Alaska Medicaid Redesign Quality and Cost Effectiveness Targets Report

September 2018

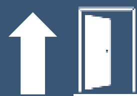
Submitted to Valerie Davidson, Commissioner, Alaska Department of Health and Social Services

Prepared by Donna Steward, DHSS Project Lead
Alaska Medicaid Redesign Quality and Cost Effectiveness Targets Stakeholder Workgroup

GOALS FOR MEDICAID REDESIGN + EXPANSION

IMPROVE HEALTH

OPTIMIZE ACCESS



INCREASE VALUE

CONTAIN COSTS

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FOREWORD

This report is submitted to Valerie Nurr'araaluk Davidson, Commissioner, Alaska Department of Health and Social Services, from the Alaska Medicaid Redesign Quality and Cost Effectiveness Targets Stakeholder Workgroup.

ALASKA MEDICAID REDESIGN QUALITY AND COST EFFECTIVENESS TARGETS STAKEHOLDER WORKGROUP

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EXECUTIVE SUMMARY

In October 2016, the Department of Health and Social Services (Department) convened the Medicaid Redesign Quality and Cost Effectiveness Targets Stakeholder Workgroup (QCE) and tasked the group with identifying Medicaid performance measures the Department could use to evaluate and monitor the overall quality of the Medicaid program during implementation of Medicaid redesign efforts. In 2017, the QCE recommended 18 Medicaid performance measures and corresponding annual and five-year performance targets for the recommended measures. The Department adopted each of the workgroup's recommendations.

The following report provides an overview of the QCE's second year activities which included affirming the process the Department will use to calculate and verify program performance against the approved measures, and affirming baseline performance calculations for those measures calculated from Alaska Medicaid claims data. During the course of the QCE workgroup's discussions, one measure was removed from the recommended list of measures and placed on the *Potential Future Measures* list. This action was necessary due to the absence of a reliable data source for performance measurement. This reduced the final list of performance measures to 17. In addition, after extensive review by the Department and its consultant Milliman, Inc., results on a second measure were placed on hold until additional assurances are received on the methodology used to calculate performance.

The report also transmits the results of the first-year of performance measured against the performance baseline for services delivered during state fiscal year 2017. Results of first-year performance demonstrate that the program met or exceeded annual performance targets for 10 measures, partially met performance targets for three measures, and failed to meet performance targets for the remaining three measures.

PROJECT BACKGROUND

Over the past two years the Department of Health and Social Services (Department) has actively pursued Medicaid program redesign opportunities outlined in Alaska Senate Bill 74 (SB74), which passed the Alaska Legislature in 2016. To support redesign efforts, the legislation also requires the Department to identify program quality and cost effectiveness measures and develop annual performance targets for those measures to monitor the Medicaid program as redesign activities unfold. The Department convened an external stakeholder workgroup to identify and recommend measures and performance targets to address this requirement. The 18-member Medicaid Redesign Quality and Cost Effectiveness Targets Stakeholder Workgroup (QCE) included representatives from hospitals, physician groups, federally qualified health centers, enrollee advocates, tribal health organizations and other health professionals. The workgroup met monthly from October 2016 through July 2017 to develop its recommendations.

At the conclusion of its work in 2017, the QCE submitted a list of 18 quality and cost effectiveness measures and corresponding annual and five-year performance targets it believed would help the Department monitor program quality as Medicaid redesign efforts evolve. The workgroup established a 10 percent performance improvement goal that each measure should either meet or exceed by the end of the five-year performance period. Corresponding annual performance targets represent the program performance necessary to achieve the 10 percent improvement goals within the five-year timeframe. Appendix A includes a description of each measure and corresponding performance goals.

The Department accepted each of the workgroup's recommended measures and performance targets. The process the QCE used to identify the recommended measures and develop the performance targets is discussed in detail in the workgroup's *Alaska Medicaid Redesign Quality and Cost Effectiveness Targets Report, September 2017* report. The report also identified varied issues with available Medicaid claims data used to inform the development of the recommended performance targets, and the lack of staff resources necessary to support the performance monitoring required under the legislation.

To inform the workgroup's development of the performance targets in 2017, the Department worked with Milliman Inc. (Milliman), which was under contract with the Department to provide actuarial support for a variety of SB74 projects. Using a subset of Alaska Medicaid claims from state fiscal years 2015 and 2016, Milliman calculated initial results for each measure requiring calculation from Medicaid claims data. The QCE used the initial results from Milliman to benchmark the annual and five-year performance targets, with the understanding that the final performance measure baselines and corresponding targets would be calculated by the Department the following year using a complete Medicaid claims data set.

The final steps necessary to operationalize the measures and performance targets were completed by the workgroup in 2018. These steps focused on affirming the Department's process for calculating measure results and affirming the measure baseline calculations. Completion of these items supports public reporting on the measures for the first time in January 2019. First-year results measure program performance during state fiscal year 2017.

The remainder of this report outlines the process the Department used to calculate and verify the algorithms used to develop baseline rates and measure performance, and transmits the results of first-year performance against the baseline rates.

METHODOLOGY

A subset of the original QCE workgroup continued its work in 2018. Participants included 11 external stakeholders representing physicians, federally qualified health centers, hospitals, tribal health organizations, provider organizations, and specialty providers. The workgroup met four times during the year and focused on two primary tasks: affirming the methodology developed by the Department to calculate performance on identified measures and affirming the baseline from which annual performance will be measured.

Each of the measures recommended by the QCE workgroup fall into one of three categories: 1) the measure (and corresponding algorithm) was developed by either the Centers for Medicare and Medicaid Services (CMS) or the National Committee for Quality Assurance (NCQA), and is a recommended national measure; 2) the measure is based on a nationally recommended measure but both the measure and the algorithm were modified to provide more specific information on Alaska Medicaid performance; or 3) the measure evaluates a unique aspect of the Alaska Medicaid program such as beneficiary satisfaction with care received or per enrollee program costs. Measures that fall into categories 1 and 2 are calculated using Medicaid claims data. A variety of sources are used to identify performance on measures included in category 3, including beneficiary surveys and program financial reports. Appendix B includes details on each measure including the data source used to identify performance.

Department staff finalized the methodology for calculating each measure in category 1 by adopting the appropriate algorithms created by either CMS or NCQA. Each measure in category 2 originated from a national measure but was modified to reflect the more specific information requested by the QCE workgroup. The algorithms for measures in category 2 were modified accordingly to align with the requested information. Each algorithm was tested using varied claim scenarios throughout the refinement process to verify the algorithm's accuracy, consistency and reliability. Milliman provided technical assistance as needed during the refinement process and helped test some of the final algorithms to validate measure results.

Once the algorithms were in final form, performance on each measure was calculated by the Department and compared to the initial results produced by Milliman in 2017. Variation between the two sets of calculations was expected given the incomplete data set available to Milliman and the refined algorithms developed by the Department. Measure results with more than a minimal difference between the Milliman initial calculations and the Department's calculations were closely scrutinized to identify the cause for the more substantive variation.

Once the internal testing and validation processes were complete, baseline performance calculations were developed using Medicaid claims information from state fiscal year 2016 and the department's refined algorithms. The baseline results and noted anomalies were presented to the QCE workgroup for review and discussion in April 2018. (Appendix B includes the complete list of measures and measure details). During this meeting, the Department identified three measures for which there remained broader than expected variation between the Department's baseline calculations and Milliman's initial calculations. These measures included:

- B.1 Follow-up After Hospitalization for Mental Illness

- B.3 Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- CH.3 Hospital Readmission Within 30 Days of Discharge

Given that all known variants between the data sets had been identified and accounted for at the time, the QCE workgroup recommended that the algorithms developed by the Department be further reviewed by Milliman to identify the cause of and resolve the remaining discrepancies. Two additional measures (CH.2 Comprehensive Diabetes Care A1C Testing and C.2 Number of Hospitalizations for Chronic Obstructive Pulmonary Disease) were also submitted to Milliman for testing to further verify and support the reliability of the Department's algorithms that produced results consistent with Milliman's initial rates.

"Based on our review of DHSS methodology and comparison of DHSS results relative to our independent analysis, we believe that DHSS has established a reasonable methodology to both establish the baseline levels for each of the quality measures and track progress towards DHSS goals over time."

Milliman Inc., Alaska Medicaid Quality Measures: Documentation of Peer Review. September 4, 2018

The results of this process were instructive and exposed additional deficiencies in the data available to Milliman when calculating initial rates. Discrepancies with the calculation of measure CH.3 Hospital Readmission within 30 Days of Discharge persisted throughout this review. It was decided that in order to ensure the reliability of the algorithm and calculation methodology for this measure, assistance would be requested from the National Committee for Quality Assurance before performance on this measure is reported. The Department placed this measure on hold.

After working through the final data discrepancies on the remaining measures, Milliman affirmed the reasonableness of the methodology and algorithms developed by the Department and the use of the algorithm methodology to help track progress toward meeting program performance goals. Appendix C includes the summary of Milliman's report on the final analysis (full report is available upon request).

Measure B.2 - Medical Assistance with Smoking and Tobacco Use

Prior to affirming the baseline, it was also necessary for the QCE workgroup to determine the disposition of measure B.2 Medical Assistance with Smoking and Tobacco Use Cessation. During the workgroup's initial discussions on the recommended measures, members felt strongly that a measure evaluating program efforts to reduce smoking and tobacco use must be included due to the high costs inherent in providing health care services to an individual with a smoking related illness. Unfortunately, due to limitations of the Medicaid claims data and the Department's commitment to not require additional provider reporting, the QCE workgroup was unable to find a measure that could reliably and consistently identify the number of Medicaid beneficiaries who either smoked or used a tobacco product.

Rather than abandon the issue, the QCE workgroup included a proxy measure on the list of measures submitted to the Department in 2017, with a directive that the Department further explore options for identifying a quantifiable measure that could be brought to the QCE workgroup for consideration in 2018.

To further explore this issue and address the QCE workgroup's goal, in 2018 the workgroup met with staff members from the Department's Division of Public Health to learn more about population health surveys and how information gathered through such could potentially be used to help measure Medicaid program performance on smoking and tobacco use cessation. After an extensive discussion on the applicability of population health surveys to specific Medicaid program performance, the QCE workgroup rejected the use of information gathered through a population survey as an effective means to measure activities within the Medicaid program.

Margaret Brodie, Director of the Department's Division of Health Care Services, shared with the QCE workgroup that the Department was exploring a Care Coordination Demonstration Project that involves a managed care option for Medicaid enrollees in the Municipality of Anchorage and Matanuska-Susitna Borough. The project is expected to begin in April 2019, and may provide new opportunities for gathering the information necessary to support a measure on smoking and tobacco use through the managed care contractor. With this opportunity on the horizon, the QCE workgroup voted to move the proxy measure B.2 from the active measure list to the "*Potential Future Measures*" list (Appendix D). The *Potential Future Measures* list was developed by the workgroup in 2017 and includes those measures identified by the QCE workgroup that could not be implemented without either adoption of preventive services regulations or identification of a reliable data source. Measure B.2 will remain on the *Potential Future Measures* list until a reliable data source is identified.

DEMONSTRATING PERFORMANCE

As noted above, the QCE workgroup used the initial measure calculations developed by Milliman to inform development of annual performance targets. As the first step to benchmarking performance, the QCE workgroup set a basic goal to improve performance on each measure by 10% within five years. Annual performance targets were then established based on the final five-year performance goals.

While the QCE workgroup was able to establish the performance targets in 2017 using the initial results prepared by Milliman, these calculations served as proxy rates until the final baseline could be calculated. The Department calculated the final baseline performance results in 2018 after all applicable algorithms had been finalized. The baseline results represent Medicaid services delivered in state fiscal year 2016 and serve as the anchor for determining performance improvement over the next five years.

*Performance improvement of **10%** is expected for each measure by 2021*

In June 2018, the QCE workgroup affirmed the baseline results for all measures except measures B.1, B.3 and CH.3, which as previously noted were under further review by Milliman. The QCE workgroup's established performance targets were applied to the baseline rates, establishing the final performance

goals. The complete list of measures and corresponding final annual and five-year performance goals can be found in Appendix A.

With the baseline affirmed and the targets for final performance goals established, the Department calculated the first year of performance against the baseline. Using Medicaid claims from services delivered during state fiscal year 2017, first year results indicate the program met or exceeded annual performance targets for 10 measures, partially met performance targets for three measures, and failed to meet performance targets for the remaining three measures. Table 1 includes results of program performance in 2017. Several of the measures require separate calculations of performance by age or category cohort. A value of Y or N in the table below notes that the performance target was either met or not met for the cohorts reported under the measure. A value of P identifies performance was met on at least one of the cohorts reported (Appendix A includes all results by applicable age or category cohort).

Table 1. Results of 2017 First-Year Performance on QCE Measures

Measure	Met 2017 Performance Target
A.1 Child and Adolescents' Access to Primary Care	N
A.2 Ability to Get Appointment With Provider As Needed	Y
B.1 Follow-up After Hospitalization for Mental Illness	Y
B.3[1] Alcohol and Other Drug Dependence Treatment	Y
CH.1 Emergency Department Utilization	N
CH.2 Diabetic A1C Testing	Y
CH.3 Hospital Readmission Within 30 days - All Diagnoses	On Hold
C.1 Medicaid Spending Per Enrollee	N
C.2 Hospitalization Chronic Obstructive Pulmonary Disease	Y
C.3 Hospitalizations Attributed to Diabetic Condition	Y
C.4 Hospitalizations Attributed Congestive Heart Failure	P
M.1 Live Births Weighing Less Than 2,500 Grams	Y
M.2 Follow-up After Delivery	Y
M.3 Prenatal Care During First Trimester	Y
P.1 Childhood Immunization Status	Y
P.2 Well-Child Visits for Children 0-6 by Age	P
P.3 Developmental Screening in the First Three Years of Life	P

Y = Met Performance Goal; N = Did Not Meet Performance Goal; P = Partially Met Performance Goal

A NATIONAL PERSPECTIVE

For additional verification on the reliability of the final algorithms, Department staff worked informally with quality management staff from Mathematica Policy Research (Mathematica) to gather additional feedback on the measures and corresponding algorithms. Although Mathematica was unable to test Alaska's algorithms with relevant Medicaid claims, they were able to provide comment on how closely the algorithms and corresponding calculated results compared with national norms. Mathematica reviewed the 11 of 17 measures aligned with the CMS Medicaid Program Core Set Standards. They identified that

[1] Measure B.2 Medical Assistance with Smoking and Tobacco Cessation, was moved to the *Potential Future Measures List* by the QCE workgroup in 2018

for seven of the 11 measures, calculated performance on those measures aligned closely with federal fiscal year 2016 CMS Core Set medians calculated nationally for state Medicaid programs. Two of the four measures where performance did not align were the focus of the additional Milliman review noted above. Mathematica did a cursory review and provided nominal comment on the QCE workgroup's measures that were not derived from a national source.

While the majority of the QCE measures are based on the CMS Core Set, three of the CMS Core Set measures (C.4 Number of Hospitalizations due to Congestive Heart Failure, P.2 Average Number of Well-Child Visits for Children and P.3 Developmental Screening in the First Three Years of Life) were selected by the QCE workgroup and then modified to represent the specific interests of the group. For these measures, algorithms were based on the corresponding CMS Core Set algorithms and were modified to capture the specific information of interest. As an example for measure P.3, the CMS Core Set algorithm specifies which developmental screens should be included when calculating measure results. The result reflects a subset of all developmental screens a provider can administer to infants and toddlers. For several years Alaska Medicaid has reported on the more narrow CMS Core Set measure identifying the subset of developmental screens. The QCE workgroup felt it was important to also know the percentage of infants and toddlers that received any type of developmental screen. The measure and corresponding algorithm were thereby modified to capture this information.

In support of Mathematica's mission for national measures that can be used to measure performance in all states and across all state Medicaid programs, the group cautions against the use of too many measures that cannot be compared to other health or state Medicaid programs. Although Mathematica's review was limited, it did identify that results from the algorithms developed by the Department aligned with federal fiscal year 2016 CMS Core Set measure results.

COORDINATION WITH REDESIGN EFFORTS

The Department has engaged in a number of initiatives aimed at improving the effectiveness of the Alaska Medicaid program and the overall health of Medicaid enrollees. The Department's initiatives to develop Care Coordination Demonstration Projects (CCDP) and pursue an 1115 demonstration waiver to realign behavioral health services were also authorized under SB74. Once fully implemented, these initiatives should have positive impacts on Medicaid enrollee health.

One of the CCDP initiatives will bring focused managed care strategies to the State of Alaska for the very first time. The managed care demonstration will place Medicaid enrollees within the Municipality of Anchorage and Matanuska-Susitna Borough in a managed care health plan beginning April 2019.

Once implemented, claims for services provided to enrollees in the managed care plan will be processed directly by the managed care contractor. A coordinated approach that requires the managed care contractor to timely provide claim information relative to each of the QCE measures to the MMIS system will be necessary to ensure annual results reflect a complete picture of Medicaid program performance.

In addition, an Administrative Services Organization (ASO) will be used to support behavioral health reform. It is possible the ASO will have responsibility for processing claims for the delivery of behavioral health services covered under the waiver beginning in state fiscal year 2020. Three of the QCE measures will rely on data from claims that are potentially processed by the ASO contractor (measures B.1, B.3 and CH.3). If the ASO is assigned this responsibility, it will also be necessary to coordinate with this contractor to ensure they too are providing the information necessary for the Department to calculate performance on these measures.

Claims information and supporting documentation will be needed from each potential contractor in order to develop a complete picture of program performance. Performance results for state fiscal years 2017 and 2018 will be calculated solely from the Department's MMIS system. However, beginning with state fiscal year 2019 when the first of the new contractors is introduced, these program contractors will become part of the Department's efforts to track and monitor performance based on the measures developed by the QCE workgroup.

APPENDIX A

Alaska Medicaid Quality and Cost Effectiveness Measures and Performance Targets State Fiscal Years 2016-2021

Category	Measure	Program Cohort	Baseline SFY 2016	Target SFY 2017	Actual 2017	Target SFY 2018	Target SFY 2019	Target SFY 2020	5-YR Target SFY2021
Access	A.1: Child and Adolescents' Access to Primary Care Practitioners	Age: 12 to 24 mos	87.0%	88.7%	87.8%	90.5%	92.2%	94.0%	95.7%
		Age: 25 mos to 6 yrs	77.6%	79.2%	78.7%	80.7%	82.3%	83.8%	85.4%
		Age: 7 yrs to 11 yrs	82.6%	84.3%	82.5%	85.9%	87.6%	89.2%	90.9%
		Age: 12 yrs to 19 yrs	83.7%	85.4%	83.7%	87.1%	88.8%	90.4%	92.1%
	A.2: Ability To Get An Appointment w/Provider as Needed	Age: 0-21 yrs	67.2%	68.5%	71.0%	69.9%	71.2%	72.6%	73.9%
		Age: 21+ yrs	60.6%	61.8%	68.7%	63.0%	64.2%	65.4%	66.7%
Behavioral Health*	B.1: Follow-Up After Hospitalization for Mental Illness	Child - Acute	34.3%	35.0%	43.1%	35.7%	36.4%	37.1%	37.7%
		Child - Psych	36.3%	37.0%	39.7%	37.7%	38.4%	39.2%	39.9%
		Adult - Acute	40.1%	40.9%	43.4%	41.7%	42.5%	43.3%	44.1%
		Adult - Psych	41.6%	42.4%	56.3%	43.2%	44.1%	44.9%	45.8%
	B.3: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Initiation	31.1%	31.7%	38.1%	32.3%	32.9%	33.6%	34.2%
		Engagement	15.0%	15.3%	18.3%	15.6%	15.9%	16.2%	16.5%
Chronic Illness	CH.1: Emergency Department Utilization (visits/1,000)	All program participants	637.2	624.5	727.3	611.8	599.1	586.4	573.5
	CH.2: Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing	Age: 18-64 yrs	63.1%	64.4%	68.1%	65.7%	66.9%	68.2%	69.4%
		Age: 65-75 yrs	34.6%	35.3%	38.2%	36.0%	36.7%	37.4%	38.1%
	CH.3: Hospital readmission w/in 30 days - all diagnoses	Age 18+ yrs: Mental illness admits	MEASURE CURRENTLY ON HOLD						
		Age 18+ yrs: All other admits							
Cost	C.1: Medicaid spending per enrollee	Age: 0-21yrs	$ 5,828	$ 5,711	$ 6,761	$ 5,595	$ 5,478	$ 5,362	$5,245
		Age: 21+ yrs	$ 10,436	$ 10,319	$ 12,283	$ 10,203	$ 10,086	$ 9,970	$9,392
	C.2: Number of hospitalizations for Chronic Obstructive Pulmonary Disease	Age: 40-64 yrs	43.8	42.9	35.9	42.0	41.1	40.2	39.4
		Age: 65+ yrs	69.8	68.4	57.9	67.0	65.6	64.2	62.8
	C.3: Number of hospitalizations for a diabetic condition	Age: 18-64 yrs	22.1	21.7	20.2	21.3	20.9	20.5	19.9
		Age: 65+ yrs	21.9	21.5	13.7	21.1	20.7	20.3	19.7
	C.4: Number of hospitalizations for Congestive Heart Failure	Age: 18-64 yrs	14.4	14.1	15.2	13.8	13.5	13.2	13.0
		Age: 65+ yrs	58.9	58.0	54.8	57.1	56.2	55.3	53.0
Maternal	M.1: Live Births Weighing Less Than 2,500 Grams	All program participants	6.8%	6.7%	6.3%	6.6%	6.4%	6.3%	6.1%
	M.2: Postpartum Care Rate	All program participants	38.8%	39.6%	40.5%	40.4%	41.2%	41.9%	42.7%
	M.3: Percent of newborns whose mothers had prenatal visit during first trimester	All program participants	77.9%	79.5%	80.6%	81.0%	82.6%	84.1%	85.7%
Preventive	P.1: Childhood Immunization Status	Age: 19-35 mos	59.5%	60.7%	62.7%	61.9%	63.1%	64.3%	65.5%
	P.2: AverAge Number of Well-Child Visits	Second yr of life	1.53	1.56	2.04	1.59	1.62	1.65	1.68
		Third yr of life	0.61	0.62	0.89	0.63	0.65	0.66	0.67
		Fourth yr of life	0.55	0.56	0.55	0.57	0.58	0.59	0.61
		Fifth yr of life	0.60	0.61	0.57	0.62	0.64	0.65	0.66
		Sixth yr of life	0.16	0.16	0.54	0.17	0.17	0.17	0.18
	P.3: Developmental Screenings First Three Years of Life	First yr of life	12.9%	13.2%	13.1%	13.4%	13.7%	13.9%	14.2%
		Second yr of life	10.6%	10.8%	9.3%	11.0%	11.2%	11.4%	11.7%
		Third yr of life	5.9%	6.0%	6.3%	6.1%	6.2%	6.3%	6.5%
		Ages 0-3 combined	10.0%	10.2%	9.8%	10.4%	10.6%	10.8%	11.0%

Results denoted in red font indicate performance was not met on the established target

Performance calculations completed August 2018

* Measure B.2 Medical Assistance with Smoking and Tobacco Use Cessation has been deferred until a data source is found

APPENDIX B

Alaska Medicaid Program
Quality and Cost Effectiveness Measure
ACCESS | A.1 Children and Adolescents' Access to Primary Care

NUMBER	MEASURE	COHORT	2016 BASELINE	2017 PERFORMANCE	2021 FIVE YEAR GOAL
A.1	Child and Adolescents' Access to Primary Care Practitioners	Age 12-24 mos	87.0%	87.8%	95.7%
		Age 25 mos-6 yrs	77.6%	78.7%	85.4%
		Age 7-11 yrs	82.6%	82.5%	90.9%
		Age 12-19 yrs	83.7%	83.7%	92.1%

Description: Percentage of children 12 months to 19 years who had a visit with a primary care practitioner during the reporting year.
Measure Origin: Centers for Medicare and Medicaid Services (CMS): Core Set of Children's Health Care Quality Measures for Medicaid and CHIP.
Data Source: Medicaid claims data.
Comparable HEDIS Measure: Yes. https://www.ncqa.org/hedis/measures/
Note: This measure is annually reported to CMS and in accordance with CMS reporting requirements, calculations are performed using calendar year data rather than state fiscal year data. All other calculated measures use state fiscal year data.

Alaska Medicaid Program
Quality and Cost Effectiveness Measure
ACCESS | A.2 Ability to Get Appointment With Provider As Needed

NUMBER	MEASURE	COHORT	2016 BASELINE	2017 PERFORMANCE	2021 FIVE YEAR GOAL
A.2	Ability to Get an Appointment for Care As Needed	Age 0-21 yrs	67.2%	71.0%	73.9%
		Age 21+ yrs	60.6%	68.7%	66.7%

Description: Adult's perception of whether they were able to get an appointment as quickly as the adult felt was necessary. Parent's perception of whether they were able to get an appointment for their child as quickly as the parent felt was necessary.
Measure Origin: National Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey.
Data Source: Annual CAHPS Survey.
Comparable HEDIS Measure: No

Alaska Medicaid Program Quality and Cost Effectiveness Measure **BEHAVIORAL HEALTH | B.1 Follow-up After Hospitalization for Mental Illness**					
NUMBER	**MEASURE**	**COHORT**	**2016 BASELINE**	**2017 PERFORMANCE**	**2021 FIVE YEAR GOAL**
B.1	Follow-up After Hospitalization for Mental Illness	Child - Acute	34.3%	43.1%	37.7%
		Child - Psych	36.3%	39.7%	39.9%
		Adult - Acute	40.1%	43.4%	44.1%
		Adult - Psych	41.6%	56.3%	45.8%

Description: Percent of discharges for children ages 6-20 and adults age 21+ years hospitalized for treatment of a mental health diagnosis who had an outpatient visit, intensive outpatient encounter, or partial hospitalization with a mental health practitioner w/in 30 days of discharge.
Measure Origin: CMS: Core Set of Children's Health Care Quality Measures for Medicaid and CHIP; Core Set of Adult Health Care Quality Measures for Medicaid.
Data Source: Medicaid claims data.
Comparable HEDIS Measure: Yes. https://www.ncqa.org/hedis/measures/
Note: ***Acute*** refers to services provided in a non-specialty hospital; ***Psych*** refers to services provided in a psychiatric hospital

Alaska Medicaid Program Quality and Cost Effectiveness Measure **BEHAVIORAL HEALTH | B.3[2] Alcohol and Other Drug Dependence Treatment**					
NUMBER	**MEASURE**	**COHORT**	**2016 BASELINE**	**2017 PERFORMANCE**	**2021 FIVE YEAR GOAL**
B.3	Initiation and Engagement of Alcohol and Other Drug Dependent Treatment	Age 18+ yrs			
		Initiation	31.1%	38.1%	34.2%
		Engagement	15.0%	18.3%	16.5%

Description: Percentage of Medicaid enrollees age 18 and older with a new episode of alcohol or other drug (AOD) dependence who received the following: treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of diagnosis; or initiated treatment and had two or more additional services with a diagnosis of AOD within 30 days of initiating visit.
Measure Origin: CMS: Core Set of Adult Health Care Quality Measures for Medicaid.
Data Source: Medicaid claims data.
Comparable HEDIS Measure: Yes https://www.ncqa.org/hedis/measures/
Note: ***Initiation*** identifies individuals with a new episode of alcohol or other drug dependence who initiated treatment within 14 days of diagnosis. ***Engagement*** identifies individuals who both initiated treatment and engaged in two or more additional services within 30 days of the initial diagnosis.

[2] Measure B.2 Medical Assistance with Smoking and Tobacco Use Cessation was moved to the Potential Futures Measures list

Alaska Medicaid Program Quality and Cost Effectiveness Measure **CHRONIC HEALTH | CH.1 Emergency Department Utilization**					
NUMBER	**MEASURE**	**COHORT**	**2016 BASELINE**	**2017 PERFORMANCE**	**2021 FIVE YEAR GOAL**
CH.1	Emergency Department Utilization (visits per 1,000)	All program enrollees	637.2	727.3	573.5

Description: The number of emergency Department visits per 1,000 Medicaid enrollees.
Measure Origin: Quality and Cost Effectiveness Targets Stakeholder Workgroup.
Data Source: Medicaid claims data.
Comparable HEDIS Measure: No

Alaska Medicaid Program Quality and Cost Effectiveness Measure **CHRONIC HEALTH | CH.2 Diabetic A1C Testing**					
NUMBER	**MEASURE**	**COHORT**	**2016 BASELINE**	**2017 PERFORMANCE**	**2021 FIVE YEAR GOAL**
CH.2	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing	Age 18-64 yrs	63.1%	68.1%	69.4%
		Age 65-75	34.6%	38.2%	38.1%

Description: Percentage of Medicaid enrollees ages 18 to 75 with diabetes (type 1 and type 2) who had a hemoglobin A1c (HbA1c) test during the reporting year.
Measure Origin: CMS: Core Set of Adult Health Care Quality Measures for Medicaid.
Data Source: Medicaid claims data.
Comparable HEDIS Measure: Yes. https://www.ncqa.org/hedis/measures/

Alaska Medicaid Program Quality and Cost Effectiveness Measure **CHRONIC HEALTH | CH.3 Hospital Readmission Within 30 days - All Diagnoses**					
NUMBER	**MEASURE**	**COHORT**	**2016 BASELINE**	**2017 PERFORMANCE**	**2021 FIVE YEAR GOAL**
CH.3	Hospital readmission within 30 days - all diagnoses	Age 18+ yrs			
		Mental illness admits	*On Hold*	*On Hold*	*On Hold*
		All other admits	*On Hold*	*On Hold*	*On Hold*

Description: For Medicaid enrollees age 18 and older, the number of acute inpatient stays during the reporting year that were followed by an unplanned acute readmission for any diagnosis within 30 days.
Measure Origin: CMS: Core Set of Adult Health Care Quality Measures for Medicaid.
Data Source: Medicaid claims data.
Comparable HEDIS Measure: Yes. https://www.ncqa.org/hedis/measures/
Note: Due to persistent anomalies in results calculated for this measure, final performance calculations are on hold until all issues are identified and resolved.

Alaska Medicaid Program
Quality and Cost Effectiveness Measure
COST | C.1 Medicaid Spending Per Enrollee

NUMBER	MEASURE	COHORT	2016 BASELINE	2017 PERFORMANCE	2021 FIVE YEAR GOAL
C.1	Medicaid spending per enrollee	Age 0-21 yrs	$5,828	$6,761	$5,245
		Age 21+ yrs	$10,436	$12,283	$9,392

Description: Consistent with information currently provided, the Department will produce per member and aggregate costs for non-waiver services by service category. Aggregate annual spending per enrollee will be used to measure performance.
Measure Origin: Quality and Cost Effectiveness Targets Stakeholder Workgroup.
Data Source: DHSS Annual Report: MMIS Medicaid Claim Activity, January 24, 2018
Comparable HEDIS Measure: No

Alaska Medicaid Program
Quality and Cost Effectiveness Measure
COST | C.2 Number of Hospitalizations for Chronic Obstructive Pulmonary Disease (COPD)

NUMBER	MEASURE	COHORT	2016 BASELINE	2017 PERFORMANCE	2021 FIVE YEAR GOAL
C.2	Number of hospitalizations for Chronic Obstructive Pulmonary Disease	Age 40-64 yrs	43.8	35.9	39.4
		Age 65+ yrs	69.8	57.9	62.8

Description: Per 100,000 enrollee months, number of hospitalizations due to COPD during the reporting period
Measure Origin: CMS: Core Set of Adult Health Care Quality Measures for Medicaid.
Data Source: Medicaid claims data.
Comparable HEDIS Measure: No
Note: Hospitalizations attributed to COPD as a first, second or third diagnoses are included in the measure.

Alaska Medicaid Program
Quality and Cost Effectiveness Measure
COST | C.3 Number of Hospitalizations Attributed to a Diabetic Condition

NUMBER	MEASURE	COHORT	2016 BASELINE	2017 PERFORMANCE	2021 FIVE YEAR GOAL
C.3	Number of hospitalizations attributed to a diabetic condition	Age 18-64 yrs	22.1	20.2	19.9
		Age 65+ yrs	21.9	13.7	19.7

Description: Per 100,000 enrollee months, number of hospitalizations due to a diabetic condition during reporting period.
Measure Origin: Quality and Cost Effectiveness Targets Stakeholder Workgroup.
Data Source: Medicaid claims data.
Comparable HEDIS Measure: No
Note: Hospitalizations attributed to diabetes as a first, second or third diagnoses are included in the measure.

Alaska Medicaid Program
Quality and Cost Effectiveness Measure
COST | C.4 Number of Hospitalizations Attributed to Congestive Heart Failure

NUMBER	MEASURE	COHORT	2016 BASELINE	2017 PERFORMANCE	2021 FIVE YEAR GOAL
C.4	Number of hospitalizations due to Congestive Heart Failure	Age 18-64 yrs	14.4	15.2	13.0
		Age 65+ yrs	58.9	54.8	53.0

Description: Per 100,000 enrollee months, number of hospitalizations due to Congestive Heart Failure during reporting period.
Measure Origin: Modified CMS: Core Set of Adult Health Care Quality Measures for Medicaid.
Data Source: Medicaid claims data.
Comparable HEDIS Measure: No
Note: Hospitalizations attributed to congestive heart failure as a first, second or third diagnoses are included in the measure.

Alaska Medicaid Program
Quality and Cost Effectiveness Measure
MATERNAL HEALTH | M.1 Live Births Weighing Less Than 2,500 Grams

NUMBER	MEASURE	COHORT	2016 BASELINE	2017 PERFORMANCE	2021 FIVE YEAR GOAL
M.1	Live Births Weighing Less Than 2,500 Grams	All live births within program	6.8%	6.7%	6.1%

Description: Percentage of live births weighing less than 2,500 grams delivered to Medicaid recipients in the state during the reporting period.
Measure Origin: CMS: Core Set of Children's Health Care Quality Measures for Medicaid/CHIP
Data Source: Alaska's Indicator-Based Information System for Public Health Data (IBIS).
Comparable HEDIS Measure: Yes. https://www.ncqa.org/hedis/measures/

Alaska Medicaid Program
Quality and Cost Effectiveness Measure
MATERNAL HEALTH | M.2 Postpartum Care

NUMBER	MEASURE	COHORT	2016 BASELINE	2017 PERFORMANCE	2021 FIVE YEAR GOAL
M.2	Follow-up after delivery	All live births within program	38.8%	40.5%	42.7%

Description: Percentage of women who had live births during the reporting year that also had a postpartum visit on or between 21 and 56 days after delivery.
Measure Origin: CMS: Core Set of Adult Health Care Quality Measures for Medicaid.
Data Source: Medicaid claims data.
Comparable HEDIS Measure: Yes. https://www.ncqa.org/hedis/measures/
Note: Calculated results may be lower than actuals due to differences in the codes providers use to identify these services.

Alaska Medicaid Program
Quality and Cost Effectiveness Measure

MATERNAL HEALTH | M.3 Prenatal Care During First Trimester

NUMBER	MEASURE	COHORT	2016 BASELINE	2017 PERFORMANCE	2021 FIVE YEAR GOAL
M.3	Prenatal Care During First Trimester	All live births within program	77.9%	80.6%	85.7%

Description: Percentage of newborns whose mothers had a prenatal visit during first trimester.
Measure Origin: CMS: Core Set of Children's Health Care Quality Measures for Medicaid/CHIP
Data Source: Medicaid claims data.
Comparable HEDIS Measure: Yes. https://www.ncqa.org/hedis/measures/
Note: Calculated results may be lower than actuals due to differences in the codes providers use to identify these services.

Alaska Medicaid Program
Quality and Cost Effectiveness Measure

PREVENTIVE HEALTH | P.1 Childhood Immunization Status

NUMBER	MEASURE	COHORT	2016 BASELINE	2017 PERFORMANCE	2021 FIVE YEAR GOAL
P.1	Childhood Immunization Status	Age 0-24 mos	59.5%	62.7%	65.5%

Description: Percentage of children in the Alaska Medicaid program age 0-24 months receiving recommended immunizations for age.
Measure Origin: Quality and Cost Effectiveness Targets Stakeholder Workgroup.
Data Source: VacTrAK Immunization Registry of Alaska.
Comparable HEDIS Measure: No

Alaska Medicaid Program
Quality and Cost Effectiveness Measure

PREVENTIVE HEALTH | P.2 Well-Child Visits for Children 0-6 by Age

NUMBER	MEASURE	COHORT	2016 BASELINE	2017 PERFORMANCE	2021 FIVE YEAR GOAL
P.2	Average Number of Well Child Visits by Age	Second yr of life	1.53	2.04	1.68
		Third yr of life	0.61	0.89	0.67
		Fourth yr of life	0.55	0.55	0.61
		Fifth yr of life	0.60	0.57	0.66
		Sixth yr of life	0.16	0.54	0.18

Description: Average number of well child visits during the reporting period, reported by age for children ages 0 to 6.
Measure Origin: Modified CMS: Core Set of Child Health Care Quality Measures for Medicaid.
Data Source: Medicaid claims data.
Comparable HEDIS Measure: No
Notes: The workgroup acknowledges that children may be seen more frequently by a provider but that the Medicaid claim submitted by the provider could reflect a purpose separate from a well-child visit. The workgroup's recommendation is to specifically monitor those visits focused on wellness of the child as a means to evaluate opportunities for early detection of adverse health conditions.

Alaska Medicaid Program
Quality and Cost Effectiveness Measure
PREVENTIVE HEALTH | P.3 Developmental Screening in the First Three Years of Life

NUMBER	MEASURE	COHORT	2016 BASELINE	2017 PERFORMANCE	2021 FIVE YEAR GOAL
P.3	Developmental Screening in First Three Years of Life	First yr of life	12.9%	13.1%	14.2%
		Second yr of life	10.6%	9.3%	11.7%
		Third yr of life	5.9%	6.3%	6.5%
		Ages 0-3 combined	10.0%	9.8%	11.0%

Description: Percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding their first, second, or third birthday.

Measure Origin: Modified CMS: Core Set of Children's Health Care Quality Measures for Medicaid and CHIP.

Data Source: Medicaid claims data.

Comparable HEDIS Measure: No

Notes: The workgroup's desire is to assess the frequency of any developmental screen performed on the child and acknowledges that CMS Core reporting will report on the subset of CMS identified screens as a more narrow focus that reflects national interests.

APPENDIX C

Milliman Client Report

Alaska Medicaid Quality Measures

Documentation of Peer Review

State of Alaska

Department of Health and Social Services

Date: September 27, 2018

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I. BACKGROUND

Milliman, Inc. (Milliman) has been retained by the State of Alaska Department of Health and Social Services (DHSS) to provide actuarial and consulting services related to the State of Alaska's Medicaid Payment Reform, including the Innovative Payment Reform Models. DHSS has been working to select Quality and Cost Effectiveness indicators intended to monitor effectiveness of the state Medicaid program. The intent of these measures is to provide an annual snapshot of program performance across several domains including quality, access, and cost. Since October 2016, DHSS has convened the Medicaid Redesign Quality and Cost Effectiveness Targets Stakeholder Workgroup (Workgroup) to select and prioritize measures, and to establish annual targets for the next state fiscal year (SFY). Once the measures are established, annual targets will be set to promote growth toward higher levels of program quality, performance and cost effectiveness.

Milliman provided a report delivered on June 9, 2017 to DHSS documenting the calculation of several quality measures selected by the Workgroup for the SFY 2015 and SFY 2016 experience period. The report was updated on June 30, 2017 in response to input from the Workgroup. Over the past several months, DHSS has been working on internal calculations for a subset of the initial measures to establish baseline levels for the SFY 2017 experience period. Milliman was requested to review DHSS methodology and compare DHSS and Milliman results of the five quality measures for reasonableness. The remainder of this report documents our review of DHSS developed quality measure calculations.

II. EXECUTIVE SUMMARY

Exhibit 1 documents a list of five quality measures that DHSS has chosen for which baseline levels will be established. Annual targets for each measure will be determined with the intent to promote growth toward higher levels of program quality, performance and cost effectiveness. DHSS has calculated and shared SFY 2016 and SFY 2017 results for the selected five quality measures. Additionally, DHSS has provided their detailed methodology used to calculate each of the quality measures.

Exhibit 1: List of Calculated Measures

No.	Category	Measure	Source
B.1	Behavioral	Follow-Up After Hospitalization for Mental Illness	CMS Child & Adult Core Measure Set
B.3	Behavioral	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	CMS Adult Core Measure Set
CH.2	Chronic	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing	CMS Adult Core Measure Set
CH.3	Chronic	Hospital readmission w/in 30 days - all diagnoses - exclude or create separate measure for mental illness	CMS Adult Core Measure Set
C.2	Cost	Number of hospitalizations for Chronic Obstructive Pulmonary Disease	CMS Adult Core Measure Set MEASURE PQI05-AD: PQI 05

Appendix A provides the technical specifications from the Core Measure Set for each of the five measures included in this analysis. We have reviewed DHSS' detailed methodology in relation to the technical specifications included in the Centers for Medicare and Medicaid Services (CMS) published Medicaid and CHIP Core Set of Health Care Quality Measures (Core Measure Set) for Children and Adults[1]. We have also independently calculated the SFY 2016 and SFY 2017 results for each of the quality measures following the technical specifications from the Core Measure Set. DHSS results were compared to our independent findings and reviewed for reasonability. We have noted some differences between DHSS and Milliman results. However, these differences may be attributable to the varying levels of claims availability and application of exclusion logic between the two calculations. DHSS utilized claims paid through the end of August 2018 for all claims transactions (e.g. paid and denied) whereas we have only received paid data through March 2018. DHSS was also able to incorporate additional exclusion logic to better follow the Core Measure Set technical specifications utilizing fields that were unavailable in the dataset provided to Milliman.

Based on our review of DHSS methodology and the comparison of DHSS results relative to our independent analysis, we believe that DHSS has established a reasonable methodology to both establish baseline levels for each of the quality measures and track progress towards DHSS goals over time.

Please note that it is critical to maintain consistency in coding methodology when calculating quality measures over time. If discrepancies occur between DHSS methodology and the technical specifications, it still may be appropriate to track results over time on the condition that the methodology remains consistent from year to year. Due to the small sample size that some of the quality measures represent, it may be difficult to associate a change with program quality versus general fluctuation from one year to the next.

[1] https://www.medicaid.gov/medicaid/quality-of-care/downloads/medicaid-and-chip-child-core-set-manual.pdf
https://www.medicaid.gov/medicaid/quality-of-care/downloads/medicaid-adult-core-set-manual.pdf

III. METHODOLOGY

We have reviewed DHSS' detailed methodology in relation to the technical specifications documented in Appendix A. Additionally, we compared DHSS' quality measure calculation results relative to our independent analysis. In particular, we reviewed DHSS' methodology used and results separately for the numerator, denominator, and rate for each of the quality measures calculated for SFY 2016 and SFY 2017. The following describes the definitions for the metrics reviewed:

- **Numerator –** The number of unique beneficiaries who are both eligible for the measure and receive the appropriate procedure as described in the technical specifications.
- **Denominator –** The number of unique beneficiaries eligible for the measure. The measures may limit the eligible population by age or other criteria such as a maternity delivery. For many of the measures, the technical specifications outline continuous enrollment requirements to be eligible for the measure.
- **Rate –** The numerator divided by the denominator. The rate can represent many different things, including percentages, ratios, means, medians, and counts. We have provided the measure description, which defines the rate being illustrated, for each of the quality measures listed in Appendix A.

We used SFY 2016 (July 1, 2015 through June 30, 2016) and SFY 2017 (July 1, 2016 through June 30, 2017) eligibility data and incurred claims data paid through March 31, 2018 to calculate each quality measure. As a result, the rates illustrated for SFY 2017 may be impacted because of the use of incomplete claims data.

The data received from DHSS did not include populated information for the admit source or the patient status code. Both of these fields are utilized to exclude certain claims from the quality measure numerator and/or denominator based on the technical specifications in Appendix A.

State-Specific Methodology

The following describes the state-specific methodology that was used in conjunction with the Core Measure Set technical specifications to calculate the requested quality measures. Please note that we adjusted the measurement period prescribed for each quality measure by the Core Measure Set to line up with Alaska's state fiscal year.

- **B.1: Follow-Up After Hospitalization for Mental Illness:** We have illustrated this measure for 30-day follow-up visits separately for both acute and psychiatric inpatient hospitals. For purposes of this analysis, we defined inpatient hospital claims as those with billing provider type code = '001', '002' (psychiatric), or '005' and place of service codes '21', '23', '51', or '56'. For the mental health follow-up visits, we defined a qualifying mental health practitioner as provider type '008','020','042','105','107', or '108' and place of service '51','52','53','55','56', or '57'.

- **B.3 Initiation and Engagement of Alcohol and Other Drug Dependence Treatment:** We have solely relied upon the CMS technical specifications and the corresponding value sets for purposes of this analysis.

- **CH.2 Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing:** We have solely relied upon the CMS technical specifications and the corresponding value sets for purposes of this analysis.

- **CH.3 Hospital Readmission w/in 30 Days - All Diagnoses:** We have illustrated this measure separately for mental illness readmissions and all other readmissions. We have defined a mental illness readmission as a readmission where the anchor discharge occurred at a psychiatric inpatient hospital (identified as billing provider type code = '002' for this analysis).

- **C.2 Number of hospitalizations for Chronic Obstructive Pulmonary Disease:** For purposes of this analysis, we defined inpatient hospital claims as those with billing provider type code = '001', '002', or '005'. Additionally, we excluded maternity delivery claims (MS-DRG = '765','766 ','767 ','768 ','774 ', or '775') from this analysis.

IV. LIMITATIONS

The services provided for this correspondence were performed under the signed contract between Milliman and the State of Alaska, Department of Health and Social Services approved October 27, 2016 and amended effective July 1, 2018.

This report has been prepared solely for the internal business use of and is only to be relied upon by the Alaska, Department of Health and Social Services, related Divisions, and their advisors. No portion of this report may be provided to any other party without Milliman's prior written consent. Milliman does not intend to benefit or create a legal duty to any third party recipient of its work.

In performing this analysis, we relied on data and other information provided by Alaska, Department of Health and Social Services, related Divisions, and their advisors. We have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete.

We performed a limited review of the data used directly in our analysis for reasonableness and consistency and have not found material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of our assignment.

Differences between our projections and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is certain that actual experience will not conform exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that actual experience deviates from expected experience.

Qualifications:
Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. Jeremy Cunningham is a member of the American Academy of Actuaries, and he meets the qualification standards for performing the analyses in this report.

APPENDIX D

POTENTIAL FUTURE MEASURES RECOMMENDED BY MEDICAID REDESIGN QUALITY AND COST EFFECTIVENESS TARGETS STAKEHOLDER WORKGROUP

The Medicaid Redesign Quality and Cost Effectiveness Targets Stakeholder Workgroup requests that the Department of Health and Social Services adopt the following Medicaid program performance measures as soon as possible following elimination of program impediments:

AFTER PASSAGE OF PREVENTIVE SERVICES REGULATIONS

- Child /Adolescent Major Depressive Disorder: Suicide Risk Assessment
- Chlamydia Screening in Women
- HIV Screening - All Ages
- Breast Cancer Screening (BCS)
- Cervical Cancer Screening (CCS)
- Mammogram Screening
- Colorectal Cancer Screening
- LDL-C Screening
- Flu Vaccinations for Adults Age 18 and Older (FVA)
- Flu Vaccinations for Children Age 18 and Under
- HPV Vaccinations for Children Age 18 and Under
- Pneumonia Vaccine for Older Adults
- Alcohol Screening in Pregnant Women
- HIV Screening - Pregnant Women
- Diabetes Care - Eye Exam
- Diabetes Care - LDL Assessment
- Diabetes Care - Screening for Nephropathy
- Hypertension - Screening for Nephropathy
- Nephropathy - Screening for Nephropathy
- Heart Failure - Screening for Nephropathy

AFTER CONSISTENT DATA SOURCE IS IDENTIFIED

- Child /Adolescent Major Depressive Disorder: Suicide Risk Assessment
- Screening for Clinical Depression and Follow-Up Plan (CDF)
- Body Mass Index Assessment (ABA) for Adults
- Body Mass Index Assessment (ABA) for Children/Adolescents
- Behavioral Health Risk Assessment for Pregnant Women (BHRA)
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents
- Controlling High Blood Pressure
- Percent of Adult Medicaid Recipients that Smoke
- Medication Management for People with Asthma
- Annual cost of Medicaid per member vs annual cost of Private/Exchange premium
- Adherence to HIV Viral Load Suppression Therapy
- B.2 - Medical Assistance with Tobacco Use and Cessation Assistance