Interim Medicaid Review Panel

October 21, 2024

IDAHO DEPARTMENT OF HEALTH & WELFARE

Agenda

- Medicaid Contracts Overview
- Idaho Behavioral Health Plan Updates
- Healthy Connections Value Care Performance Year 2 and Additional Updates

Medicaid Contracts

Medicaid Contracts

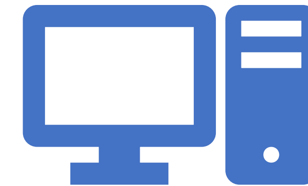
Idaho Medicaid contracts with vendors to support critical functions and provide expertise outside of agency staff. This allows the division to obtain needed resources and knowledge without hiring additional state staff.

All contracts are managed by Medicaid staff; department contract staff; and for some, the Department of Administration.

Types of Medicaid Contracts

Administrative Functions

Managed Care Contracts



Medicaid Management Information Systems

Administrative Contracts

Contract Name	Description	Annual Dollar Amount Most Recent Contract Amendment	Current Status
Telligen	Provide utilization management and case management support to Idaho Medicaid through contracted clinical staff.	$3,840,000	Contract from 2023 through 2027.
Liberty	Assessments for youth and adults for disability and mental health services and supports.	$11,040,000	Contract from 2016 to 2024.
Myers & Stauffer	Accounting, auditing, and provider reimbursement review services.	$4,610,533	Three contracts ranging from 2019 through 2027.
Health Management System Inc.	Third Party Liability and recovery services.	$2,277,833	Contract from 2019 through 2024.
National Vision Administrators	Vision services administrator.	$2,200,000	Contract from 2022 through 2025.

Administrative Contracts

Contract Name	Description	Annual Dollar Amount Most Recent Contract Amendment	Status
Milliman	Actuarial services for managed care and value care contracts.	$1,686,554	Contract from 2022 through 2025.
Rise Inc.	Compliance support for Certified Family Homes providing residential habilitation, often for family members with intellectual or developmental disabilities.	$1,404,000	Contract from 2021 through 2024.
Pennsylvania State University	Federally mandated evaluation of the 1115 Behavioral Health Transformation Waiver.	$210,432	Contract from 2021 through 2027.
Datastat	Federally mandated Consumer Assessment of Healthcare Providers and Systems. This is an annual review of consumer data on healthcare experience and access.	$80,320	Annual contract.

Administrative Contracts

Contract Name	Description	Annual Dollar Amount- Most Recent Contract Amendment	Status
Center for Evidence-Based Policy	Supports the Department to more efficiently manage its pharmacy program; support medical program benefit decisions; and inform the development of coverage policy to contain costs and support high-value, prevention-oriented services.	$301,650	Contract from 2022 through 2024.
Human Services Research Institute	Required contract to support work to develop a new adult developmental disabilities resource allocation model as part of the KW Settlement Agreement.	$63,370	Contract from 2016 through 2024.
Rathbone Falvey Research	Federally mandated independent assessment of all 1915(b) managed care waivers.	$71,000	Contract from 2023 through 2027.

Medicaid Management Information System Contracts

Contract Name	Description	Annual Dollar Amount- Most Recent Contract Amendment	Status
Gainwell Technologies	Claims and provider enrollment vendor.	$26,511,758	Contract from 2018 through 2025.
International Business Machines (IBM)	Data warehouse for all Medicaid claims data; supports required federal reporting and some data analytics.	$3,864,263	Contract from 2018 through 2026.
Prime Therapeutics	Pharmacy Benefit Administrator (not manager).	$3,697,843	Contract from 2018 through 2025.
CSG Government Solutions	Technical assistance and project management for MMIS procurement	$6.2M in FY2025; $7.7M in FY2026	Contract through 2031.
NTT Data	Technical assistance over system integration for MMIS procurement.	$2.1M in FY2025; $2.0M in FY2026	Contract through 2031.

Managed Care Contracts

Contract Name	Description	Annual Dollar Amount- Most Recent Contract Amendment	Status
Blue Cross of Idaho	Idaho Medicaid Plus (IMPlus) and Medicare Medicaid Coordinated Plans (MMCP) serving primarily older adults who have Medicare and Medicaid.	$286,851,513	Annual agreements. Going through procurement now for contract launch in January 2026.
Molina	Idaho Medicaid Plus (IMPlus) and Medicare Medicaid Coordinated Plans (MMCP) serving primarily older adults who have Medicare and Medicaid.	$194,285,833	Annual agreements. Going through procurement now for contract launch in January 2026.
Magellan	Behavioral health services.	$507,250,988	5-year contract including lead up. Terminates in 2028.

Contract Name	Description	Annual Dollar Amount- Most Recent Contract Amendment	Status
MCNA	Routine, preventative, and emergency dental care.	$82,500,000	9th amendment of contract starting in 2016. Procurement scheduled for 2025 with launch in 2026.
MTM	Non-emergency medical Transportation.	$45,405,266	Contract from 2023 to 2027.

Idaho Behavioral Health Plan Updates

New Idaho Behavioral Health System of Care

- Brought together a historically fragmented system under one contractor to better coordinate services and work with behavioral health providers across the state.
  - Inpatient, outpatient, and residential-level of care all under Magellan.
  - Services historically provided by DHW Division of Behavioral Health now contracted to community providers through Magellan.
- Improved access to prevention-oriented and intensive community-based services to support individuals to receive service at the appropriate level of care vs. overuse of emergency department visits or higher levels of care.
- Focus on partnership and collaboration between Magellan and DHW to build out provider capacity and the behavioral health workforce.

Go-Live

Contract went live on 7/1/24.

DHW staff and Magellan met daily in person to work through anticipated bumps during start of new contract.

Launched prevention-oriented services across the state.

Example: Assertive Community Treatment which keeps adults with serious mental illness out of the hospital and in the community.

Majority of service coordination successfully executed.

Contract Requirements for Provider Payment

- Magellan must pay providers for clean claims in a timely manner.
  - 95% of clean claims within 30 days or pay the state liquidated damaged of $15,000 for each percentage point beneath
  - 99% of clean claims within 90 days
  - Must escalate any claim denial trends to us in writing within 48 hours
- Magellan must support providers to get their systems and operational policies to submit claims.
  - Daily technical assistance; live and recorded trainings; multiple full-time claims resolution specialists
- Anticipated provider challenges during go-live and ongoing
  - Paper checks for first 60 days following national data breech.
  - Learning new Magellan systems and sorting through billing requirements.

Compliance and DHW Action

Management letter sent to Magellan on August 16, 2024 called for them to address:

Clarity of letters to participants and other clinical administration

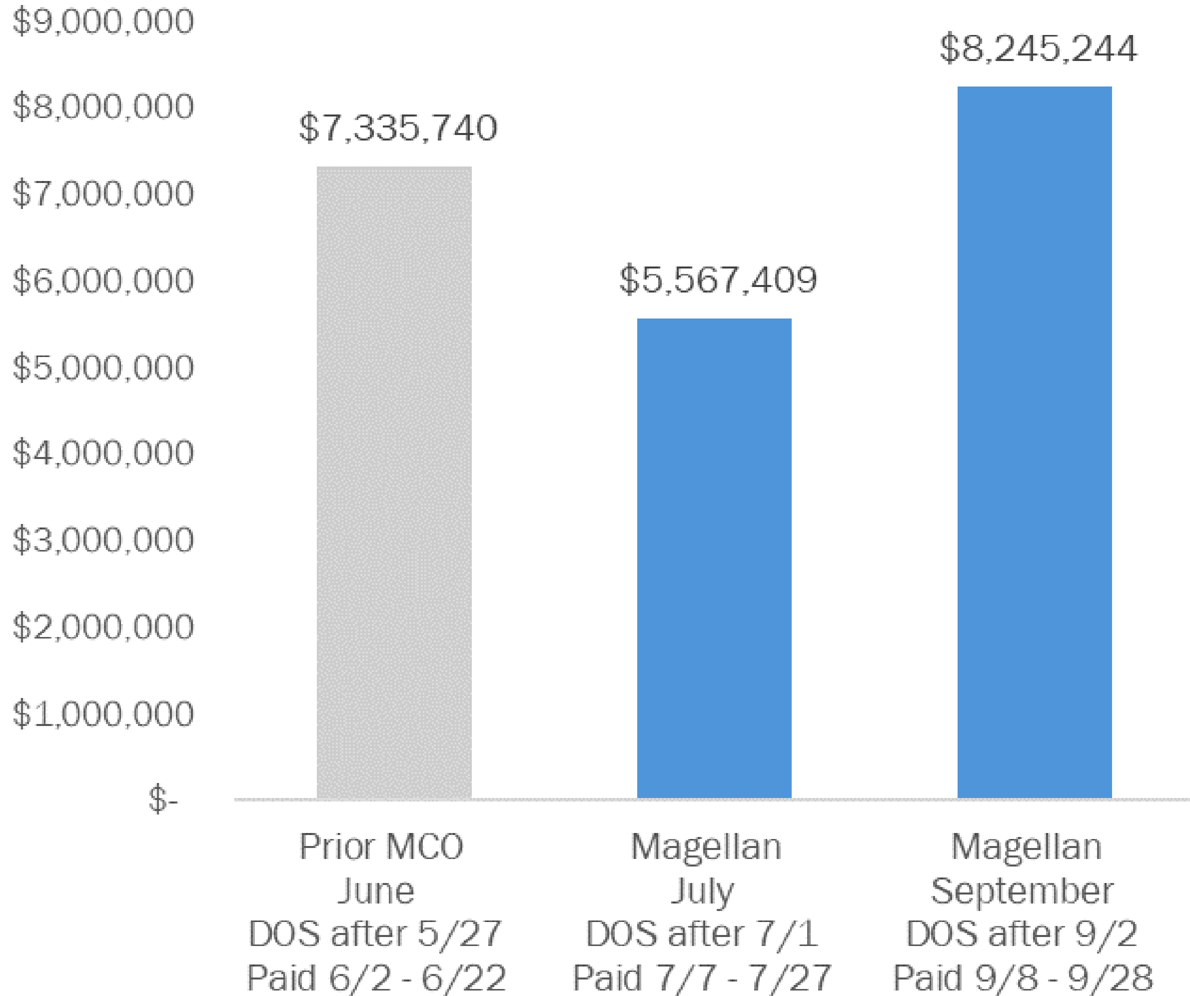
Care coordination

Follow up on specific provider's claims processing issues

Resolution to most issues completed by September 2024.

Continue to work through care coordination challenges and individual provider issues such as double billing and using incorrect billing modifiers.

Magellan Processing Payments Efficiently



- Smoother roll out of claims processing compared to go-live with last IBHP contract.
- Magellan is processing payments more efficiently now than the previous MCO did at full capacity at the end of their contract in June.
- Comparison using same service array.

Provider Experience Still Varies

	Billed by Month							
Provider Name	Jul	Aug	Sep	Oct 1 - 17	Total Sum of Billed	Denied Amount	Total Sum of PAIDAMT	% Paid to Billed Total
FQHC 1	$3,351	$6,415	$10,336	$898	$21,001	$11,705	$4,942	22%
FQHC 2	$3,072	$13,643	$27,593	$7,923	$52,231	$1,755	$48,020	90%
FQHC 3		$195,397	$120,173	$65,447	$381,017	$10,229	$188,035	48%
FQHC 4			$174	$9,604	$9,778	$0	$8,345	85%
FQHC 5	$4,012	$132,996	$66,903	$39,613	$243,525	$14,219	$217,801	85%
FQHC 6	$127,845	$164,603	$171,434	$139,733	$603,615	$147,457	$259,461	42%
FQHC 7	$44,558	$151,600	$109,410	$66,384	$371,952	$58,914	$170,775	45%
FQHC 8		$33,284	$255,207	$52,951	$341,442	$9,193	$226,830	65%
FQHC 9		$204,358	$399,942	$153,610	$757,910	$194,261	$465,014	59%
FQHC 10	$1,267	$1,031,061	$587,083	$340,513	$1,959,924	$325,849	$1,494,989	75%
FQHC 11		$646	$185,095	$138,639	$324,379	$74,111	$121,281	36%
FQHC 12		$14,922	$464,224	$85,389	$564,535	$30,051	$416,301	74%
FQHC 13	$14,380	$70,463	$23,008	$5,033	$112,885	$56,082	$42,421	38%
FQHC 14	$21,155	$398,987	$545,550	$280,315	$1,246,007	$364,260	$494,247	39%
FQHC 15	$30	$43,300	$41,895	$20,944	$106,169	$9,403	$92,789	81%

Healthy Connections Value Care Performance Year 2 and Additional Updates

Goal – Expand Value Based Payments

- Meet targeted quality measures with the goal of improving health outcomes
- Stabilize and control Medicaid spending
- Collaborate with providers across the state to build a more accountable Medicaid program

House Bill 351[1] Signed
Establish value-based payment methods for inpatient and outpatient hospital services

3/2020

Initial implementation
5 VCOs contracted, covering 80,000 Medicaid lives.
(*postponed due to pandemic*)

7/2020

SPA: 21-0002 submitted

6/2021

CMS approved SPA: 21-0001
Modify the case management reimbursement and structure for the PCCM program (Healthy Connections) and align it with HCVC.

Healthy Connections[2] Primary Care Program restructured
Required participation in VCO through Tier addendum[3]

Healthy Connections Value Care Program Implemented
Upside only in PY1 or shared savings and downside risk

11 VCOs contracted, covering 242,648 Medicaid lives

7/2021

Start PY1

1/2022

[1] https://legislature.idaho.gov/wp-content/uploads/sessioninfo/2020/legislation/H0351.pdf
[2] https://adminrules.idaho.gov/rules/current/16/160309.pdf#page61
[3] https://healthandwelfare.idaho.gov/providers/idaho-medicaid-providers/healthy-connections-and-healthy-connections-value-care

Timeline

PY3 contracts signed
VCO required to take downside risk
Quality Performance Program expanded

End PY1
Start PY2

PY2 contracts signed
Expansion population included

9/2022

1/2023

9/2023

Timeline

PY1
Settlement Payments processed

End PY2

Start PY3

PY2 claims runout end
Start of Performance Year 2 evaluation

PY4 contracts signed
VCO required to take downside risk
Quality Performance Program updated

PY2 Settlements Final

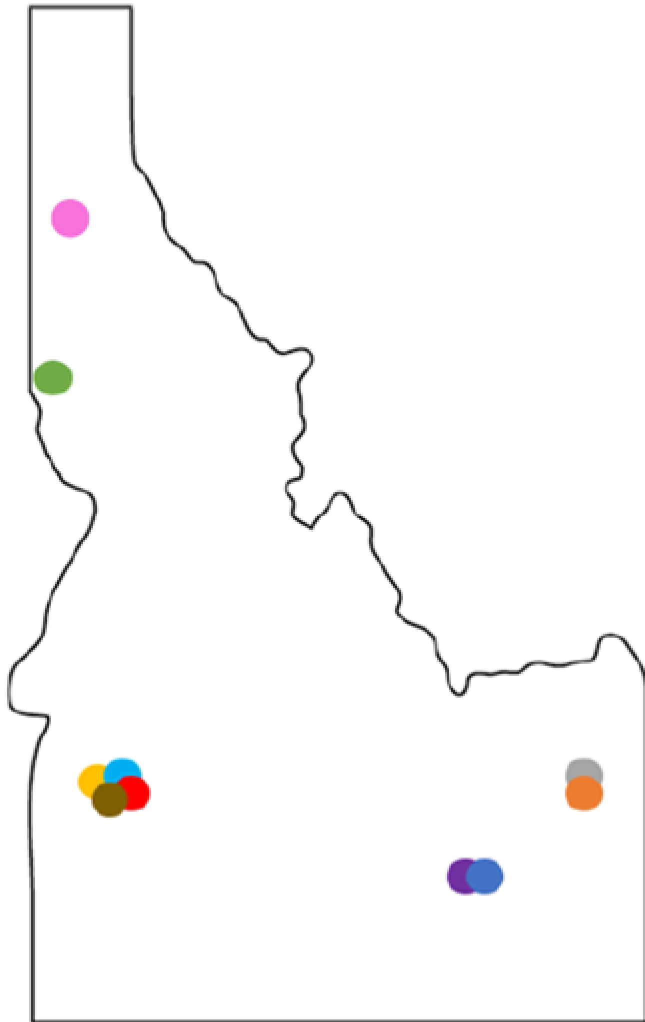
1/1/2024

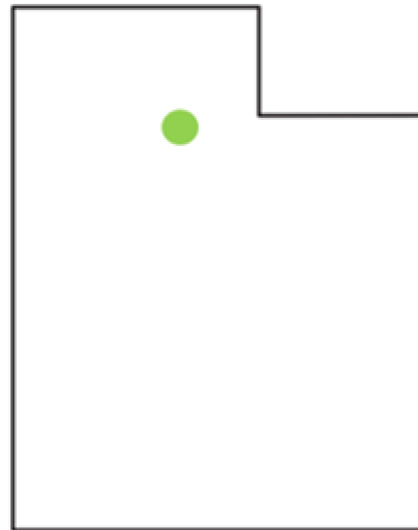
6/30/2024

9/1/2024

12/2024

Value Care Organizations





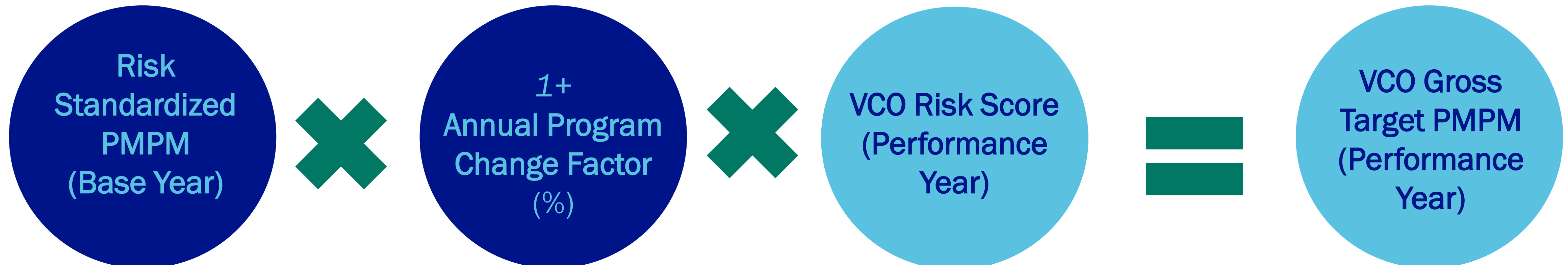
VCO	# of Members *(based on PY2 attribution)*
Boise	
● Community Health Center Network of Idaho	48,245
● Alliance Medical Group, LLC (Primary Health)	11,017
● Saint Alphonsus Health Alliance	36,506
● St. Luke's Health Partners	110,841
Lewiston	
● Advantage Point Health Alliance	11,040
Idaho Falls	
● Mountain View Network	16,643
● The Pediatric Center *(PY1&PY2 only)*	6,055
Pocatello	
● Patient Quality Alliance	7,597
● Pocatello Children's Clinic	7,607
Coeur D'Alene	
● Kootenai Value Care, LLC	21,450
Salt Lake City, UT	
● Castell, LLC *(PY1, PY2 & PY3 only)*	16,797

Total Cost of Care

- **VCOs held accountable for meeting quality and cost targets for attributed members** (≥7 months with VCO)
- **Each VCO has a unique target cost based on the complexity of their attributed population** (both utilization and severity of illness)
  - VCOs exceeding target cost (per member per month cost) are held responsible for a share of excess spending based on the risk level selected
  - VCOs that keep costs below target cost AND meet quality targets, can share in savings based on the risk level selected
- **Excluded costs:**
  - Healthy Connections Case Management Payment,
  - Managed Care Products (outpatient behavioral health, dental, non-emergent medical transportation)
  - Pharmacy
  - Nursing Home & Intermediate Care Facilities
  - Long-term Supports & Services
  - Home & Community Based
  - Outliers (Large Claim Threshold $100,000)
- **Excluded Participants:** Dual eligible participants (Medicaid & Medicare)

Total Cost of Care

- Calculated using:
  - Statewide Risk Standardized Per Member Per Month cost (PMPM) for Base Year
  - Annual Program Change Factor
    - Typically based on trend and used to drive costs down. This factor was negotiated with VCOs.
  - Milliman Advanced Risk Adjusters (MARA) Risk Score for VCO for Performance Year
    - A risk score tool using participant medical history to predict healthcare cost risk
    - Accounts for severity of disease/complexity and utilization of the VCO population during the performance year
    - Calculated 6 months AFTER end of Performance Year, to account for claims runout



PY1 & PY2 Contract Terms

Term	Year 1 (CY2022)	Year 2 (CY2023)
Population	Legacy	Legacy + Expansion
Base Year	SFY 2019	SFY 2021
Quality Measures	6 Mandatory measures	6 Mandatory measures
Risk level	5% upside only - 80%	5% upside only - 80%
Statewide Risk Standardized PMPM	$155.07	$148.00 Negotiated
Annual Program Change Factor	0%	0%

PY1 & PY2 Risk Level Selection

VCO Alias	PY1 Risk	PY2 Risk
VCO A	80%	Upside only 5%
VCO B	50%	Upside only 5%
VCO C	40%	Upside only 5%
VCO D	35%	80%
VCO E	25%	25%
VCO F	25%	Upside only 5%
VCO G	Upside only 5%	Upside only 5%
VCO H	Upside only 5%	Upside only 5%
VCO I	Upside only 5%	Upside only 5%
VCO J	Upside only 5%	Upside only 5%
VCO K	Upside only 5%	Upside only 5%

Performance Year 2 Results

Caveat: *Performance Year 2 results are preliminary. VCOs have 45 days to review the draft settlement report which was provided October 7th, 2024. Draft settlement will become final when:*

1. *The Department has received written acceptance from the VCO, or*
2. *45 days have passed from final distribution of PY2 settlement reports, and the Department has not received any written acceptance or dispute from VCOs, or*
3. *Any objection raised by the VCO is finally resolved.*

Preliminary Performance Year 2 – VCO Results

VCO Alias	VCO Gross Target PMPM	PY2 Actual Cost PMPM	Gross Savings/ (Loss) PMPM	VCO Risk Sharing Level Selection	Quality Performance Program Adjustment	Net Distributable Savings\(Loss) Total
VCO A	$ 281.65	$ 261.65	$ 20.00	Upside Only-5%	75%	$898,926
VCO B	$ 295.62	$ 272.49	$ 23.13	Upside Only – 5%	75%	$102,480
VCO C	$ 262.56	$ 247.54	$ 15.02	Upside Only - 5%	75%	$102,536
VCO D	$ 236.37	$ 214.37	$ 22.00	Symmetrical – 80%	100%	$2,085,607
VCO E	$ 164.16	$ 158.79	$ 5.37	Symmetrical – 25%	100%	$114,238
VCO F	$ 213.92	$ 196.32	$ 17.60	Upside Only - 5%	100%	$203,758
VCO G	$ 335.74	$ 333.68	$ 0.00	Upside Only - 5%	75%	$0
VCO H	$ 246.14	$ 228.06	$ 18.08	Upside Only- 5%	75%	$268,308
VCO I	$ 316.90	$ 303.67	$ 13.23	Upside Only – 5%	75%	$40,962
VCO J	$ 180.33	$ 200.63	$ (20.30)	Upside Only – 5%	50%	$0
VCO K	$ 357.97	$ 366.03	$ (8.06)	Upside Only - 5%	75%	$0

Net Distributable Savings for PY2 (Payout to VCOs)= $3,816,814 or .0008 % of Medicaid budget

PY1 & PY2 Quality Performance Program

	Healthy Connections Quality Measures PY1+2
1	**DIABETES HBA1C TEST** indicates the percentage of patients with type 1 or type 2 diabetes, aged 18 to 75 years, who had an HbA1c test done.
2	**HEDIS W30 Well Visit GT 5 in first fifteen (15) months** indicates the percentage of children, during their first 15 months of life, who had six or more well-child visits with a primary care practitioner.
3	**HEDIS WCV WELL CARE PCP VISITS ADOLESCENTS** indicates the percentage of adolescents, aged 3-21 years, who had at least one comprehensive well-care visit with a primary care physician (PCP) or a gynecologist during the measurement year.
4	**HEDIS BCS BREAST CANCER SCREENING** indicates the percentage of women, aged 52 to 74 years at the end of the measurement period, who had a mammogram done during a twenty-seven (27)- month measurement period.
5	**AMBULATORY CARE EMERGENCY DEPT VISITS** Calculates the number of emergency department (ED) visits per one thousand (1,000) enrolled months.
6	**READMISSIONS WITHIN 30 DAYS AGE 18 TO 64** Calculates the percentage of acute inpatient stays during the reporting time period, for Participants aged 18 to 64, that were followed by an acute readmission for any diagnosis, excluding pregnancy-related stays, within thirty (30) days of discharge.

Payment Distribution

# Applicable Measures	# Measures Target Met	Savings Payout
6	6	100%
6	5	100%
6	4	100%
6	3	75%
6	2	50%
6	1	25%
6	0	0%

Performance Year 2 Quality Measures

- **All** VCOs met at least one target
- **2** VCOs met at least 4 out of 6 quality measure targets and **1** VCO met 2 out of 3 targets*. These 3 VCOs qualified for a **100%** quality adjustment if savings were achieved.
- **53%** of quality measures saw improvement compared to the baseline

*Two VCOs are pediatric only and worked on 3 quality measures

PY2 Quality: ED Utilization

Performance Year 2 Results vs Target

Full Period with 6 Months Runout for Dates of Service Ended - December 31, 2023

Emergency Department Utilization per 1,000 Member Months

VCO Alias	Target	Difference ..
VCO A	Not Met	-3.81
VCO B	Not Met	-6.34
VCO C	Not Met	-3.39
VCO D	Not Met	-0.58
VCO E	Met	10.48
VCO F	Met	3.90
VCO G	Not Met	-3.81
VCO H	Not Met	-3.86
VCO I	Not Met	-4.88
VCO J	Met	5.69
VCO K	Not Met	-5.09

PY2 Quality: 30 Day Readmission

Performance Year 2 Results vs Target

Full Period with 6 Months Runout for Dates of Service Ended - December 31, 2023

30 Day Readmission Rates for Ages 18 to 64

VCO Alias	Target	Difference
VCO A	Not Met	-1.7%
VCO B	Not Met	-4.0%
VCO C	Met	0.5%
VCO D	Met	4.4%
VCO F	Met	4.3%
VCO G	Not Met	-2.2%
VCO H	Met	1.4%
VCO I	Not Met	-2.6%
VCO K	Met	1.2%

PY2 Quality: Breast Cancer Screening

Performance Year 2 Results vs Target

Full Period with 6 Months Runout for Dates of Service Ended - December 31, 2023

Breast Cancer Screening

VCO Alias	Target	Difference
VCO A	Met	3.7%
VCO B	Met	11.9%
VCO C	Met	8.0%
VCO D	Met	9.8%
VCO F	Met	10.1%
VCO G	Met	0.7%
VCO H	Not Met	-1.4%
VCO I	Met	3.2%
VCO K	Met	11.5%

Statewide Target: 63.77%

0.0% 10.0% 20.0% 30.0% 40.0% 50.0% 60.0% 70.0%

PY2 Quality: Diabetes Testing

Performance Year 2 Results vs Target

Full Period with 6 Months Runout for Dates of Service Ended - December 31, 2023

Diabetes HbA1c Testing

VCO Alias	Target	Difference
VCO A	Not Met	-4.9%
VCO B	Not Met	-4.2%
VCO C	Not Met	-2.3%
VCO D	Met	2.1%
VCO F	Not Met	-4.0%
VCO G	Not Met	-7.3%
VCO H	Not Met	-1.3%
VCO I	Met	0.0%
VCO K	Not Met	-3.4%

PY2 Quality: Wellness Visits first 15 Months

Performance Year 2 Results vs Target

Full Period with 6 Months Runout for Dates of Service Ended - December 31, 2023

Wellness Visits (first 15 months of life, six or more well-child visits)

VCO Alias	Target	Difference
VCO A	Met	2.1%
VCO B	Met	1.3%
VCO C	Not Met	-1.7%
VCO D	Not Met	-5.6%
VCO E	Met	5.0%
VCO F	Met	0.7%
VCO G	Met	6.4%
VCO H	Met	4.4%
VCO I	Not Met	-5.2%
VCO J	Not Met	-8.1%
VCO K	Not Met	-3.3%

PY2 Quality: Wellness Visits Adolescents

Performance Year 2 Results vs Target

Full Period with 6 Months Runout for Dates of Service Ended - December 31, 2023

Wellness Visits Adolescents Ages 3 to 21

VCO Alias	Target	Difference
VCO A	Met	2.3%
VCO B	Met	9.2%
VCO C	Met	1.7%
VCO D	Met	10.1%
VCO E	Not Met	-1.8%
VCO F	Not Met	-3.4%
VCO G	Met	7.3%
VCO H	Met	11.5%
VCO I	Met	2.4%
VCO J	Not Met	-3.4%
VCO K	Met	2.8%

Statewide Target: 61.97%

0.0% 10.0% 20.0% 30.0% 40.0% 50.0% 60.0% 70.0%

PY2 Successes

Establish Levers for Savings	Quality	Collaboration

• The level of risk taken by the VCOs was less in PY2 in comparison to PY1, resulting in a lower share in savings.
 	
• VCOs successful in meeting cost target and quality measure thresholds.
 	
• Most VCOs shared in savings.
	• Continued progress on quality measures expected to lead to improved health outcomes & lower costs.
	
	• 53% of quality measure targets were met during the performance year.
	
	• There were improvements in breast cancer screening rates and wellness visit rates for adolescents ages 3 to 21.
		• Monthly meetings between the Department and the VCOs.
		    • Statewide Care Collaborative (SCC)
		    • Quality Workgroup
		
		• Collaboration allowing program to evolve to better meet state and VCO goals.
		
		• Collaboration not limited to the scope of the contract; also includes sharing of best practices related to patient engagement, data collection, etc.

Opportunities

- Inclusion of additional services

- New/additional quality measures

- Experience post-covid
  - Starting this program in 2022 presented unique challenges tied to workforce, data, and populations to include within the contract.

- Director's Bulletin
  - 2024-15 (Ensuring a Sustainable and High Performing Medicaid Delivery System)

Needs and Challenges

- Resources to effectively administer the program, supporting administration and data efforts to be good partners with providers.

- Data lag issues tied to claims data (inherent to using claims data).

- To align the quality performance program with existing programs from other payers and to shift to quality measures that are focused on health outcomes, additional (supplemental) data collection is needed.

- Not all VCOs are the same resulting in unique challenges or benefits.
  - VCOs have different levels of value-based care knowledge, experience and resources
  - VCOs include different provider types (hospitals vs primary care only)
  - VCOs have different populations (pediatrics only, rural vs urban, # members)

- Public Health Emergency (PHE) unwinding in PY2, affecting member attribution.

Performance Year Contract Terms

Term	Year 1 (CY2022)	Year 2 (CY2023)	Year 3 (CY2024)	Year 4 (CY2025)
Population	Legacy	Legacy + Expansion	Legacy + Expansion	Legacy + Expansion
Base Year	SFY 2019	SFY 2021	SFY 2022	SFY 2023
Quality Measures	6 Mandatory measures	6 Mandatory measures	3 Mandatory measures + 3-6 Optional measures	3 Mandatory measures + 3 Optional measures + 1 Bonus measure
Risk level	5% upside only - 80%	5% upside only - 80%	15%-80% Symmetrical	15%-80% Symmetrical
Statewide Risk Standardized PMPM	$155.07	$148.00 Negotiated	$138.44	$138.44
Annual Program Change Factor	0%	0%	0%	0%

PY3 Risk Level Selection

VCO Alias	PY3 Risk
VCO A	15%
VCO B	25%
VCO C	15%
VCO D	80%
VCO E	25%
VCO F	15%
VCO G	15%
VCO H	15%
VCO I	15%
VCO J	N/A
VCO K	15%

*PY4 risk selection is due 12/01/2024

PY3 & PY4 Quality Measures

HCVC Quality Measures	PY1	PY2	PY3	PY4
Emergency department visits per 1,000 member months	*Required*	*Required*	*Required*	*NA*
Well visit age 6 in first 15 months	*Required*	*Required*	*Required*	*Required*
Well care visits adolescents (ages 3 to 21)	*Required*	*Required*	*Required*	*Required*
Breast cancer screening	*Required*	*Required*	*Optional*	*Optional*
Readmissions within 30 days age 18-64	*Required*	*Required*	*Optional*	*NA*
Diabetes hba1c testing	*Required*	*Required*	*Optional*	*NA*
Well-child visits for age 15 months–30 months	*NA*	*NA*	*Optional* New	*Optional*
Concurrent use of opioids and benzodiazepines	*NA*	*NA*	*Optional* New	*Optional*
Developmental screening in the first three years of life	*NA*	*NA*	*Optional* New	*Optional*
Screening for depression and follow-up plan: ages 12 to 17	*NA*	*NA*	*Optional* New	*Optional*
Screening for depression and follow-up plan: age 18 and older	*NA*	*NA*	*Optional* New	*Optional*
Follow-up after hospitalization for mental illness: ages 6 to 17	*NA*	*NA*	*Optional* New	*NA*
Follow-up after hospitalization for mental illness: age 18 to 64	*NA*	*NA*	*Optional* New	*NA*
ED visits per 1,000 beneficiary months among children up to age 19	*NA*	*NA*	*NA*	*Required* New
Weight assessment and counseling for nutrition and physical activity for children/adolescents	*NA*	*NA*	*NA*	*Optional* New
Controlling high blood pressure	*NA*	*NA*	*NA*	*Optional* New
Hemoglobin A1c control for patients with diabetes	*NA*	*NA*	*NA*	*Optional* New
Bonus Measure: Health related social needs assessment and referral	*NA*	*NA*	*NA*	*Optional* New