering event (i.e., members who are denominator-positive for these indicators but numerator-negative for the expected healthcare services) to better understand the rates. Additionally, if DMAS elects to survey the child welfare populations regarding their experience of care, DMAS may consider including questions about members' experience with behavioral health services specifically.
- Similar to the recommendations for children in foster care, to address disparities identified by region, DMAS may consider evaluating whether provider availability and appointment availability align with the regional disparities identified for children receiving adoption assistance. DMAS may also consider utilizing either stratified surveys or targeted surveys to collect information about the barriers for these groups and identify opportunities for improvement. Finally, case managers may also be able to provide additional insight on differences in barriers across regions now that most case managers for the children receiving adoption assistance population will be concentrated under the single FCSP.
- Effective July 2025, children receiving adoption assistance are now enrolled in the FCSP statewide program administered by HealthKeepers, though these members can opt out into a different MCO upon request.⁵⁹ Among the 15 indicators presented in the Primary Care, Oral Health, Behavioral Health, Substance Use, and Respiratory Health domains, the rate for children receiving adoption assistance enrolled with HealthKeepers exceeded the rate for all eligible controls for 10 indicators during MY 2024. High rates on these measures indicate high performance. Of note, HealthKeepers had a statistically significantly higher rate for 36 percent of study indicators for children receiving adoption assistance, including all indicators in the Oral Health domain and several *Behavioral*

⁵⁹ Virginia Department of Social Services. Virginia Medicaid Announces Intent to Award Managed Care Contracts. Available at: <https://dmas.virginia.gov/media/ntehanym/dmas-press-release-february-29-2024.pdf>. Accessed on Oct 9, 2025.

Health Encounters indicators. Similar to the recommendations for children in foster care, HSAG recommends monitoring the impact of the transition to the FCSP using surveys or administrative data analyses. For the administrative data analyses, DMAS could compare the performance of the FCSP to the performance of other MCOs, if the denominator for children receiving adoption assistance who opted out is sufficiently large. Additionally, DMAS may consider evaluating the utilization of members who transitioned into the FCSP over time to determine whether there were disruptions in care. HSAG also recommends that DMAS collect information on why members choose to opt out of the FCSP, as it may inform opportunities for improvement in the FCSP. For example, the Medicare Part C and Medicare Part D Star Rating programs utilize a disenrollment reasons survey to evaluate contracted health plans, which assesses the percentage of members who indicated that they disenrolled from the plan due to a particular issue.⁶⁰ These issues include getting the plan to provide and pay for needed care, problems with coverage of doctors and hospitals, problems with prescription drug benefits and coverage, and problems getting information and help from the plan. DMAS could consider modeling its approach after these disenrollment surveys.

- While the current study design provides insight into utilization of healthcare services, it does not assess health outcomes or member experiences among children receiving adoption assistance. Similar to the recommendations for children in foster care, DMAS may consider implementing a survey evaluating members' experience with the FCSP, including quality of care, access to care, health-related quality of life, coverage transparency, usefulness of the value-added benefits, prior authorizations, and communication with the FCSP. Additionally, DMAS could consider an analysis evaluating the prevalence of pertinent outcomes among members enrolled with the FCSP, such as obesity, type 2 diabetes, teen pregnancy, suicide, and mortality, as well as evaluating causes of ED visits and inpatient visits.

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.⁶¹ This study demonstrated that former foster care members have higher rates of appropriate healthcare utilization than comparable controls for a slight majority of study indicators in MY 2022, MY 2023, and MY 2024. During MY 2024, former foster care members had higher rates than controls for the one indicator in the Primary Care domain, three of four indicators in the Oral Health domain, two of nine indicators in the Behavioral Health Domain, the one indicator in the Respiratory Health domain, and eight of 10 indicators in the Service Utilization domain.

⁶⁰ Centers for Medicare & Medicaid Services. Medicare 2025 Part C & D Star Ratings Technical Notes. Available at: <https://www.cms.gov/files/document/2025-star-ratings-technical-notes.pdf>. Accessed on: Oct 23, 2025.

⁶¹ 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: Oct 23, 2025.

Rate differences between former foster care members and controls across study indicators persisted even after matching on many demographic and health characteristics.

During MY 2024, former foster care members had lower rates compared to controls for 10 study indicators. The study indicators *Initiation and Engagement of SUD Treatment—Initiation of SUD Treatment*, *Initiation and Engagement of SUD Treatment—Engagement of SUD Treatment*, and *Ambulatory Care Visits* were the only indicators with rates statistically significantly lower than the rates for controls. The largest rate difference was for the *Initiation and Engagement of SUD Treatment—Initiation of SUD Treatment* indicator (by 18.8 percentage points). Additionally, the former foster care members' rate for *ED Visits* was statistically significantly higher than controls during MY 2024, MY 2023, and MY 2022, which may reflect worse management of health conditions for former foster care members compared to controls.

Among former foster care members, 12 study indicator rates increased, while 13 study indicator rates decreased from MY 2023 to MY 2024. Of note, the largest rate increases from MY 2023 to MY 2024 were for the *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up*, *Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up*, and *Use of Pharmacotherapy for Opioid Use Disorder* study indicators (by 13.9, 7.4, and 7.3 percentage points, respectively). The largest decline from MY 2023 to MY 2024 was for the *Asthma Medication Ratio* indicator (by 16.7 percentage points). However, the denominator for this indicator has historically been small and is therefore subject to greater year-to-year variability. There were also large declines for the *Oral Evaluation*, *Dental Services* and *Preventive Dental Services* study indicators (by 6.8 and 6.1 percentage points, respectively); however, the MY 2024 rates for both study indicators were still substantially higher than the MY 2022 rates.

For former foster care members, male members had a high percentage of study indicators with disparities during MY 2024, for which rates were significantly lower than female members. These indicators included five of the study indicators in the Service Utilization domain and well-care visits. Additionally, members in the Roanoke/Alleghany region had significantly lower rates for three of four study indicators in the Oral Health domain during MY 2024, while members in the Central region had significantly higher rates for three of four study indicators in the Oral Health domain.

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

- To address the low rates for Behavioral Health domain indicators and the high rate of ED visits, DMAS may consider strengthening case management for former foster care members to monitor behavioral health needs and emphasize preventive services to reduce preventable ED visits. Case managers may also be able to advise the FCSP and DMAS on common barriers to behavioral and preventive healthcare, causes of delays, and member choice for this population to provide guidance on how to address these utilization patterns. For example, the FCSP offers transportation to medical appointments and virtual urgent care access via a free cell phone as value-added benefits. Case managers may be able to advise on whether members reporting transportation challenges have been able to utilize the transportation benefit and whether members seeking care in the ED had an opportunity to utilize the urgent care benefit. Additionally, the MY 2024 rates for former foster care members enrolled with HealthKeepers were lower than All Eligible Members and lower than controls for six of nine and five of nine indicators in the Behavioral Health domain, respectively. While the denominators for these indicators tended to be small, and none of these rate differences were statistically significant, performance in this area should be monitored following the transition to

the FCSP. DMAS may consider working with the FCSP to evaluate and, if needed, address any regional network adequacy issues for behavioral health providers contracted with the FCSP.

- To address the disparities identified for former foster care members, DMAS may consider focusing quality improvement efforts toward male members. Quality improvement efforts could include conducting focus groups with, administering surveys to, or enhancing individual member outreach to male members to understand challenges associated with utilization of these services and implement targeted interventions for the greatest impacts.
- Effective July 2025, former foster care members are now enrolled in the FCSP statewide program administered by HealthKeepers, though these members can opt out into a different MCO upon request.⁶² Among the 15 indicators in the Primary Care, Oral Health, Behavioral Health, Substance Use, and Respiratory Health domains, the rate for former foster care members enrolled with HealthKeepers exceeded the rate for all eligible controls for nine indicators during MY 2024. High rates on these measures indicate high performance. Similar to the recommendations for children receiving adoption assistance, HSAG recommends that DMAS monitor the impact of the transition to the FCSP on healthcare utilization for former foster care members through surveys or administrative data analyses. Additionally, surveys may be particularly informative for former foster care members, given that all age groups in this study population can complete the survey directly.
- While the current study design provides insight into utilization of healthcare services, it does not assess health outcomes or member experiences among former foster care members. HSAG recommends assessing chronic conditions disproportionately impacting former foster care members. For example, a future focus study could assess rates of outcomes such as mortality or utilize a cascade of care measure evaluating the treatment progression of former foster care members diagnosed with an outcome, such as SUD, from initial diagnosis to remission. Additionally, capturing member experience could provide additional insight into the quality of care and ease of access to care for former foster care members, as well as their health-related quality of life. Therefore, DMAS may consider utilizing custom surveys of former foster care members to capture this information.

Timely Access to Care

SFY 2024–25 is the fourth year to include analyses for timely access to care in this study. VDSS guidelines require that children in foster care receive a medical examination no later than 30 days after initial placement in foster care.⁶³ 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.⁶⁴ These guidelines are independent of Medicaid and MCO enrollment; therefore, a child may not be enrolled in Medicaid or an MCO for the entirety of this 60-day window. DMAS' CCMC 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

⁶² Virginia Department of Social Services. Virginia Medicaid Announces Intent to Award Managed Care Contracts. Available at: <https://dmas.virginia.gov/media/nthany/dmas-press-release-february-29-2024.pdf>. Accessed on Oct 9, 2025.

⁶³ 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/09_2024/section_12_identifying_services_to_be_provided.pdf. Accessed on: Oct 9, 2025.

⁶⁴ Ibid.

prior to enrollment.⁶⁵ However, it is important to note that this time frame may be exceeded by the time the child is enrolled with an MCO. MCOs may also encounter challenges obtaining information from the child's social worker or foster care parent for recently placed children in foster care. The SFY 2024–25 study found that most new 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, only 44.8 percent of new foster care members received timely access to dental care, and this rate declined slightly from MY 2023 to MY 2024.

Study indicators also assessed timely access to primary and dental care for members who aged out of foster care. Findings demonstrate that most members who aged out of foster care in the year prior to the MY had a visit with a PCP during MY 2024; however, this rate declined substantially from MY 2023 to MY 2024. Similar to new foster care members, 40.4 percent of members who aged out of foster care had a visit with a dental provider during MY 2024.

Several study indicators assessed timely access to behavioral healthcare for new foster care members, new adoption assistance members, and members who aged out of foster care. The SFY 2024–25 study found that most 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, nearly all 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, most members with a behavioral health diagnosis had a visit with an MHP within a year after enrollment, and this rate increased from MY 2023 to MY 2024 (by 3.4 percentage points). These findings are consistent with prior measurement years. Lastly, most members who aged out of foster care had a behavioral health diagnosis, and 49.4 percent of these members had a visit with an MHP during MY 2024. This rate declined from MY 2023 to MY 2024 (by 5.4 percentage points) yet remained notably higher than the MY 2022 rate.

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 but more likely to have a visit with a dental provider. Only 20.0 percent of children 2 years of age or younger received a timely visit with a dental provider, despite that dental examinations are required for children in foster care beginning at age six months or when the child develops teeth, whichever is later. ADA also recommends that all children have a dental visit between their first tooth and their first birthday.⁶⁶ Among all new foster care members, older members were more likely to have an MHP visit for both the 60-day and one-year time frames; however, this trend was mostly explained by older members being more likely to have a behavioral health diagnosis. Female members who aged out of foster care were significantly more likely to have a visit with a PCP than male members. Members newly enrolled in foster care in the Northern & Winchester region were significantly less likely to have a PCP 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.

⁶⁵ Commonwealth of Virginia, Department of Medical Assistance Services. Cardinal Care Managed Care Contract, October 1, 2023 – June 30, 2024. Available at: <https://www.dmas.virginia.gov/media/d0dixoar/fy24-cardinal-contract-mid-year-amendment.pdf>. Accessed on: Oct 9, 2025.

⁶⁶ Mark AM. Key points for your child's teeth. *The Journal of the American Dental Association*. 2022; 153: 94. Available at: [https://jada.ada.org/article/S0002-8177\(21\)00657-7/fulltext](https://jada.ada.org/article/S0002-8177(21)00657-7/fulltext). Accessed on: Oct 16, 2025.

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

- The study indicator findings identified 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 transition to the single FCSP in MY 2025 presents an opportunity to improve timely MCO assignment, which may also improve timely processing of key information from the child's social worker or foster care parent. Additionally, efforts to improve these processes can now be applied more consistently across each population under the single FCSP. Among the 16 timely access study indicators, the rates for members enrolled with HealthKeepers were significantly higher for two study indicators (i.e., access to dental care among new foster care members and access to primary care and dental care for new foster care members) and were not significantly lower for any indicators compared to the rate for members enrolled with other MCOs during MY 2024. DMAS may consider monitoring whether timely access to care, or any of the key drivers of timely access, improve after the transition to the FCSP. DMAS may consider working with the FCSP to implement lessons learned from previous pilot studies and test new processes to support timely access. Given that routine dental services are carved out to the VA Medicaid dental benefit manager, DentaQuest, DMAS may consider working with DentaQuest as well to ensure timely access to dental services for these populations.
- To address disparities identified for timely access to care, DMAS may consider focusing quality improvement efforts for timely access to care toward male members who aged out of foster care and younger new foster care members. DMAS may also consider working with the FCSP to educate foster parents on the expected dental visit schedule for children 2 years of age and younger and that oral inspections performed by PCPs are not a substitute for complete dental evaluations performed by dentists.
- In addition to programmatic challenges to timely access to care, other factors impacting timely access to care may include provider availability and appointment availability. These factors could be evaluated either through network adequacy analyses limited to the child welfare populations or surveying foster parents and members who aged out of foster care on their perceived access to care. HealthKeepers has stated that it will endeavor to identify out-of-network providers seen by child welfare population members and will contract with those determined to meet quality standards. DMAS may consider monitoring and quantifying HealthKeepers' progress toward expanding its network to include these providers. For example, DMAS could assess how many providers seen by the child welfare populations in the year prior to the transition are in HealthKeepers' network. DMAS may also consider assessing this progress by provider type and region, as network adequacy challenges are often related to these factors.

Appendix A: Study Indicators

For reference, Appendix A provides the technical specifications set, description, denominator, and numerator(s) for each of the 27 measures (i.e., 50 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 2025 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, Encounter for 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, Encounter for 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 2025 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 Visit Value Set, Encounter for 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 modifications to the numerator to allow providers such as Federally Qualified Health Centers and 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 for a dental service (i.e., a claim/encounter with a CDT code) with any provider qualified to provide dental services 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 2025 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 2025 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 2025 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 date of their first antidepressant medication prescription, 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 2025 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 and Intentional Self-Harm Value Set).
- *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 2025 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 and Intentional Self Harm Value Set).
- *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 Health Diagnosis 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 2025 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 (APM Antipsychotic 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 2025 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) or residential behavioral health treatment (Residential Behavioral Health Treatment Value Set) during the look-back period.

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

- ***Specifications Set:*** FFY 2025 Child Core Set technical specifications, with study-specific continuous enrollment modifications and modifications to the follow-up time periods.
- ***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.

Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

- ***Specifications Set:*** FFY 2025 Adult Core Set technical specifications, with study-specific continuous enrollment modifications.
- ***Description:*** Percentage of members with schizophrenia, schizoaffective disorder, or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.
- ***Denominator:*** Members who are at least 18 years of age as of the end of the measurement year, who had a qualifying encounter with a diagnosis of schizophrenia, schizoaffective disorder, or bipolar disorder, and who did not already have diabetes.
- ***Numerator:*** Members with a glucose test (Glucose Lab Test Value Set, Glucose Test Result or Finding Value Set) or an HbA1c test (HbA1c Lab Test Value Set, HbA1c Test Result or Finding Value Set) performed during the measurement year.

Substance Use

Follow-Up After ED Visit for Substance Use—30-Day Follow-Up (FUA)

- *Specifications Set:* FFY 2025 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 2025 Adult Core Set technical specifications, with study-specific continuous enrollment modifications.
- *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, nonresidential substance abuse treatment facility visit, community mental health center visit, SUD service, a withdrawal management event, an ED visit, an e-visit or virtual check-in, a telehealth visit, a telephone visit, a 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.

Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD)

- *Specifications Set:* FFY 2025 Adult Core Set technical specifications, with study-specific continuous enrollment modifications.
- *Description:* Percentage of members with an OUD who filled a prescription for or were administered or dispensed an FDA-approved medication for the disorder during the measurement year.

- *Denominator:* Members ages 18 years and older as of the start of the measurement year who had at least one encounter with a diagnosis of opioid abuse, dependence, or remission (primary or other) at any time during the measurement year.
- *Numerator:* Members with evidence of at least one prescription filled, or who were administered or dispensed an FDA-approved medication, for OUD during the measurement year.

Respiratory Health

Asthma Medication Ratio (AMR)

- *Specifications Set:* FFY 2025 Adult and Child Core Set technical specifications, with study-specific continuous enrollment modifications and a one-year look-back period for all eligible members.
- *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 for an ambulatory outpatient visit, telephone visit, or online assessment.

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 2025 Adult and Child Core Set ED Value Set or with a code in the ED Procedure Code Value Set and Place Of Service (POS) code 23. 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 2025 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 traditional services, CMH services, RTC services, therapeutic services, and ARTS.
- **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 SUD 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 set⁶⁷ developed by DMAS and HSAG. Additionally, some visits require a primary behavioral health diagnosis on the claim/encounter, as indicated in the code sets.

⁶⁷ Please note, acute inpatient psychiatric hospital stays, identified by revenue code 0204, are included as RTC services.

- *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 *2024–25 Task 1.2 Child Welfare Focus Study Methodology* document.
- *Description*: Percentage of members who were newly enrolled in the foster care program who received timely access to care.
- *Denominator*: Members in the study population who were under 18 years of age as of January 1 of the measurement year and who were newly enrolled in the foster care program between January 1 of the measurement year and December 1 of the measurement year. Members must be continuously enrolled in Managed Care 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 for a dental service (i.e., a claim/encounter with a CDT code) with any

provider qualified to provide dental services 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 at least one visit for a dental service (i.e., a claim/encounter with a CDT code) with any provider qualified to provide dental services 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 for a dental service (i.e., a claim/encounter with a CDT code) with any provider qualified to provide dental services 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 2024–25 Task I.2 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 Managed Care 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 2024–25 Task I.2 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 Managed Care 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 *2024–25 Task I.2 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 Managed Care 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 *2024–25 Task I.2 Child Welfare Focus Study Methodology* document.

- **Description:** Percentage of members who aged out of 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 Managed Care under aid category “76” (i.e., foster care) on their 18th birthday. Members must be continuously enrolled in Managed Care 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 for a dental service (i.e., a claim/encounter with a CDT code) with any provider qualified to provide dental services 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 at least one visit for a dental service (i.e., a claim/encounter with a CDT code) with any provider qualified to provide dental services 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 at least one visit for a dental service (i.e., a claim/encounter with a CDT code) with any provider qualified to provide dental services 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 *2024–25 Task 1.2 Child Welfare Focus Study Methodology* document.
- **Description:** Percentage of members who aged out of 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 Managed Care under aid category “76” (i.e., foster care) on their 18th birthday. Members must be continuously enrolled in Managed Care 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=3,071) and Controls (n=557,809) 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	546	17.8%	93,461	16.8%
3 to 5 years	542	17.6%	95,931	17.2%
6 to 10 years	753	24.5%	159,584	28.6%
11 to 13 years	420	13.7%	90,917	16.3%
≥ 14 years	810	26.4%	117,916	21.1%
Sex				
Male	1,611	52.5%	285,347	51.2%
Female	1,460	47.5%	272,462	48.8%

Category	Number of Children in Foster Care	Percent of Children in Foster Care	Number of Controls	Percent of Controls
Race				
Black or African American	1,100	35.8%	204,214	36.6%
White	1,865	60.7%	294,190	52.7%
Other	106	3.5%	59,405	10.6%
Region				
Central	708	23.1%	144,972	26.0%
Charlottesville/Western	590	19.2%	63,156	11.3%
Northern & Winchester	392	12.8%	140,819	25.2%
Roanoke & Alleghany	474	15.4%	50,997	9.1%
Southwest	S	S	S	S
Tidewater	516	16.8%	127,811	22.9%
Unknown	S	S	S	S
Continuously Enrolled MCO				
Aetna	322	10.5%	64,064	11.5%
HealthKeepers	913	29.7%	182,689	32.8%
Molina	153	5.0%	29,271	5.2%
Sentara	1,414	46.0%	219,169	39.3%
United	209	6.8%	58,222	10.4%
More Than One MCO	60	2.0%	4,394	0.8%
Medicaid Population				
MLTSS	31	1.0%	20,619	3.7%
Acute	3,024	98.5%	534,031	95.7%
More Than One Medicaid Population	16	0.5%	3,159	0.6%

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.

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=6,998) and Controls (n=557,809) 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	114	1.6%	93,461	16.8%
3 to 5 years	700	10.0%	95,931	17.2%
6 to 10 years	2,172	31.0%	159,584	28.6%

Category	Number of Children Receiving Adoption Assistance	Percent of Children Receiving Adoption Assistance	Number of Controls	Percent of Controls
11 to 13 years	1,612	23.0%	90,917	16.3%
≥ 14 years	2,400	34.3%	117,916	21.1%
Sex				
Male	3,800	54.3%	285,347	51.2%
Female	3,198	45.7%	272,462	48.8%
Race				
Black or African American	2,042	29.2%	204,214	36.6%
White	4,766	68.1%	294,190	52.7%
Other	190	2.7%	59,405	10.6%
Region				
Central	1,425	20.4%	144,972	26.0%
Charlottesville/Western	1,155	16.5%	63,156	11.3%
Northern & Winchester	1,039	14.8%	140,819	25.2%
Roanoke & Alleghany	1,263	18.0%	50,997	9.1%
Southwest	S	S	S	S
Tidewater	1,196	17.1%	127,811	22.9%
Unknown	S	S	S	S
Continuously Enrolled MCO				
Aetna	631	9.0%	64,064	11.5%
HealthKeepers	2,093	29.9%	182,689	32.8%
Molina	330	4.7%	29,271	5.2%
Sentara	3,302	47.2%	219,169	39.3%
United	586	8.4%	58,222	10.4%
More Than One MCO	56	0.8%	4,394	0.8%
Medicaid Population				
MLTSS	195	2.8%	20,619	3.7%
Acute	6,765	96.7%	534,031	95.7%
More Than One Medicaid Population	38	0.5%	3,159	0.6%

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.

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=1,368) and Controls (n=160,211) 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	814	59.5%	82,504	51.5%
23 to 26 years	554	40.5%	77,707	48.5%
Sex				
Male	738	53.9%	67,886	42.4%
Female	630	46.1%	92,325	57.6%
Race				
Black or African American	472	34.5%	59,875	37.4%
White	859	62.8%	80,628	50.3%
Other	37	2.7%	19,708	12.3%
Region				
Central	366	26.8%	42,050	26.2%
Charlottesville/Western	222	16.2%	18,620	11.6%
Northern & Winchester	165	12.1%	35,501	22.2%
Roanoke & Alleghany	226	16.5%	15,351	9.6%
Southwest	142	10.4%	9,927	6.2%
Tidewater	247	18.1%	38,762	24.2%
Continuously Enrolled MCO				
Aetna	107	7.8%	23,069	14.4%
HealthKeepers	407	29.8%	47,341	29.5%
Molina	86	6.3%	12,553	7.8%
Sentara	632	46.2%	57,587	35.9%
United	125	9.1%	18,127	11.3%
More Than One MCO	11	0.8%	1,534	1.0%
Medicaid Population				
MLTSS	S	S	17,343	10.8%
Acute	1,304	95.3%	139,787	87.3%
More Than One Medicaid Population	S	S	3,081	1.9%

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.

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 within the claims for continuously enrolled cases and the claims for continuously enrolled controls for which prevalence differed between the two groups. For members older than 2 years of age as of January 1, 2024, the claims assessment period was January 1, 2023, through December 31, 2023. For children 2 years of age or younger as of January 1, 2024, the claims assessment period was January 1, 2024, through December 31, 2024, 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, 2023, through December 31, 2023) 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.

These diagnoses were grouped into 14 categories using version 2019.1 CCS:^{68,69} For the health characteristics used in the original 2019 Foster Care Focus Study (e.g., adjustment disorder), HSAG added any new pertinent diagnosis codes from the version 2025.1 CCSR. 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 2025.1 CCSR.

- **Adjustment Disorder:** At least one primary diagnosis during the claims assessment period meeting any of the following:
 - The diagnosis code is in the second-level CCS category Adjustment Disorders [5.1].
 - The diagnosis code is one of the following from CCSR: F4381 or F4389.
- **ADHD:** At least one primary diagnosis during the claims assessment period meeting any of the following:
 - The diagnosis code is in the second-level CCS category Attention Deficit, Conduct, and Disruptive Behavior Disorders [5.3] or 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:
 - The diagnosis code is in the second-level CCS category Anxiety Disorders [5.2].
- **Congenital Anomaly:** At least one primary diagnosis during the claims assessment period meeting any of the following:⁷⁰
 - The diagnosis code is in the second-level CCS category Cardiac and Circulatory Congenital Anomalies [14.1], Digestive Congenital Anomalies [14.2], Genitourinary Congenital Anomalies [14.3], Nervous System Congenital Anomalies [14.4], or Other Congenital Anomalies [14.5].

⁶⁸ 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: Nov 18, 2025.

⁶⁹ Agency for Healthcare Research and Quality. Tools Archive for Clinical Classifications Software Refined. Available at: https://www.hcup-us.ahrq.gov/toolssoftware/ccsr/ccsr_archive.jsp#ccsr. Accessed on: Nov 18, 2025.

⁷⁰ 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.

- **Developmental Disorder:** At least one primary diagnosis during the claims assessment period meeting any of the following:⁷¹
 - The diagnosis code is in the second-level CCS category Developmental Disorders [5.5] or Disorders Usually Diagnosed in Infancy, Childhood, or Adolescence [5.6]
 - The diagnosis code is one of the following from CCSR: F78A1 or F78A9.
- **Intentional Self-Harm:** At least one primary diagnosis during the claims assessment period meeting any of the following:
 - The diagnosis code is in the second-level CCS category Suicide and Intentional Self-Inflicted Injury [5.13].
 - The diagnosis code is one of the following from CCSR: R4588, T40712A, T40712D, T40712S, T40722A, T40722D, T40722S, T40412A, T40422A, T40492A, T43642A, T43652A, or T50912A.
- **Maltreatment/Abuse:** At least one primary diagnosis during the claims assessment period meeting any of the following:⁷²
 - The diagnosis code is in the first-level, second-level, third-level, outpatient, or inpatient CCSR category Maltreatment/Abuse [INJ032] or Maltreatment/Abuse, Subsequent Encounter [INJ068].
- **Mood Disorder:** At least one primary diagnosis during the claims assessment period meeting any of the following:
 - The diagnosis code is in the second-level CCS category Mood Disorders [5.8].
 - The diagnosis code is one of the following from CCSR: F32A.
- **Neurological Disorder:** At least one primary diagnosis during the claims assessment period meeting any of the following:⁷³
 - The diagnosis code is in the first-level CCSR category Cerebral Palsy [NVS007] or Epilepsy; Convulsions [NVS009].
- **Obesity and Metabolic Syndrome:** At least one primary diagnosis during the claims assessment period meeting any of the following:
 - The diagnosis code is in the second-level CCS category Diabetes Mellitus Without Complication [3.2], Diabetes Mellitus with Complications [3.3], Other Endocrine Disorders [3.4], Nutritional Deficiencies [3.5], Disorders of Lipid Metabolism [3.6], or Other Nutritional, Endocrine, and Metabolic Disorders [3.11].
 - The diagnosis code is one of the following from CCSR: E66811, E66812, E66813, E6689, Z6855, Z6856.
- **Other Mental Health Disorder:** At least one primary diagnosis during the claims assessment period meeting any of the following:
 - The diagnosis code is in the second-level CCS category Miscellaneous Mental Disorders [5.15].

⁷¹ The percent of members with a developmental disorder 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, developmental disorders are not used in the matching for former foster care members.

⁷² 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.

⁷³ The percent of members with a neurological disorder 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, neurological disorders are not used in the matching for former foster care members.

- **Psychotic Disorder:** At least one primary diagnosis during the claims assessment period meeting any of the following:
 - The diagnosis code is in the second-level CCS category 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:
 - The diagnosis code is in the second-level CCS category Alcohol-related Disorders [5.11] or Substance-related Disorders [5.12].
 - The diagnosis code is one of the following from CCSR: T40714D, T40714S, T40715A, T40715D, T40715S, T40721D, T40721S, T40724D, T40724S, T40725A, T40725D, or T40725S.
- **Rheumatologic Condition:** At least one primary diagnosis during the claims assessment period meeting any of the following:
 - The diagnosis code is in the second-level CCS category 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 2024 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 2024 CMS Core Set Inpatient Stay Value Set.
 - The claim's revenue code and type of bill code is not included in the FFY 2024 CMS Core Set Nonacute Inpatient Stay Value Set.
 - The claim's primary diagnosis is included in the FFY 2024 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=3,071) and Controls (n=557,809) 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	971	31.6%	15,700	2.8%
Attention Deficit Hyperactivity Disorder	995	32.4%	41,574	7.5%
Anxiety Disorder	777	25.3%	20,080	3.6%
Congenital Anomaly	178	5.8%	16,471	3.0%
Developmental Disorder	827	26.9%	52,355	9.4%
Maltreatment/Abuse	90	2.9%	1,229	0.2%
Mood Disorder	587	19.1%	17,343	3.1%
Obesity and Metabolic Syndrome	590	19.2%	36,528	6.5%
Other Mental Health Disorder	252	8.2%	2,781	0.5%
Neurological Disorder	86	2.8%	7,519	1.3%
Substance Use Disorder	98	3.2%	1,443	0.3%
ED Visit for Mental Health	81	2.6%	1,831	0.3%

Table B-5 presents the health characteristic assessment findings for continuously enrolled children receiving adoption assistance and controls, prior to matching.

Table B-5—Distribution of Health Characteristics Among Children Receiving Adoption Assistance (n=6,998) and Controls (n=557,809) 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	619	8.8%	15,700	2.8%
Attention Deficit Hyperactivity Disorder	2,380	34.0%	41,574	7.5%
Anxiety Disorder	929	13.3%	20,080	3.6%
Congenital Anomaly	279	4.0%	16,471	3.0%
Developmental Disorder	1,351	19.3%	52,355	9.4%
Mood Disorder	750	10.7%	17,343	3.1%
Obesity and Metabolic Syndrome	528	7.5%	36,528	6.5%
Psychotic Disorder	32	0.5%	412	0.1%
Rheumatologic Condition	442	6.3%	23,025	4.1%
Neurological Disorder	213	3.0%	7,519	1.3%
Other Mental Health Disorder	110	1.6%	2,781	0.5%
Substance Use Disorder	89	1.3%	1,443	0.3%
ED Visit for Mental Health	70	1.0%	1,831	0.3%

Table B-6 presents the health characteristic assessment findings for continuously enrolled former foster care members and controls, prior to matching.

Table B-6—Distribution of Health Characteristics Among Former Foster Care Members (n=1,368) and Controls (n=160,211) 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	63	4.6%	3,465	2.2%
Attention Deficit Hyperactivity Disorder	74	5.4%	5,095	3.2%
Anxiety Disorder	218	15.9%	15,169	9.5%
Intentional Self-Harm	60	4.4%	1,900	1.2%
Mood Disorder	281	20.5%	16,952	10.6%
Rheumatologic Condition	117	8.6%	9,966	6.2%
Substance Use Disorder	110	8.0%	5,396	3.4%
ED Visit for Mental Health	55	4.0%	2,156	1.3%

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=2,948) and Controls (n=2,948) 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 <i>p</i>	Standardized Differences Assessment <i>d</i>
Age Category						
≤ 2 years	524	17.8%	524	17.8%	1.00	0.000
3 to 5 years	516	17.5%	516	17.5%		0.000
6 to 10 years	723	24.5%	723	24.5%		0.000
11 to 13 years	403	13.7%	403	13.7%		0.000
≥ 14 years	782	26.5%	782	26.5%		0.000
Sex						
Male	1,555	52.7%	1,520	51.6%	0.36	0.024
Female	1,393	47.3%	1,428	48.4%		-0.024
Race						
Black or African American	1,050	35.6%	1,050	35.6%	1.00	0.000
White	1,797	61.0%	1,797	61.0%		0.000
Other	101	3.4%	101	3.4%		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 <i>p</i>	Standardized Differences Assessment <i>d</i>
Region						
Central	681	23.1%	681	23.1%	1.00	0.000
Charlottesville/Western	565	19.2%	565	19.2%		0.000
Northern & Winchester	385	13.1%	385	13.1%		0.000
Roanoke & Alleghany	442	15.0%	442	15.0%		0.000
Southwest	374	12.7%	374	12.7%		0.000
Tidewater	501	17.0%	501	17.0%		0.000
Continuously Enrolled MCO						
Aetna	293	9.9%	293	9.9%	1.00	0.000
HealthKeepers	884	30.0%	884	30.0%		0.000
Molina	143	4.9%	143	4.9%		0.000
Sentara	1,384	46.9%	1,384	46.9%		0.000
United	193	6.5%	193	6.5%		0.000
More Than One MCO	51	1.7%	51	1.7%		0.000
Medicaid Population						
MLTSS	30	1.0%	83	2.8%	<0.001*	-0.131*
Acute	2,903	98.5%	2,851	96.7%		0.115*
More Than One Medicaid Population	15	0.5%	14	0.5%		0.005

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

The age category, race, region, and MCO distributions were identical in the children in foster care study population and the controls due to exact matching on these characteristics. Neither the covariate-level Chi-square tests nor the standardized differences test identified any significant differences in sex. The Chi-square test and the standardized differences assessment both found imbalance in the Medicaid Population category. However, as a result of the matching process, the difference in the distribution of Medicaid Population between children in foster care and controls improved from 2.8 percentage points to 1.8 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=6,973) and Controls (n=6,973) 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 <i>p</i>	Standardized Differences Assessment <i>d</i>
Age Category						
≤ 2 years	114	1.6%	114	1.6%	1.00	0.000
3 to 5 years	698	10.0%	698	10.0%		0.000
6 to 10 years	2,163	31.0%	2,163	31.0%		0.000
11 to 13 years	1,605	23.0%	1,605	23.0%		0.000
≥ 14 years	2,393	34.3%	2,393	34.3%		0.000
Sex						
Male	3,785	54.3%	3,696	53.0%	0.13	0.026
Female	3,188	45.7%	3,277	47.0%		-0.026
Race						
Black or African American	2,034	29.2%	2,034	29.2%	1.00	0.000
White	4,753	68.2%	4,753	68.2%		0.000
Other	186	2.7%	186	2.7%		0.000
Region						
Central	1,419	20.3%	1,419	20.3%	1.00	0.000
Charlottesville/Western	1,148	16.5%	1,148	16.5%		0.000
Northern & Winchester	1,039	14.9%	1,039	14.9%		0.000
Roanoke & Alleghany	1,258	18.0%	1,258	18.0%		0.000
Southwest	915	13.1%	915	13.1%		0.000
Tidewater	1,194	17.1%	1,194	17.1%		0.000
Continuously Enrolled MCO						
Aetna	630	9.0%	630	9.0%	1.00	0.000
HealthKeepers	2,082	29.9%	2,082	29.9%		0.000
Molina	329	4.7%	329	4.7%		0.000
Sentara	3,296	47.3%	3,296	47.3%		0.000
United	582	8.3%	582	8.3%		0.000
More Than One MCO	54	0.8%	54	0.8%		0.000
Medicaid Population						
MLTSS	195	2.8%	210	3.0%	0.75	-0.013
Acute	6,740	96.7%	6,724	96.4%		0.013
More Than One Medicaid Population	38	0.5%	39	0.6%		-0.002

* Indicates that the covariate balance test found imbalance between the children receiving adoption assistance and controls.

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=1,365) and Controls (n=1,365) 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 <i>p</i>	Standardized Differences Assessment <i>d</i>
Age Category						
19 to 22 years	811	59.4%	811	59.4%	1.00	0.000
23 to 26 years	554	40.6%	554	40.6%		0.000
Sex						
Male	735	53.8%	733	53.7%	0.94	0.003
Female	630	46.2%	632	46.3%		-0.003
Race						
Black or African American	471	34.5%	471	34.5%	1.00	0.000
White	858	62.9%	858	62.9%		0.000
Other	36	2.6%	36	2.6%		0.000
Region						
Central	366	26.8%	366	26.8%	1.00	0.000
Charlottesville/Western	222	16.3%	222	16.3%		0.000
Northern & Winchester	164	12.0%	164	12.0%		0.000
Roanoke & Alleghany	225	16.5%	225	16.5%		0.000
Southwest	142	10.4%	142	10.4%		0.000
Tidewater	246	18.0%	246	18.0%		0.000
Continuously Enrolled MCO						
Aetna	107	7.8%	107	7.8%	1.00	0.000
HealthKeepers	405	29.7%	405	29.7%		0.000
Molina	86	6.3%	86	6.3%		0.000
Sentara	631	46.2%	631	46.2%		0.000
United	125	9.2%	125	9.2%		0.000
More Than One MCO	11	0.8%	11	0.8%		0.000
Medicaid Population						
MLTSS	S	S	S	S	0.51	0.000
Acute	1,301	95.3%	1,305	95.6%		-0.014
More Than One Medicaid Population	S	S	S	S		0.044

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.

** Indicates that the covariate balance test found imbalance between former foster care members and controls.*

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=2,948) and Controls (n=2,948) 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 <i>p</i>	Standardized Differences Assessment <i>d</i>
Adjustment Disorder	876	29.7%	853	28.9%	0.51	0.017
Attention Deficit Hyperactivity Disorder	923	31.3%	956	32.4%	0.36	-0.024
Anxiety Disorder	698	23.7%	711	24.1%	0.69	-0.010
Congenital Anomaly	168	5.7%	195	6.6%	0.14	-0.038
Developmental Disorder	755	25.6%	766	26.0%	0.74	-0.009
Maltreatment/Abuse	69	2.3%	56	1.9%	0.24	0.031
Mood Disorder	547	18.6%	547	18.6%	1.00	0.000
Obesity and Metabolic Syndrome	532	18.0%	569	19.3%	0.22	-0.032
Other Mental Health Disorder	191	6.5%	155	5.3%	0.05*	0.052
Neurological Disorder	77	2.6%	70	2.4%	0.56	0.015
Substance Use Disorder	83	2.8%	73	2.5%	0.42	0.021
ED Visit for Mental Health	75	2.5%	61	2.1%	0.22	0.032

* 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 one health characteristic (i.e., Other Mental Health Disorder) and the omnibus test ($p < 0.001$) identified imbalance in at least one covariate, the standardized differences assessment did not identify any 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 1.3 percentage points for Obesity and Metabolic Syndrome, and this difference was a substantial improvement from the 12.7 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=6,973) and Controls (n=6,973) 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 <i>p</i>	Standardized Differences Assessment <i>d</i>
Adjustment Disorder	614	8.8%	623	8.9%	0.79	-0.005
Attention Deficit Hyperactivity Disorder	2,355	33.8%	2,380	34.1%	0.65	-0.008
Anxiety Disorder	908	13.0%	906	13.0%	0.96	0.001
Congenital Anomaly	275	3.9%	239	3.4%	0.11	0.027
Developmental Disorder	1,332	19.1%	1,283	18.4%	0.29	0.018
Mood Disorder	738	10.6%	741	10.6%	0.93	-0.001
Obesity and Metabolic Syndrome	524	7.5%	467	6.7%	0.06	0.032
Psychotic Disorder	31	0.4%	19	0.3%	0.09	0.029
Rheumatologic Condition	440	6.3%	396	5.7%	0.12	0.027
Neurological Disorder	208	3.0%	170	2.4%	0.05*	0.034
Other Mental Health Disorder	106	1.5%	79	1.1%	0.05*	0.034
Substance Use Disorder	82	1.2%	49	0.7%	0.004*	0.049
ED Visit for Mental Health	70	1.0%	64	0.9%	0.60	0.009

* Indicates that the covariate balance test found imbalance between the children receiving adoption assistance and controls.

The health characteristics distributions for the children receiving adoption assistance study population and the controls were balanced by matching. While the Chi-square tests indicated imbalance for three health characteristics (i.e., Neurological Disorder, Other Mental Health Disorder, and Substance Use Disorder) and the omnibus test ($p < 0.02$) identified imbalance in at least one covariate, the standardized differences assessment did not identify any 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 1.3 percentage points for Developmental Disorder, and this difference was a substantial improvement from the 10.0 percentage point difference between children receiving adoption assistance and controls prior to matching.

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=1,365) and Controls (n=1,365) 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 <i>p</i>	Standardized Differences Assessment <i>d</i>
Adjustment Disorder	62	4.5%	62	4.5%	1.00	0.000
Attention Deficit Hyperactivity Disorder	73	5.3%	66	4.8%	0.54	0.023
Anxiety Disorder	215	15.8%	214	15.7%	0.96	0.002
Intentional Self-Harm	57	4.2%	43	3.2%	0.15	0.055
Mood Disorder	278	20.4%	283	20.7%	0.81	-0.009
Rheumatologic Condition	117	8.6%	113	8.3%	0.78	0.011
Substance Use Disorder	107	7.8%	100	7.3%	0.61	0.019
ED Visit for Mental Health	53	3.9%	45	3.3%	0.41	0.031

* Indicates that the covariate balance test found imbalance between former foster care members and controls.

The health characteristics distributions for the former foster care members study population and the controls were balanced by matching. The Chi-square tests found no imbalances in the health characteristics, the omnibus test ($p=0.93$) indicated overall balance, and the standardized differences assessment found no imbalances in the health characteristics.