Commonwealth of Virginia
Department of Medical Assistance Services

Access Monitoring Review Plan
2016

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Virginia Access Monitoring Review Plan Overview

In November 2015, the Centers for Medicare and Medicaid Services (CMS) issued a final rule regarding member access to Medicaid services in a Medicaid fee-for-service (FFS) environment[1]. This rule creates new requirements for states to monitor access to care for Medicaid FFS members. Under these requirements, states must develop an access monitoring review plan, which must be published for public review and comment and submitted to CMS. In accordance with these requirements, the Virginia Department of Medical Assistance Services (DMAS) has prepared the access monitoring review plan contained herein.

DMAS published a notice concerning its Provider Access Monitoring Plan, providing a link to the Plan on the Agency's website and requesting public comment. The notice was published on the Virginia Regulatory Town Hall, which is an established, official web-based forum where DMAS publishes all its general notices, including those for all provider reimbursement changes. The notice was published on August 29, 2016, and was open until September 29, 2016. During this 32-day public comment period the Agency received one comment, submitted by the Virginia Hospital and Health Care Association (VHHA), which is the trade association for Virginia hospitals. The VHHA expressed concern that DMAS' Plan did not appear to include data analysis of the impact of Ambulatory Care Sensitive Conditions (ACSC), nor include a section that evaluates the availability of hospital services generally. While DMAS appreciated the thoughtful input from the VHHA, the Agency did not specifically include an evaluation of the availability of hospital services because it was not a target area identified by the access rule. DMAS recognizes, however, that if reimbursement cuts to hospitals become likely in the future, that the Agency shall need to address hospital services.

In addition, DMAS examined the VHHA's recommendation to analyze ambulatory sensitive conditions as an indicator of access. The Agency recognizes that hospital utilization may reflect access issues in the community but there may be other significant factors driving this trend such as social determinants like the poverty of the Medicaid population. This type of analysis has not typically been included in plans or research evaluating access, but DMAS will consider it in future plans or analysis. There is also the challenge of disaggregating the Medicaid data for FFS and MCO. The agency shares CMS' view that this Plan is in essence a living document that shall develop over time with changes in the Medicaid, and the VHHA's expressed concerns will be taken into serious consideration in the evolution of Virginia's Access Monitoring Plan.

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

[1] CMS Final Rule: Federal Register Vol. 80, No. 211, November 2, 2015.

DMAS provides Medicaid coverage to individuals through managed care and fee-for-service delivery models. The managed care delivery system, known as Medallion 3.0., covers Medicaid members through six commercial health plans. Virginia has been increasing its use of the managed care program, and as of December 2015, over 68% of Medicaid enrollees are in managed care. During state fiscal year (SFY) 2015, the Virginia Medicaid program provided coverage to approximately 1.35 million enrolled members, and total Medicaid spending was approximately $7.9 billion. Figures 1 through 4 illustrate Virginia's Medicaid total enrollment and expenditures for SFY 2015.

Figure 1. Total Medicaid Enrollment by Eligibility Category

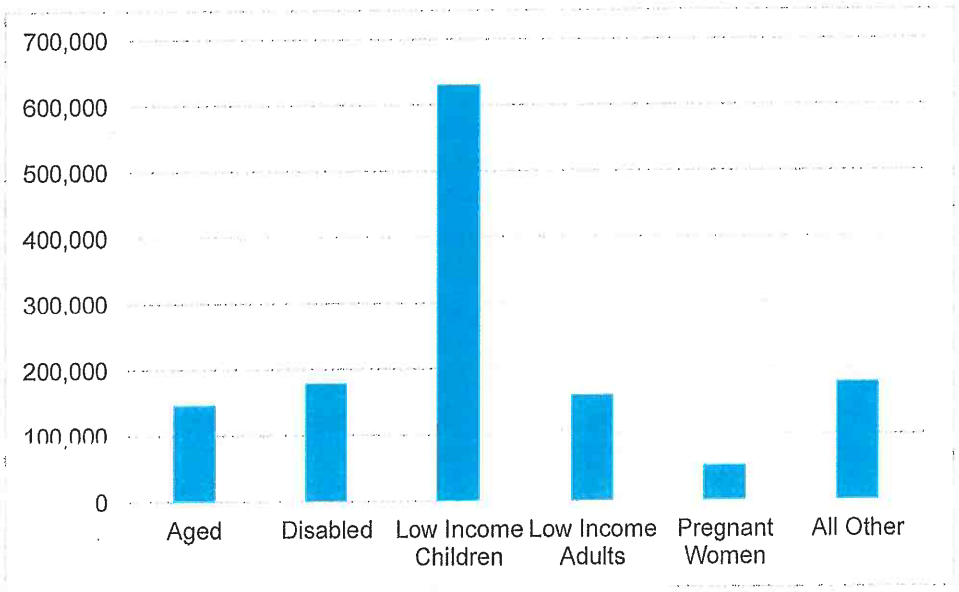


Figure 2. Total Medicaid Expenditures by Eligibility Category

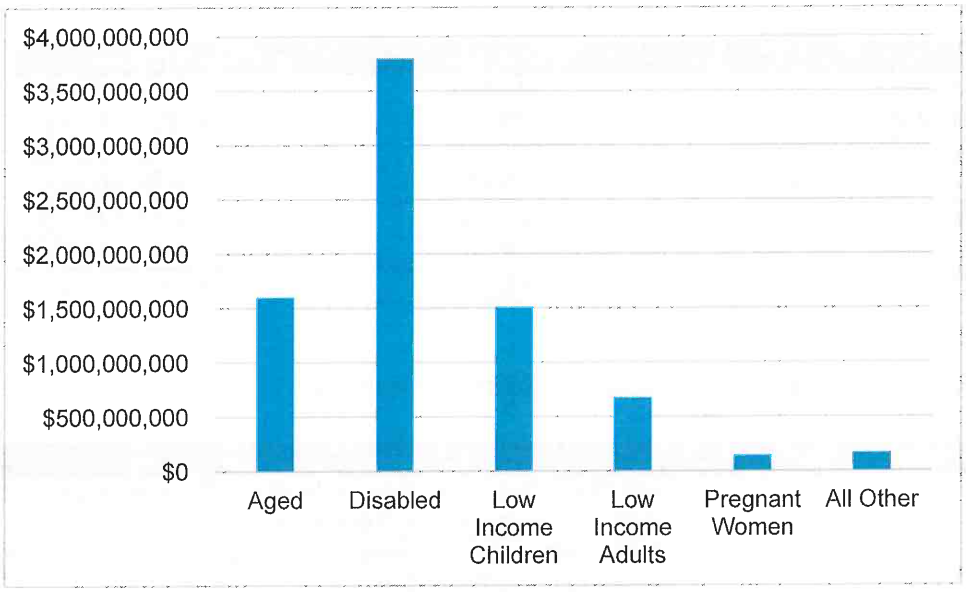


Figure 3. Comparison of Total Enrollment and Expenditures by Eligibility Category

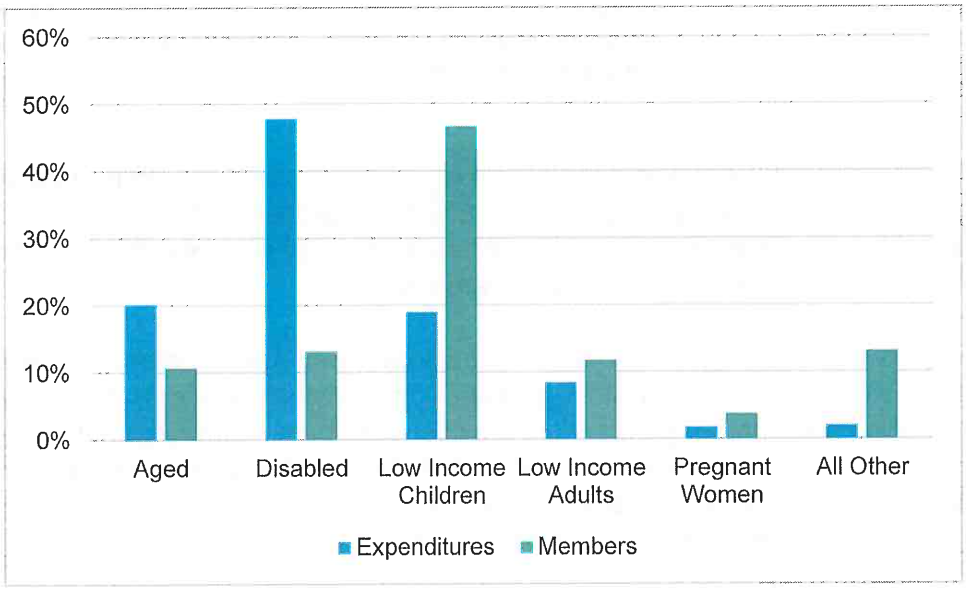


Figure 4. Enrollment and Expenditure Data for SFY 2015

	Enrollment	Expenditures
Aged	146,533	$1,606,988,250
Disabled	179,324	$3,800,147,442
Low Income Children	631,448	$1,515,323,035
Low Income Adults	160,630	$681,409,257
Pregnant Women	53,324	$150,546,596
All Other	179,187	$173,266,587
TOTALS	1,350,446	$7,927,681,167

The Medicaid eligibility categories above are defined as follows:

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

Virginia has a population of 8.4 million people, making it the 12th most populous state in the United States.[2] With 98 acute care hospitals and affiliated practices and a network of 130 federally qualified health center (FQHC) and rural health clinic (RHC) sites, there are numerous options for Medicaid members to receive health care services.

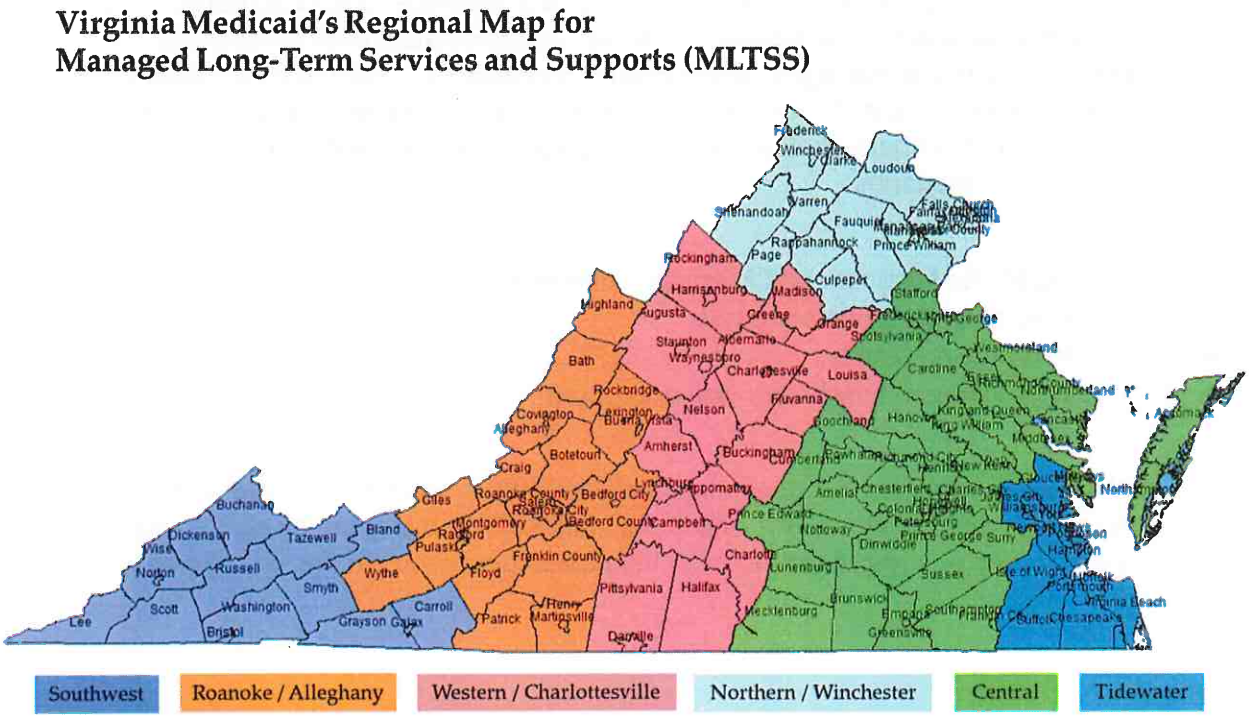
Virginia is committed to ensuring its enrolled members have adequate access to health care services. A key component of DMAS' strategic plan is ensuring adequate provider network access by monitoring and analyzing utilization, provider caseloads, reimbursement rates, and Medicaid population groups. The state has conducted other studies on member access to health care services, including a 2013 study by the Joint Legislative Audit and Review Commission (JLARC) on the impact of Medicaid payment policies on access to health care services.

[2] United States Census Bureau. State Total: Vintage 2015. Retrieved from http://www.census.gov/popest/data/state/totals/2015/index.html.

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

Because members located in different areas may have different experiences accessing health care services, this plan will analyze access to care by geographic region. Specifically, the plan will analyze access to care for the regions utilized by the Virginia Medicaid program for Managed Long-term Supports and Services (MLTSS) and the managed care program, Medallion 3.0. These regions are illustrated in Figure 5[3]. The localities comprising these regions are listed in Appendix A.

Figure 5. Map of Virginia's Regions



[3] Virginia Department of Medical Assistance Services. MLTSS Announcements and Program Information. Retrieved from http://www.dmas.virginia.gov/Content_pgs/mltss-proinfo.aspx.

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

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

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

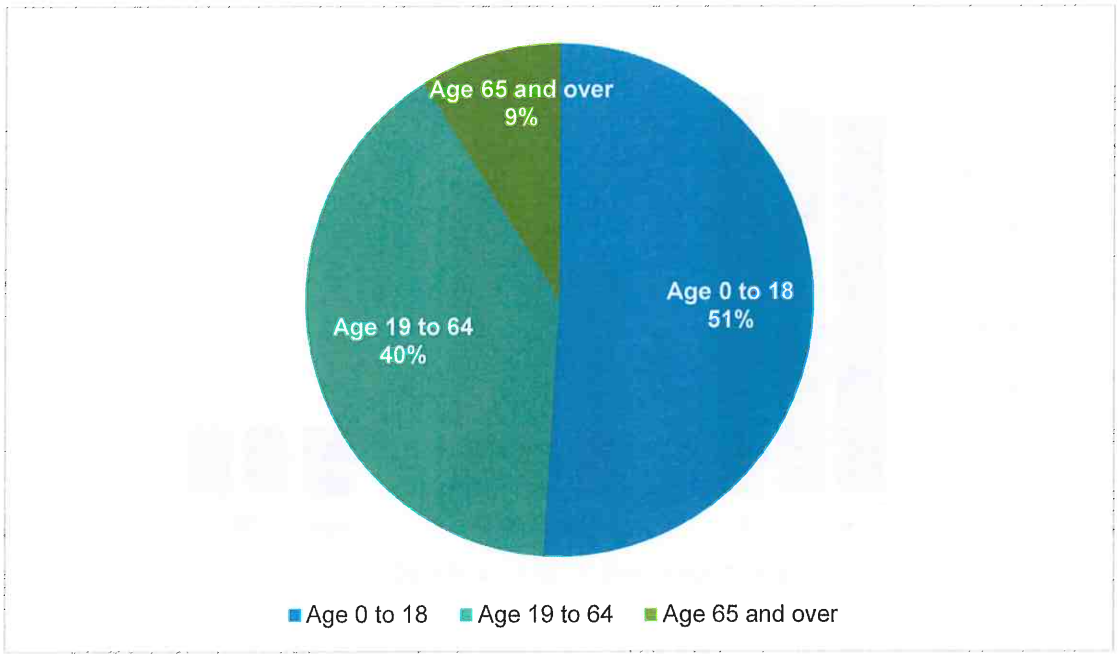
Member Population

During SFY 2015, the Virginia Medicaid program provided coverage to approximately 1.35 million enrolled members across all delivery systems. Approximately 68% of Medicaid members are enrolled in the managed care program, Medallion 3.0. Members enrolled in the managed care program consist of members that are aged and/or disabled and low income families and children. Members enrolled in the FFS program are primarily individuals in one or more of the following categories:

- Dually eligible for Medicare and Medicaid coverage
- Private insurance as a primary payer
- Reside in a nursing facility
- In a home and community based waiver program.

Characteristics of the total member population are illustrated in the figures below and on the following pages. Figure 6 illustrates the distribution of Medicaid members by age. A majority of members are 18 years of age or younger, with the next largest group in the 19 to 64 age range.

Figure 6. Medicaid Members by Age Group



Figures 7 through 9 illustrate trends in the total member population from SFY 2013 to SFY 2015. These figures illustrate trends in member enrollment in total and by age group as well as the trend in cost per member by eligibility category.

Figure 7: Change in Enrollment by SFY

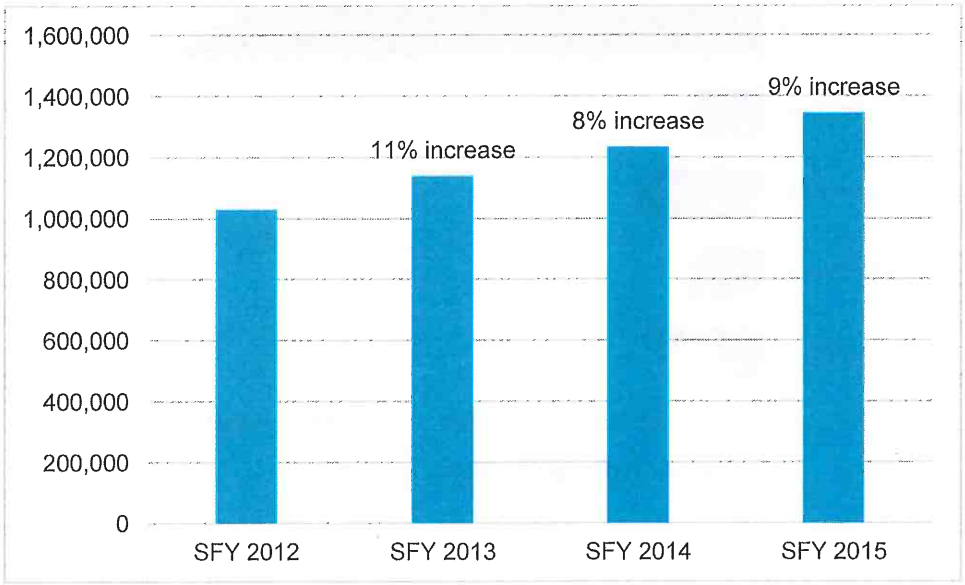


Figure 8: Enrollment by Age Group and SFY

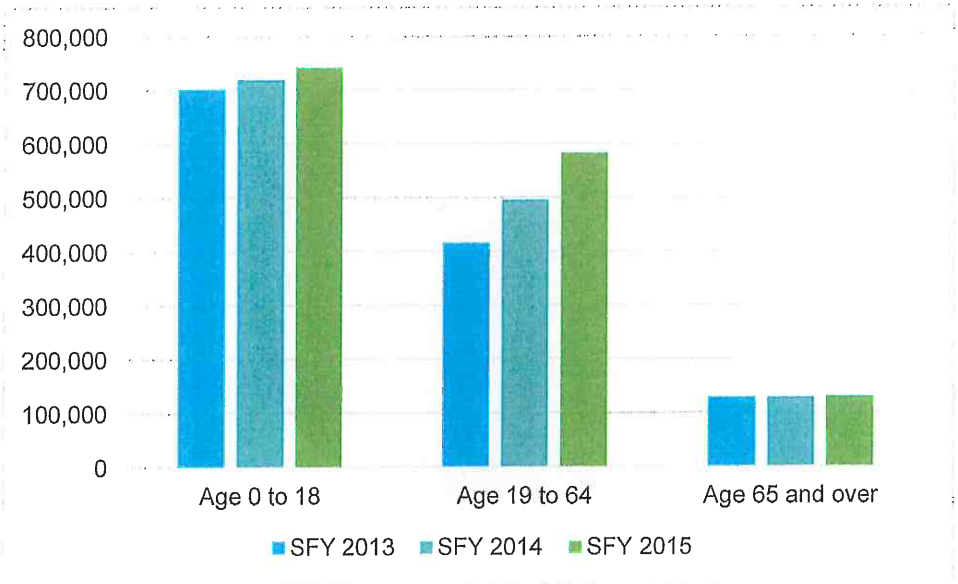
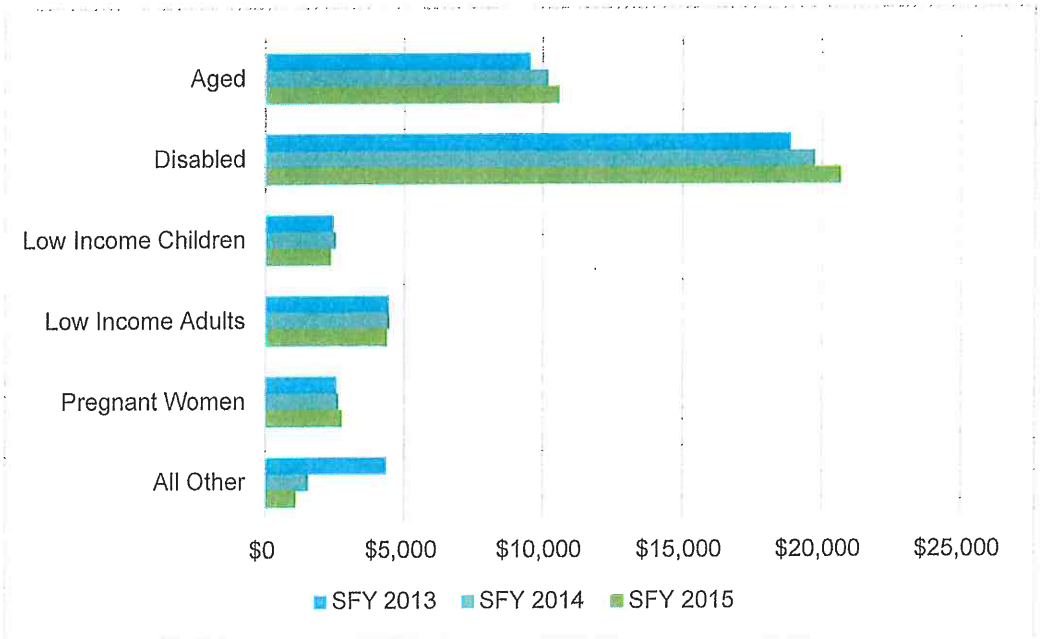


Figure 9: Cost Per Member by Eligibility Group and SFY



A few notable facts from this data are as follows:

- Overall Medicaid enrollment increased over the 3 year period by 18%. There was an 11% increase in enrollment in SFY 2013, followed by an 8% increase in SFY 2014 and a 9% increase in SFY 2015.
- The largest enrollment growth occurred in the 19 to 64 age group, increasing by 40% over 3 years compared to 18% growth across the entire Medicaid population.
- Aged and disabled members are the costliest member groups, with the highest cost per member and the largest growth in cost over the 3 year period.

Access concerns raised by members

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

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

Member perceptions of access to care

DMAS conducts an annual survey of member satisfaction and experiences for children receiving services under the Family Access to Medical Insurance Security (FAMIS) program, Virginia's children's health insurance program. The survey is conducted as required by the Children's Health Insurance Program Reauthorization Act (CHIPRA) and in accordance with the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey of the U.S. Agency for Healthcare Research and Quality. CAHPS surveys are overseen by states but are conducted by contracted vendors. Beginning in 2015, the CAHPS survey in Virginia is conducted by the Health Services Advisory Group (HSAG).

Below are selected survey questions relevant to member access and the responses to these questions obtained through the 2015 CAHPS survey.[4] For these questions regarding obtaining needed care and obtaining care quickly, respondents selected from the following response categories: Never, Sometimes, Usually, or Always. These survey results are based on a total of 1,095 respondents out of a sample of 3,423 members. This is a response rate of 32%, which

[4] Health Services Advisory Group. 2015 FAMIS Program Member Satisfaction Report (February 2016).

HSAG notes is greater than the national child Medicaid response rate reported by the National Committee for Quality Assurance (NCQA) for 2014 of 28.5%. It is important to note that the majority of FAMIS members are enrolled in managed care. However, because a small percentage of FAMIS members are enrolled in the FFS program, DMAS believes it is informative to include the results of the FAMIS CAHPS survey in this monitoring plan.

CAHPS Survey Measure and Question	Survey Response
Measure: Getting needed care	82.9% "Usually/Always"
Question 1: In the last 6 months, how often was it easy to get the care, tests, or treatment your child needed?	
Question 2: In the last 6 months, how often did you get an appointment for your child to see a specialist as soon as you needed?	
Measure: Getting care quickly	84.1% "Usually/Always"
Question 1: In the last 6 months, when your child needed care right away, how often did your child get care as soon as he or she needed?	
Question 2: In the last 6 months, when you made an appointment for a check-up or routine care for your child at a doctor's office or clinic, how often did you get an appointment as soon as your child needed?	

Provider Feedback

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

Figure 10: Provider feedback mechanisms

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

Through the state's fiscal agent contractor, Xerox, DMAS also conducts a bi-annual provider satisfaction survey. The survey collects information such as utilization of and experience with the provider web portal and helplines, utilization of Direct Data Entry of Claims (DDE), and experiences with provider revalidation processes. In addition, the survey asks providers whether they are accepting new Medicaid patients. Specifically, the survey asks the following question: "Is your practice accepting all, most, some, or no new Medicaid members?" The percentage of responses for the two most recent surveys for 2014 and 2015 are listed in the table below. These figures are based on a sample size of 423 providers for 2014 and 666 for 2015.

Figure 11: Percentage of providers accepting all, most, some, or no new Medicaid members

	2014	2015
All New Medicaid Members	62.4%	62.5%
Most New Medicaid Members	17.3%	16.8%
Some New Medicaid Members	16.1%	14.4%
No New Medicaid Members	4.3%	6.3%

The majority of providers responding to the survey are accepting new Medicaid patients. A small percentage of providers indicate they are not accepting new Medicaid patients. DMAS will continue to monitor this information for indicators of access issues.

Analysis of Primary Care Services

The state's analysis of primary care services for the FFS population will evaluate access to services provided by primary care physicians, federally qualified health centers (FQHCs), rural health clinics (RHCs), and dentists. The availability of these providers and the utilization of these services by Medicaid members are key indicators of whether Medicaid members are able to access these services. For purposes of this analysis, primary care physicians are physicians enrolled with the Virginia Medicaid program under the following specialties: family medicine, general practice, internal medicine, and preventive medicine.

The methodology for evaluating access to these services will be data-driven, comparative analyses comparing recent historical data as a baseline to subsequent years' data. This approach will facilitate the evaluation of trends and patterns over time and across geographic regions. The measures to be analyzed are designed to measure the availability of primary care providers and the utilization of primary care services by Medicaid FFS members by analyzing provider participation in the Medicaid program and trends in member utilization of services. The data for this analysis will be derived from the state's Medicaid Management Information System (MMIS) for a three year period consisting of SFY 2013 to SFY 2015. Claims data will consist of claims with dates of service during SFY 2013 through SFY 2015. This time frame provides a baseline of SFY 2013 data for comparison to SFY 2014 and 2015 and represents complete claims periods that are not impacted by paid claims lag (claims that have not been filed and/or paid).

The measures to be analyzed and the methodology utilized for the analysis are described below. The analysis of access based on these measures is under development, and this plan will be updated when the analysis is completed.

Availability of Providers

Provider availability will be analyzed using the following measures:

Provider Measure 1: Available providers by state fiscal year.

Measure:	Number of available primary care providers from SFY 2013 to SFY 2015.
Methodology:	Identify available primary care providers from SFY 2013 (baseline) to SFY 2015. Available providers are defined as providers with at least one Medicaid FFS claim during the period analyzed. Data will be analyzed on a statewide basis and by geographic region. For providers with multiple service locations, each service location will be counted separately. This measure will identify trends in provider participation.
Data source:	MMIS FFS claims and provider data

Provider Measure 2: Provider patient load by state fiscal year.

Measure:	Number of members per available primary care provider from SFY 2013 to SFY 2015.
Methodology:	Identify available primary care providers from SFY 2013 (baseline) to SFY 2015. Available providers are defined as providers with at least one Medicaid FFS claim during the period analyzed. Identify the number of members receiving at least one primary care service from SFY 2013 to SFY 2015. Calculate the ratio of members per available provider. Data will be analyzed on a statewide basis. For providers with multiple service locations, each service location will be counted separately. This measure will identify trends in patient load per provider.
Data source:	MMIS FFS claims, provider, and member data

Utilization of primary care services

Utilization of primary care services will be analyzed using the following measures:

Utilization Measure 1: Volume of primary care services by state fiscal year.

Measure:	Volume of primary care services from SFY 2013 to SFY 2015.
Methodology:	Identify volume of primary care services (number of FFS paid claims) from SFY 2013 (baseline) to SFY 2015. Data will be analyzed on a statewide basis, by geographic region, and between adult and pediatric populations. This measure will identify trends in primary care service volume.
Data source:	MMIS FFS claims and provider data

Utilization Measure 2: Number and percentage of members utilizing primary care services.

Measure:	Number and percentage of members utilizing primary care services in SFY 2015 by geographic region.
Methodology:	Identify the number of members receiving at least one primary care service in SFY 2015 and compare to the total number of members. Primary care services are defined as services provided by a primary care provider as defined in this plan (primary care physician, FQHC, RHC, or dentist). Data will be analyzed on a statewide basis, by geographic region, and between adult and pediatric populations. This measure will identify trends in member utilization.
Data source:	MMIS FFS claims, provider, and member data

Rate Comparison

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

Primary care physician services

DMAS reimburses physicians through a fee schedule that is based on a Resource Based Relative Value Scale (RBRVS) methodology. Under this methodology, each physician service is assigned relative value units (RVUs) that, when applied to a conversion factor, determine the fee schedule payment rate. Virginia's physician fee schedule RVUs are based on the RVUs developed by CMS for the Medicare program, with adjustments for budget neutrality. Each year, DMAS analyzes Medicaid rates as a percentage of Medicare rates for primary care service categories, and results are illustrated in the table below. In accordance with the Affordable Care Act, rates for primary care services for eligible physicians were increased in calendar years 2013 and 2014, which is reflected in the information below for 2014.

Figure 12: Medicaid rates primary care physician services as a percentage of Medicare rates[5]

Category	SFY 2014	SFY 2015	SFY 2016
Pediatric Primary Care	79%	77%	76%
Pediatric Preventive Care	74%	72%	72%
Adult Preventive and Primary Care	70%	68%	67%

In a 2014 study, the Urban Institute, a research organization focusing on economic and social policy, compared Medicaid physician fee schedule rates between states and against Medicare rates. From the data collected in this analysis, the researchers computed a Medicaid fee index and a Medicaid-to-Medicare fee index. The Medicaid fee index expressed the relationship of each state's rates to a national average. The Medicaid-to-Medicare fee index expressed each state's rates to Medicare rates. The table below shows Virginia's indices under these two metrics (data from 2014). Virginia's primary care physician rates were 1.26 times the national average and 73% of Medicare (above the national average).

Figure 13: Urban Institute 2014 Medicaid fee index and Medicaid-to-Medicare fee index[6]

State	Medicaid Fee Index - Primary Care	Medicaid to Medicare Fee Index - Primary Care
United States	1.00	0.59
Virginia	1.26	0.73

[5] DMAS analysis of Medicaid and Medicare reimbursement rates.
[6] Urban Institute. Reversing the Medicaid Fee Bump: How Much Could Medicaid Physician Fees for Primary Care Fall in 2015? December 2014. Retrieved from http://www.urban.org/research/publication/reversing-medicaid-fee-bump-how-much-could-medicaid-physician-fees-primary-care-fall-2015.

FQHCs and RHCs

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

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

Figure 14: FQHC and RHC rate comparison[7]

Medicare FQHC PPS Base Rate for VA	Average Medicaid FQHC Payment Rate	Medicaid to Medicare Percentage
$ 159.32	$ 138.14	87%
Medicare RHC Upper Payment Limit	**Average Medicaid RHC Per-Visit Rate**	**Medicaid to Medicare Percentage**
$ 81.32	$ 94.84	117%

Analysis of Physician Specialist Services

In reviewing physician specialist services for the FFS population, the state will evaluate access by analyzing physician services by Current Procedural Terminology (CPT) code to identify specialist services (e.g., radiology, surgery, etc.) and the providers of these services. This methodology will identify physician specialists based on the types of services rather than the specialties of the physicians. The availability of providers of these services and the utilization of these services by Medicaid members are key indicators of whether Medicaid members are able to access services provided by physician specialists.

The methodology for evaluating access to these services will be data-driven, comparative analyses comparing recent historical data as a baseline to subsequent years' data. This approach will facilitate the evaluation of trends and patterns over time and across geographic regions. The measures to be analyzed are designed to measure the availability of physicians providing specialist services and the utilization of specialist services by Medicaid FFS members by analyzing provider participation in the Medicaid program and trends in member utilization of

[7] DMAS analysis of Medicaid and Medicare reimbursement rates.

services. The data for this analysis will be derived from the state's Medicaid Management Information System (MMIS) for a three year period consisting of SFY 2013 to SFY 2015. Claims data will consist of claims with dates of service during SFY 2013 through SFY 2015. This time frame provides a baseline of SFY 2013 data for comparison to SFY 2014 and 2015 and represents complete claims periods that are not impacted by paid claims lag (claims that have not been filed and/or paid).

The measures to be analyzed and the methodology utilized for the analysis are described below. The analysis of access based on these measures is under development, and this plan will be updated when the analysis is completed.

Availability of Providers

Provider availability will be analyzed using the following measures:

Provider Measure 1: Available providers by state fiscal year.

Measure:	Number of available physician specialists from SFY 2013 to SFY 2015.
Methodology:	Identify available physician specialists from SFY 2013 (baseline) to SFY 2015. Available physician specialists are defined as physicians with at least one Medicaid FFS claim for specialist services during the period analyzed. Data will be analyzed on a statewide basis and by geographic region. For providers with multiple service locations, each service location will be counted separately. This measure will identify trends in provider participation.
Data source:	MMIS FFS claims and provider data

Provider Measure 2: Provider patient load by state fiscal year.

Measure:	Number of members per available physician specialist from SFY 2013 to SFY 2015.
Methodology:	Identify available physician specialists from SFY 2013 (baseline) to SFY 2015. Available physician specialists are defined as physicians with at least one Medicaid FFS claim for specialist services during the period analyzed. Identify the number of members receiving at least one specialist service from SFY 2013 to SFY 2015. Calculate the ratio of members per available physician specialist. Data will be analyzed on a statewide basis. For providers with multiple service locations, each service location will be counted separately. This measure will identify trends in patient load per provider.
Data source:	MMIS FFS claims, provider, and member data

Utilization of physician specialist services

Utilization of physician specialist services will be analyzed using the following measures:

Utilization Measure 1: Volume of physician specialist services by state fiscal year.

Measure:	Volume of physician specialist services from SFY 2013 to SFY 2015.
Methodology:	Identify volume of specialist services (number of FFS paid claims) from SFY 2013 (baseline) to SFY 2015. Data will be analyzed on a statewide basis, by geographic region, and between adult and pediatric populations. This measure will identify trends in physician specialist service volume.
Data source:	MMIS FFS claims and provider data

Utilization Measure 2: Number and percentage of members utilizing physician specialist services.

Measure:	Number and percentage of members utilizing physician specialist services in SFY 2015 by geographic region.
Methodology:	Identify the number of members receiving at least one physician specialist service in SFY 2015 and compare to the total number of members. Data will be analyzed on a statewide basis, by geographic region, and between adult and pediatric populations. This measure will identify trends in member utilization.
Data source:	MMIS FFS claims and member data

Rate Comparison

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

DMAS reimburses physicians through a fee schedule that is based on a Resource Based Relative Value Scale (RBRVS) methodology. Under this methodology, each physician service is assigned relative value units (RVUs) that, when applied to a conversion factor, determine the fee schedule payment rate. Virginia's physician fee schedule RVUs are based on the RVUs developed by CMS for the Medicare program, with adjustments for budget neutrality. For SFY 2016, DMAS analyzed Medicaid rates as a percentage of Medicare rates for physician specialist services, and results are illustrated in the table below.

Figure 15: Medicaid physician specialist rates as a percentage of Medicare rates[8]

Category	SFY 2016
Physician specialist services	
Radiology	85%
Surgery	86%
Oncology	86%

Analysis of Behavioral Health Services

The state's analysis of behavioral health services for the FFS population will evaluate access by identifying and analyzing behavioral health services by Current Procedural Terminology (CPT) code and the practitioners of those services (e.g., psychiatrists, psychologists, etc.). This methodology will identify the practitioners based on the types of services rather than the type of practitioner. The availability of providers of these services and the utilization of these services by Medicaid members are key indicators of whether Medicaid members are able to access behavioral health services.

The methodology for evaluating access to these services will be data-driven, comparative analyses comparing recent historical data as a baseline to subsequent years' data. This approach will facilitate the evaluation of trends and patterns over time and across geographic regions. The measures to be analyzed are designed to measure the availability of practitioners providing behavioral health services and the utilization of behavioral health services by Medicaid FFS members by analyzing provider participation in the Medicaid program and trends in member utilization of services. The data for this analysis will be derived from the state's Medicaid Management Information System (MMIS) and the state's Behavioral Health Services Administrator, Magellan, for a three year period consisting of SFY 2013 to SFY 2015. Claims data will consist of claims with dates of service during SFY 2013 through SFY 2015. This time frame provides a baseline of SFY 2013 data for comparison to SFY 2014 and 2015 and represents complete claims periods that are not impacted by paid claims lag (claims that have not been filed and/or paid).

The measures to be analyzed and the methodology utilized for the analysis are described below. The analysis of access based on these measures is under development, and this plan will be updated when the analysis is completed.

[8] DMAS analysis of Medicaid and Medicare reimbursement rates.

Availability of Providers

Provider availability will be analyzed using the following measures:

Provider Measure 1: Available providers by state fiscal year.

Measure:	Number of available behavioral health practitioners from SFY 2013 to SFY 2015.
Methodology:	Identify available behavioral health practitioners from SFY 2013 (baseline) to SFY 2015. Available behavioral health practitioners are defined as practitioners with at least one Medicaid FFS claim or Administrative Services Only (ASO) contract encounter for behavioral health services during the period analyzed. Data will be analyzed on a statewide basis and by geographic region. For providers with multiple service locations, each service location will be counted separately. This measure will identify trends in provider participation.
Data source:	MMIS FFS claims and provider data

Provider Measure 2: Provider patient load by state fiscal year.

Measure:	Number of members per available behavioral health practitioner from SFY 2013 to SFY 2015.
Methodology:	Identify available behavioral health practitioners from SFY 2013 (baseline) to SFY 2015. Available behavioral health practitioners are defined as practitioners with at least one Medicaid FFS claim or ASO encounter for behavioral health services during the period analyzed. Identify the number of members receiving at least one behavioral health service from SFY 2013 to SFY 2015. Calculate the ratio of members per available behavioral health practitioner. Data will be analyzed on a statewide basis. For providers with multiple service locations, each service location will be counted separately. This measure will identify trends in patient load per provider.
Data source:	MMIS FFS claims, provider, and member data

Utilization of behavioral health services

Utilization of behavioral health services will be analyzed using the following measures:

Utilization Measure 1: Volume of behavioral health services by state fiscal year.

Measure:	Volume of behavioral health services from SFY 2013 to SFY 2015.
Methodology:	Identify volume of behavioral health services (number of FFS paid claims) from SFY 2013 (baseline) to SFY 2015. Data will be analyzed on a statewide basis, by geographic region, and between adult and pediatric

populations. This measure will identify trends in behavioral health service volume.

Data source: MMIS FFS claims and provider data

Utilization Measure 2: Number and percentage of members utilizing behavioral health services.

Measure: Number and percentage of members utilizing behavioral health services in SFY 2015 by geographic region.

Methodology: Identify the number of members receiving at least one behavioral health service in SFY 2015 and compare to the total number of members. Data will be analyzed on a statewide basis, by geographic region, and between adult and pediatric populations. This measure will identify trends in member utilization.

Data source: MMIS FFS claims and member data

Rate Comparison

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

DMAS reimburses behavioral health physician practitioners through a fee schedule that is based on a Resource Based Relative Value Scale (RBRVS) methodology. Under this methodology, each physician service is assigned relative value units (RVUs) that, when applied to a conversion factor, determine the fee schedule payment rate. Virginia's physician fee schedule RVUs are based on the RVUs developed by CMS for the Medicare program, with adjustments for budget neutrality. For SFY 2016, DMAS analyzed Medicaid rates as a percentage of Medicare rates for behavioral health services, and results are illustrated in the table below.

Figure 16: Medicaid behavioral health services rates as a percentage of Medicare rates[9]

Category	SFY 2016
Behavioral health services	85%

[9] DMAS analysis of Medicaid and Medicare reimbursement rates.

Analysis of Pre- and Post-natal Obstetric Services

The state's analysis of obstetric services for the FFS population will evaluate access by identifying and analyzing obstetric services by Current Procedural Terminology (CPT) code and the practitioners of those services, such as obstetricians. This methodology will identify obstetric practitioners based on the types of services rather than the type of practitioner. The availability of providers of these services and the utilization of these services by Medicaid members are key indicators of whether Medicaid members are able to access obstetric services.

The methodology for evaluating access to these services will be data-driven, comparative analyses comparing recent historical data as a baseline to subsequent years' data. This approach will facilitate the evaluation of trends and patterns over time and across geographic regions. The measures to be analyzed are designed to measure the availability of practitioners providing obstetric services and the utilization of obstetric services by Medicaid FFS members by analyzing provider participation in the Medicaid program and trends in member utilization of services. The data for this analysis will be derived from the state's Medicaid Management Information System (MMIS) for a three year period consisting of SFY 2013 to SFY 2015. Claims data will consist of claims with dates of service during SFY 2013 through SFY 2015. This time frame provides a baseline of SFY 2013 data for comparison to SFY 2014 and 2015 and represents complete claims periods that are not impacted by paid claims lag (claims that have not been filed and/or paid).

The measures to be analyzed and the methodology utilized for the analysis are described below. The analysis of access based on these measures is under development, and this plan will be updated when the analysis is completed.

Availability of Providers

Provider availability will be analyzed using the following measures:

Provider Measure 1: Available providers by state fiscal year.

Measure:	Number of available obstetric practitioners from SFY 2013 to SFY 2015.
Methodology:	Identify available obstetric practitioners from SFY 2013 (baseline) to SFY 2015. Available obstetric practitioners are defined as practitioners with at least one Medicaid FFS claim for obstetric services during the period analyzed. Data will be analyzed on a statewide basis and by geographic region. For providers with multiple service locations, each service location will be counted separately. This measure will identify trends in provider participation.
Data source:	MMIS FFS claims and provider data

Provider Measure 2: Provider patient load by state fiscal year.

Measure: Number of members per available obstetric practitioner from SFY 2013 to SFY 2015.

Methodology: Identify available obstetric practitioners from SFY 2013 (baseline) to SFY 2015. Available obstetric practitioners are defined as practitioners with at least one Medicaid FFS claim for obstetric services during the period analyzed. Identify the number of members receiving at least one obstetric service from SFY 2013 to SFY 2015. Calculate the ratio of members per available obstetric practitioner. Data will be analyzed on a statewide basis. For providers with multiple service locations, each service location will be counted separately. This measure will identify trends in patient load per provider.

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

Utilization of obstetric services

Utilization of obstetric services will be analyzed using the following measures:

Utilization Measure 1: Volume of obstetric services by state fiscal year.

Measure: Volume of obstetric services from SFY 2013 to SFY 2015.

Methodology: Identify volume of obstetric services (number of FFS paid claims) from SFY 2013 (baseline) to SFY 2015. Data will be analyzed on a statewide basis, by geographic region, and between adult and pediatric populations. This measure will identify trends in obstetric service volume.

Data source: MMIS FFS claims and provider data

Utilization Measure 2: Number and percentage of members utilizing obstetric services.

Measure: Number and percentage of members utilizing obstetric services in SFY 2015 by geographic region.

Methodology: Identify the number of members receiving at least one obstetric service in SFY 2015 and compare to the total number of members. Member data for this analysis will be limited to females over the age of 11. Data will be analyzed on a statewide basis, by geographic region, and between adult and pediatric populations. This measure will identify trends in member utilization.

Data source: MMIS FFS claims and member data

Rate Comparison

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

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

Figure 17: Medicaid obstetric services rates as a percentage of Medicare rates[10]

Category	SFY 2014	SFY 2015	SFY 2016
OB/GYN Services	91%	87%	88%

In a 2014 study, the Urban Institute, a research organization focusing on economic and social policy, compared Medicaid physician fee schedule rates between states and against Medicare rates. From the data collected in this analysis, the researchers computed a Medicaid fee index and a Medicaid-to-Medicare fee index. The Medicaid fee index expressed the relationship of each state's rates to a national average. The Medicaid-to-Medicare fee index expressed each state's rates to Medicare rates. The table below shows Virginia's indices under these two metrics (data from 2014). Virginia's rates for obstetric care were 1.15 times the national average and 88% of Medicare (above the national average).

Figure 18: Urban Institute 2014 Medicaid fee index and Medicaid-to-Medicare fee index[11]

State	Medicaid Fee Index - Obstetric Care	Medicaid to Medicare Fee Index - Obstetric Care
United States	1.00	0.76
Virginia	1.15	0.88

[10] DMAS analysis of Medicaid and Medicare reimbursement rates.
[11] Urban Institute. Reversing the Medicaid Fee Bump: How Much Could Medicaid Physician Fees for Primary Care Fall in 2015? December 2014. Retrieved from http://www.urban.org/research/publication/reversing-medicaid-fee-bump-how-much-could-medicaid-physician-fees-primary-care-fall-2015.

Analysis of Home Health Services

The state's analysis of home health services for the FFS population will evaluate access to services provided by home health agencies (HHAs). The availability of these providers and the utilization of these services by Medicaid members are key indicators of whether Medicaid members are able to access these services.

The methodology for evaluating access to these services will be data-driven, comparative analyses comparing recent historical data as a baseline to subsequent years' data. This approach will facilitate the evaluation of trends and patterns over time and across geographic regions. The measures to be analyzed are designed to measure the availability of HHA providers and the utilization of HHA services by Medicaid FFS members by analyzing provider participation in the Medicaid program and trends in member utilization of services. The data for this analysis will be derived from the state's Medicaid Management Information System (MMIS) for a three year period consisting of SFY 2013 to SFY 2015. Claims data will consist of claims with dates of service during SFY 2013 through SFY 2015. This time frame provides a baseline of SFY 2013 data for comparison to SFY 2014 and 2015 and represents complete claims periods that are not impacted by paid claims lag (claims that have not been filed and/or paid).

The measures to be analyzed and the methodology utilized for the analysis are described below. The analysis of access based on these measures is under development, and this plan will be updated when the analysis is completed.

Availability of Providers

Provider availability will be analyzed using the following measures:

Provider Measure 1: Available providers by state fiscal year.

Measure:	Number of available HHA providers from SFY 2013 to SFY 2015.
Methodology:	Identify available HHA providers from SFY 2013 (baseline) to SFY 2015. Available HHA providers are defined as HHA providers with at least one Medicaid FFS claim during the period analyzed. Data will be analyzed on a statewide basis and by geographic region. For providers with multiple service locations, each service location will be counted separately. This measure will identify trends in provider participation.
Data source:	MMIS FFS claims and provider data

Provider Measure 2: Provider patient load by state fiscal year.

Measure: Number of members per available HHA provider from SFY 2013 to SFY 2015.

Methodology: Identify available HHA providers from SFY 2013 (baseline) to SFY 2015. Available HHA providers are defined as HHA providers with at least one Medicaid FFS claim during the period analyzed. Identify the number of members receiving at least one HHA service from SFY 2013 to SFY 2015. Calculate the ratio of members per available HHA provider. Data will be analyzed on a statewide basis. For providers with multiple service locations, each service location will be counted separately. This measure will identify trends in patient load per provider.

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

Utilization of home health services

Utilization of home health services will be analyzed using the following measures:

Utilization Measure 1: Volume of home health services by state fiscal year.

Measure: Volume of HHA services from SFY 2013 to SFY 2015.

Methodology: Identify volume of services (number of FFS paid claims) from SFY 2013 (baseline) to SFY 2015 by HHA provider. Data will be analyzed on a statewide basis, by geographic region, and between adult and pediatric populations. This measure will identify trends in home health service volume.

Data source: MMIS FFS claims and provider data

Utilization Measure 2: Number and percentage of members utilizing HHA services.

Measure: Number and percentage of members utilizing HHA services in SFY 2015 by geographic region.

Methodology: Identify the number of members receiving at least one HHA service in SFY 2015 and compare to the total number of members. Data will be analyzed on a statewide basis, by geographic region, and between adult and pediatric populations. This measure will identify trends in member utilization.

Data source: MMIS FFS claims and member data

Rate Comparison

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

A direct rate comparison for home health services is difficult because of the differences between the Medicare and Virginia Medicaid reimbursement methodologies. Under Medicare's reimbursement system, HHAs are reimbursed through a 60-day episode rate, whereas under the Virginia Medicaid reimbursement methodology, payment is made through per-visit rates. However, the Medicare methodology does contain per-visit rates for low utilization episodes, which are defined as episodes with four or fewer visits. The rate comparison below utilizes the current (calendar year 2016) Medicare low-utilization per-visit rates for HHAs submitting quality data compared to the current (state fiscal year 2017) Medicaid per-visit rates by HHA discipline. The Medicaid reimbursement methodology contains separate rates for the initial assessment, follow-up, and comprehensive visits for certain disciplines. Furthermore, the Medicaid rates are different for the three HHA peer groups in Virginia. The HHA peer groups are the Virginia Department of Health HHAs (VDOH), non-Department of Health HHAs in northern Virginia (NOVA), and non-Department of Health HHAs in the rest of the state. The various Medicaid rate segments are compared to Medicare by discipline in the figure below.

Figure 19: HHA rate comparison[12]

Medicaid HHA Assessment Rates				
Discipline	**Peer Group**	**Medicare Rate**	**Medicaid Rate**	**Medicaid to Medicare Percentage**
Skilled Nursing	VDOH	$134.42	$152.96	114%
	NOVA	$134.42	$150.08	112%
	Rest of State	$134.42	$117.29	87%
Physical Therapy	VDOH	$146.95	$143.90	98%
	NOVA	$146.95	$130.90	89%
	Rest of State	$146.95	$137.38	93%
Occupational Therapy	VDOH	$147.95	$147.82	100%
	NOVA	$147.95	$128.36	87%
	Rest of State	$147.95	$131.04	89%
Speech Therapy	VDOH	$159.71	$154.82	97%
	NOVA	$159.71	$139.14	87%
	Rest of State	$159.71	$124.16	78%
Medicaid HHA Follow-Up Rates				
Discipline	**Peer Group**	**Medicare Rate**	**Medicaid Rate**	**Medicaid to Medicare Percentage**
Skilled Nursing	VDOH	$134.42	$137.96	103%

[12] DMAS analysis of Medicaid and Medicare reimbursement rates.

	NOVA	$134.42	$135.08	100%
	Rest of State	$134.42	$102.29	76%
Physical Therapy	VDOH	$146.95	$128.90	88%
	NOVA	$146.95	$115.90	79%
	Rest of State	$146.95	$122.38	83%
Occupational Therapy	VDOH	$147.95	$132.82	90%
	NOVA	$147.95	$113.36	77%
	Rest of State	$147.95	$116.04	78%
Speech Therapy	VDOH	$159.71	$139.82	88%
	NOVA	$159.71	$124.14	78%
	Rest of State	$159.71	$109.16	68%

Medicaid HHA Comprehensive Rates

Discipline	Peer Group	Medicare Rate	Medicaid Rate	Medicaid to Medicare Percentage
Skilled Nursing	VDOH	$134.42	$275.91	205%
	NOVA	$134.42	$270.16	201%
	Rest of State	$134.42	$204.58	152%
Home Health Aid	VDOH	$60.87	$78.29	129%
	NOVA	$60.87	$90.30	148%
	Rest of State	$60.87	$58.75	97%

Medicaid HHA Rates for Home Health Aides

Discipline	Peer Group	Medicare Rate	Medicaid Rate	Medicaid to Medicare Percentage
Home Health Aid	VDOH	$60.87	$78.29	129%
	NOVA	$60.87	$90.30	148%
	Rest of State	$60.87	$58.75	97%

Availability of Transportation and Telemedicine

It can be informative to an analysis of member access to health care services to include an evaluation of transportation services and telemedicine services. The availability of transportation services can be a critical factor in a Medicaid member's ability to access needed health care services. Medicaid members often do not have their own transportation or are unable to obtain transportation from a friend or family member. Likewise, the availability of telemedicine services is another important factor in a member's ability to access health care services. This is especially true in certain circumstances, such as for members in rural areas or members needing access to a physician specialists. An analysis of transportation and telemedicine services is under development, and this plan will be updated when the analysis is completed.

Appendix A: Managed Long-term Supports and Services (MLTSS) Regions [13]

[13] Virginia Department of Medical Assistance Services. MLTSS Announcements and Program Information. Retrieved from http://www.dmas.virginia.gov/Content_pgs/mltss-proinfo.aspx.

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