IPRO

Better healthcare, realized.

External Quality Review Annual Technical Report

Reporting Year 2024

Review Period: January 1, 2022–December 31, 2023

Table of Contents

List of Tables

I. Executive Summary

Purpose of Report

The Balanced Budget Act (BBA) of 1997 established that state agencies contracting with managed care entities (MCEs) provide for an annual external, independent review of the outcomes related to the quality, timeliness, and access to services included in the contract between the state agency and the MCE. *Title 42 Code of Federal Regulations (CFR) Section (§) 438.350 External quality review (a)* through *(f)* sets forth the requirements for the annual external quality review (EQR) of contracted MCEs. States are required to contract with an external quality review organization (EQRO) to perform an annual EQR for each contracted MCE. The states must further ensure that the EQRO has sufficient information to conduct this review, that the information be obtained from EQR-related activities, and that the information provided to the EQRO be obtained through methods consistent with the protocols established by the Centers for Medicare and Medicaid Services (CMS). Quality, as it pertains to an EQR, is defined in *Title 42 CFR § 438.320 Definitions* as "the degree to which an MCO[1], PIHP,[2] PAHP,[3] or PCCM[4] entity increases the likelihood of desired health outcomes of its enrollees through: (1) its structural and operational characteristics. (2) The provision of health services that are consistent with current professional, evidence-based knowledge. (3) Interventions for performance improvement."

Title 42 CFR § 438.364 External review results (*a)* through *(d)* requires that the annual EQR be summarized in a detailed annual technical report (ATR) that aggregates, analyzes, and evaluates information on the quality of, timeliness of, and access to health care services that MCEs furnish to Medicaid recipients. The report must also contain an assessment of the strengths and weaknesses of the MCEs regarding health care quality, timeliness, and access, as well as make recommendations for improvement.

To comply with *Title 42 CFR Section § 438.364 External review results* (*a)* through *(d)* and *Title 42 CFR § 438.358 Activities related to external quality review*, the Alabama Medicaid Agency (AMA) contracted with IPRO, an EQRO, to conduct the calendar year (CY) 2023 EQR activities for seven primary care case management entities (PCCM-Es) contracted to furnish Medicaid services in the state. During the period under review, CY 2023 (January 1, 2023–December 31, 2023), AMA's PCCM-Es included Alabama Care Network Mid-State (ACN Mid-State, also referred to as ACNM); Alabama Care Network Southeast (ACN Southeast, also referred to as ACNS); Gulf Coast Total Care (GCTC); My Care Alabama Central (MCA-C); My Care Alabama East (MCA-E); My Care Alabama Northwest (MCA-NW); and North Alabama Community Care (NACC). This report presents aggregate and PCCM-E-level results of the EQR activities for ACN Mid-State, ACN Southeast, GCTC, MCA-C, MCA-E, MCA-NW, and NACC.

Scope of External Quality Review Activities Conducted

This EQR ATR focuses on the three mandatory EQR activities that were conducted. As set forth in *Title 42 CFR Section § 438.358 Activities related to external quality review(b)(1)*, these activities are:

(i) ***CMS Mandatory Protocol 1*: Validation of Performance Improvement Projects (PIPs)** – This activity validates that MCE performance improvement projects (PIPs) were designed, conducted, and reported in a methodologically sound manner, allowing for real improvements in care and services. In Alabama, this activity is referred to as the Validation of Quality Improvement Projects (QIPs). Throughout this ATR, the terms PIP and QIP are used interchangeably.

[1] managed care organization.
[2] prepaid inpatient health plan.
[3] prepaid ambulatory health plan.
[4] primary care case management.

(ii) ***CMS Mandatory Protocol 2:*** **Validation of Performance Measures** – This activity assesses the accuracy of performance measures (PMs) reported by each MCE and determines the extent to which the rates calculated by the MCE follow state specifications and reporting requirements.

(iii) ***CMS Mandatory Protocol 3:*** **Review of Compliance with Medicaid and CHIP[5] Managed Care Regulations** – This activity determines MCE compliance with their contract and with state and federal regulations.

(iv) ***CMS Mandatory Protocol 4:*** **Validation of Network Adequacy –** This activity ensures that Medicaid and CHIP MCPs maintain provider networks that are sufficient to provide timely and accessible care to Medicaid and CHIP beneficiaries across the continuum of services. This protocol is applicable to MCOs, PIHPs, or PAHPs. As a result, it does not apply to Alabama's PCCM-E model.

CMS defines "validation" in *Title 42 CFR § 438.320 Definitions* as "the review of information, data, and procedures to determine the extent to which they are accurate, reliable, free from bias, and in accord with standards for data collection and analysis."

The results of these EQR activities are presented in individual activity sections. Each of the activity sections includes information on:

- data collection and analysis methodologies;
- comparative findings; and
- where applicable, the PCCM-E's performance strengths and opportunities for improvement.

High-Level Program Findings and Recommendations

IPRO used the analyses and evaluations of 2022 and 2023 EQR activity findings to assess the performance of Alabama Coordinated Health Network (ACHN) entities in providing quality, timely, and accessible health care services to Medicaid members. The individual entities were evaluated against state and national benchmarks for measures related to the **quality**, **timeliness**, and **access** domains, and results were compared to previous years for trending, when possible.

The following provides a high-level summary of these findings for the ACHN program. The overall findings for the entities were also compared and analyzed to develop overarching conclusions and recommendations for each entity. These entity-level findings are discussed in each EQR activity section.

Strengths Related to Quality, Timeliness, and Access

The EQR activities conducted in CY 2022 and CY 2023 demonstrated that AMA and the entities share a commitment to improvement in providing high-quality, timely, and accessible care for eligible individuals (EIs). The following outlines program strengths identified during the EQR.

Quality Improvement Projects

From baseline (CY 2019) to final measurement (CY 2022), six of the seven entities demonstrated an improvement in at least one adverse birth outcomes QIP performance indicator; all seven entities demonstrated an improvement in at least one childhood obesity QIP performance indicator; and six of the seven entities demonstrated an improvement in at least one substance use disorder QIP performance indicator. Over the course of CY 2022, the entities continued to track their intervention progress in an effort to sustain the results from CY 2021 and refined interventions to target performance indicators that either declined or remained stagnant from baseline. In the domain of **quality**, there were 27 performance indicators that demonstrated an improvement. In the domain of **timeliness**, there were 10 performance indicators that demonstrated an improvement. In the domain of **access**, there were nine performance indicators that

[5] Children's Health Insurance Program.

demonstrated an improvement. For detailed QIP results, refer to **Section III, Validation of Performance Improvement Projects**.

Performance Measures

*(National Committee for Quality Assurance (NCQA) national Medicaid benchmarks are referenced in **Section IV, Validation of Performance Measures** unless stated otherwise.)*

In the domain of quality, the statewide average was above the 95th percentile for Asthma Medication Ratio (adult). In the domain of access, the statewide average was above the 95th percentile for Weight Assessment and Counseling for Children/Adolescents: BMI Assessment.

Minimum Performance Standards

The ACHNs have the opportunity to participate in an incentive program based upon the achievement of AMA-determined benchmarks for each of the Quality Measures. If the ACHN achieves the minimum necessary of the annual benchmarks, it will be eligible to receive up to a 10 percent incentive payment. AMA will distribute earned incentive funds based on the ACHN's performance for the incentive measures of the previous calendar year (CY).

Systems Performance Review

A comprehensive systems performance review (SPR) is conducted once every three years. The most recent review of the ACHN entities covered the state fiscal year (SFY) 2023 review period of October 1, 2022–September 30, 2023. All entities demonstrated full compliance in the areas of Disenrollment, Provider Selection and Participation, Subcontractual Relationships and Delegation, and Health Information Management Systems, and partial compliance in Quality Assurance and Performance Improvement (QAPI).

For detailed results of the 2023 SPR, refer to **Section V, Review of Compliance with Medicaid and CHIP Managed Care Regulations**.

Opportunities for Improvement Related to Quality, Timeliness, and Access

The following outlines program opportunities for improvement identified during the EQR.

Quality Improvement Projects

From baseline (CY 2019) to final measurement (CY 2022), five of the seven entities demonstrated a decline in performance in at least one adverse birth outcomes QIP performance indicator; four of the seven entities demonstrated a decline in performance in at least one childhood obesity QIP performance indicator; and two of the seven entities demonstrated a decline in performance in at least one substance use disorder QIP performance indicator. In the domain of **quality**, there were 11 performance indicators that demonstrated a decline in performance. In the domain of **timeliness**, there were three performance indicators that demonstrated a decline in performance. In the domain of **access**, there were 11 performance indicators that demonstrated a decline in performance. For detailed QIP results, refer to **Section III, Validation of Performance Improvement Projects**.

Performance Measures

*(NCQA national Medicaid benchmarks are referenced in **Section IV, Validation of Performance Measures** unless stated otherwise.)*

All seven entities performed below the state benchmarks and did not qualify for incentives for the following measures: *Antidepressant Medication Management (continuation phase), Children and Adolescents' Access to Primary Care Practitioners (ages 12–24 months, 25 months–6 years, 12 years–19 years), Initiation and Engagement of Treatment for AOD (Initiation), and Well-Child Visits in the First 15 Months of Life (6 or more visits).*

In the domain of **quality**, the statewide average was below the 5th percentile for Antidepressant Medication Management. In the domain of **timeliness**, the statewide average was in the 5th percentile for the Timeliness of Prenatal Care and Initiation and Engagement of Treatment for AOD (Initiation) measures. In the domain of **access**, the statewide average was in the 10th percentile for Cervical Cancer Screening.

Systems Performance Review

Each of the ACHN entities achieved an overall review determination of "partial," indicating that one or more of the requirements reviewed during the 2023 SPR did not demonstrate full compliance. All the entities received a partial determination for QAPI, while four of the seven entities received a partial determination for Care Coordination, Information Requirements and EI Materials. For detailed results of the 2023 SPR, refer to **Section V, Review of Compliance with Medicaid and CHIP Managed Care Regulations**.

Recommendations for ACHN Entities and AMA

The following recommendations are based on the opportunities for improvement previously identified**.**

Quality Improvement Projects

Adverse Birth Outcomes

- **ACN Mid-State** should continuously assess interventions to make improvements in the performance indicators. The entity should consider targeting a larger population for the 2023–2024 QIP.
- **ACN Southeast** should continuously assess interventions to make improvements in the performance indicators. Lessons learned should be applied in the next cycle as the ACHN is continuing with the project topic.
- **GCTC** should ensure there are no major changes to the data collection process as this caused discrepancies with interpretation of results. Lessons learned should be applied in the next cycle as the ACHN is continuing with the project topic.
- **MCA-C** should consider adding new interventions when previous interventions are discontinued. Additionally, the entity should consider not making any changes to the performance indicator measures during the final measurement year. Some performance indicators were too new to assess trends.
- **MCA-E** should continuously assess interventions to make improvements in the performance indicators. Lessons learned should be applied in the next cycle as the ACHN is continuing with the project topic.
- **MCA-NW** should continue their performance improvement project interventions in an effort to reach their target indicator rates.
- **NACC** should continuously assess interventions to make improvements in the performance indicators.

Childhood Obesity

- **ACN Mid-State** should continuously assess interventions to make improvements in the performance indicators. The entity should consider targeting a larger population for the 2023–2024 QIP.
- **ACN Southeast** should continuously assess interventions to make improvements in the performance indicators. Lessons learned should be applied in the next cycle as the ACHN is continuing with the project topic.
- **GCTC** is encouraged to strengthen interventions by adding alternatives when initial interventions are discontinued. Lessons learned should be applied in the next cycle as the ACHN is continuing with the project topic.
- **MCA-C** should continuously assess interventions to make improvements in the performance indicators. Lessons learned should be applied in the next cycle as the ACHN is continuing with the project topic.
- **MCA-E** should continue their performance improvement project interventions in an effort to reach their target indicator rates.

- **MCA-NW** should continue their performance improvement project interventions in an effort to reach their target indicator rates.
- **NACC** should continuously assess interventions to make improvements in the performance indicators.

Substance Use Disorder

- **ACN Mid-State** should continuously assess interventions to make improvements in the performance indicators. There was decline in improvement with some of the quarterly intervention tracking measures (ITMs). Additionally due to the lack of reported data for some of the ITMs a determination of improvement could not be made with some of the interventions.
- **ACN Southeast** should continuously assess interventions to make improvements in the performance indicators. It was unclear whether the interventions, which were implemented late in the QIP, could have helped the entity reach the target in the last measurement period.
- **GCTC** should enhance the barrier analysis process by considering the inclusion of multiple methods for identifying barriers.
- **MCA-C** should continuously assess interventions to make improvements in the performance indicators. The performance indicators had varied performance or were too new to assess trends.
- **MCA-E** should continuously assess interventions to make improvements in the performance indicators.
- **MCA-NW** should continuously assess interventions to make improvements in the performance indicators.
- **NACC** should ensure there are no major changes to the data collection process as this caused discrepancies with interpretation of results. Lessons learned should be applied in the next cycle as the ACHN is continuing with the project topic.

Performance Measures

- **Each entity** should review and analyze their performance trends for the following measures: Antidepressant Medication Management, Initiation of Treatment for AOD, Live Births Weighing Less than 2,500 Grams, and Children and Adolescents' Access to Primary Care. Based on this analysis, entities should develop or refine interventions tailored to improve performance in these measures. Additionally, they should identify any demographic subgroups that are underrepresented or disproportionately affected.
- **MCA-C** and **MCA-E** should review and trend their performance for the Cervical Cancer Screening measure and develop or modify interventions to specifically target performance for this measure.
- **ACNM**, **MCA-C**, and **MCA-E** should review and trend their performance for the Engagement of Treatment for AOD measure and develop or modify interventions to specifically target performance for this measure.
- **MCA-E** and **NACC** should review and trend their performance for the Timeliness of Prenatal Care measure and develop or modify interventions to specifically target performance for this measure.
- **ACNM, GCTC, MCA-C, MCA-E, MCA-NW,** and **NACC** should review and trend their performance for the Well-Child Visits in the First 15 Months of Life measure and develop or modify interventions to specifically target performance for this measure.

Systems Performance Review

Each ACHN entity should address the recommendations made in the SPR finding reports issued February 2024. Entity-specific care coordination file review findings and recommendations are as follows:

- **ACN Mid-State**
  - Maternity care coordination (CC): 1 of 15 Maternity CC files reviewed did not meet the requirements. The entity should adhere to the first follow-up encounter requirements, which indicates this encounter must occur within the second trimester.
  - Sickle cell care coordination: 6 of 15 cases reviewed did not have evidence of a follow-up encounter. The entity should adhere to the first follow-up encounter requirements.
- **ACN Southeast**

- Maternity care coordination: 1 of 15 Maternity CC files reviewed did not meet the requirements. The entity should continue to train staff on the appropriate follow-up encounter requirements.
- Sickle cell care coordination: 3 of 15 Sickle Cell CC files reviewed did not meet the requirements. The entity should continue to train staff on the appropriate follow-up encounter requirements.

- **GCTC**
  - Family planning care coordination: 6 of 15 Family Planning CC files reviewed did not meet the requirements. The entity should continue to train staff on the appropriate follow-up encounter requirements and ensure that all identified needs are addressed and documented in the care plan/task notes.
  - General care coordination: 4 of 15 General CC files reviewed did not meet the requirements. The entity should continue to train staff on the appropriate follow-up encounter requirements.
  - Maternity care coordination: 3 of 15 Maternity CC files reviewed did not meet the requirements. The entity should continue to train staff on the appropriate follow-up encounter requirements.
  - Sickle cell care coordination: 8 of 15 Sickle Cell CC files reviewed did not meet the requirements. The entity should continue to train staff on the SCD risk stratification requirements.
- **MCA-C**
  - Family planning care coordination: 3 of 15 Family Planning CC files reviewed did not meet the requirements. The entity should ensure staff are addressing all medical conditions identified in the EI's Health Risk and Psychosocial Assessment and that the appropriate follow-up encounters are being conducted.
  - General care coordination: 2 of 15 General CC files reviewed did not meet the requirements. The entity should ensure staff are conducting all required screenings and that the appropriate follow-up encounters are being conducted.
  - Maternity care coordination: 3 of 15 Maternity CC files reviewed did not meet the requirements. The entity should ensure staff are trained on the requirements for follow-up encounters.
  - Sickle cell care coordination: 6 of 15 Sickle Cell CC files reviewed did not meet the requirements. The entity should ensure staff are trained on the requirements for follow-up encounters and multidisciplinary care team (MCT) meetings.
- **MCA-E**
  - Family planning care coordination: 3 of 15 Family Planning CC files reviewed did not meet the requirements. The entity should ensure staff are trained on the requirements for follow-up encounters.
  - General care coordination: 1 of 15 General CC files reviewed did not meet the requirements. The entity should ensure staff are trained on the requirements for follow-up encounters.
  - Maternity care coordination: 6 of 15 Maternity CC files reviewed did not meet the requirements. The entity should ensure staff are trained on the requirements for follow-up encounters and are updating care plans timely.
  - Sickle cell care coordination: 4 of 11 Sickle Cell CC files reviewed did not meet the requirements. The entity should ensure staff are trained on the requirements for the initial outreach and for follow-up encounters. The entity should ensure staff are conducting appropriate screenings.
- **MCA-NW**
  - Family planning care coordination: 4 of 15 Family Planning CC files reviewed did not meet the requirements. The entity should ensure staff are addressing all identified needs and documenting in the care plans/task notes.
  - General care coordination: 2 of 15 General CC files reviewed did not meet the requirements. The entity should continue to monitor cases to ensure staff are following the requirements for evaluations and encounters.

- Maternity care coordination: 4 of 15 Maternity CC files reviewed did not meet the requirements. The entity should ensure staff are trained and adhere to the requirements for follow-up encounters.
- Sickle cell care coordination: 9 of 15 Sickle Cell CC files reviewed did not meet the requirements. The entity should ensure staff are trained and adhering to the requirements and accurately documenting in the care plans/task notes regarding MCTs and follow-up encounters.

- **NACC**
  - Family planning care coordination: 6 of 15 Family Planning CC files reviewed did not meet the requirements. The entity should ensure that all identified needs are being addressed and clearly documented within the care plans.
  - General care coordination: 7 of 15 General CC files reviewed did not meet the requirements. The entity should ensure that all identified needs are being addressed and clearly documented within the care plans. The entity should ensure that crisis plans are put in place for an EI with behavioral health conditions, as applicable.
  - Maternity care coordination: 4 of 15 Maternity CC files reviewed did not meet the requirements. The entity should ensure staff are following the requirements for screenings and follow-up encounters. Additionally, the entity should continue to monitor cases to ensure all encounters are accurately documented within the care plan/task notes.
  - Sickle cell care coordination: 7 of 15 Sickle Cell CC files reviewed did not meet the requirements. The entity should ensure staff are addressing all identified needs. Additionally, the entity should continue to monitor cases to ensure all encounters are accurately documented within the care plan/task notes.

II. Alabama Medicaid Managed Care Program

Managed Care in Alabama

The state of Alabama's Medicaid program is administered through the AMA. The Medicaid program provides healthcare coverage for approximately 1 million individuals enrolled in the ACHN program. There are seven ACHN entities contracted with AMA, each responsible for a defined region of the state.

In 2019, the state went live with their 1915(b) waiver, which consolidated their previous programs (Patient 1st, Health Home, Maternity Care, and Plan First) into a single, region-specific care coordination program referred to as the ACHN.

The Patient 1st program was launched in 2004 and followed a traditional PCCM model, wherein AMA contracted with physicians who had agreed to serve as primary medical providers, providing medical services directly or through a referral process. The Health Home program was established regionally in 2012 and expanded statewide in 2015. This program relied on primary medical providers contracted with Health Home to provide PCCM services to Health Home enrollees. The Maternity Care program was established in 1988 and was developed to address infant mortality and the lack of delivering healthcare professionals (DHCPs). The Plan First program was implemented in 2000 to address the need for continued family planning services to individuals who would have otherwise lost eligibility, with services designed to reduce unintended pregnancies and improve the well-being of children and families. Women 19–55 years of age with incomes at or below 141% of the federal poverty level (FPL) were eligible. A standard income disregard of 5% of the FPL was applied if the individual was not eligible for coverage due to excess income. In 2015, AMA began coverage of vasectomies and care coordination for Medicaid-eligible males aged 21 years or older. It is anticipated that combining these programs (Patient 1st, Health Home, Maternity Care, and Plan First) will help improve care coordination efforts and health outcomes among Alabama's Medicaid population.

Alabama's Medicaid Child Health Plus (CHIP) program offers medical coverage to uninsured children under 19 years who do not qualify for Medicaid. Medicaid CHIP recipients are eligible to receive ACHN services.

Table 1 displays Medicaid enrollment and assignment across the seven entities as of December 2023.

Table 1: Medicaid Enrollment and Assignment by ACHN Entity

ACHN Entity	Number of EIs Enrolled in ACHN (1/1/23–12/31/23)	Number of EIs Assigned to Region (12/1/23–12/31/23)
ACN Mid-State	16,465	139,851
ACN Southeast	14,021	142,574
Gulf Coast Total Care	14,173	156,086
My Care Alabama Central	11,398	122,580
My Care Alabama East	13,962	133,014
My Care Alabama Northwest	12,397	122,977
North Alabama Community Care	14,138	132,898

[1] Includes eligible individuals in the following capitation categories: FLMCD ACHN Full Medicaid, FMCHP ACHN Full Medicaid CHIP, FPLAN ACHN Family Planning, and SOBRA ACHN Maternity.
ACHN: Alabama Coordinated Health Network; EI: eligible individual; ACN: Alabama Care Network.

Alabama Medicaid Quality Strategy

In AMA's continued effort to place an emphasis on quality and care coordination and to improve health outcomes for Alabama Medicaid enrollees, the quality strategy serves as a framework for communicating

AMA's approach to ensuring that individuals have timely access to high-quality services in a coordinated, cost-effective manner that contributes to the improved health of the population.

AMA has used lessons learned from establishing regional care organizations (RCOs), the Maternity Care program, the Patient 1st program, the Patient Care Networks of Alabama (PCNA), and the Health Home program to design and implement a new approach for improving health care outcomes. As with any other new program, Alabama's Medicaid program faces significant challenges related to quality, access, and cost of health care services. These challenges are heightened, in part, due to a lack of provider incentives to coordinate care across the continuum of physical and behavioral health. In offering incentives through a new payment model and by addressing these challenges, AMA, in partnership with the ACHN program, can more effectively manage the total cost of care, improve health outcomes, and reduce avoidable hospital care. In addition, Alabama providers have limited means of sharing essential medical information through information technology. However, with the inception of this newly designed program, AMA is actively trying to ensure quality improvement, as providers are encouraged to not only adopt and implement electronic health record technology but also to utilize the AMA's current health information exchange (HIE). The ACHN entities are also responsible for creating their own Health Information Management System (HIMS) to track and monitor patient progress.

In moving toward a system of coordinated care, Alabama has placed an emphasis on quality and has identified maternity outcomes, obesity, and substance use as opportunities/priority areas. Through the ACHN program, AMA seeks to accomplish the following objectives:

- Improve care coordination and reduce fragmentation in the state's delivery system.
- Create aligned incentives to improve beneficiary clinical outcomes.
- Improve access to health care providers.

Further, AMA has established the following three clinical goals: better birth outcomes, reduce childhood obesity, and improve substance abuse initiation and continuation of treatment. As such, each of the ACHN entities are required to carry out a QIP that targets these topics. The Alabama Child Health Improvement Alliance (ACHIA), Alabama Perinatal Quality Collaborative (ALPQC), and the Department of Mental Health are collaborating with the entities in developing, implementing, and monitoring their QIPs.

To ensure consistent communication and engagement in quality improvement, AMA has established various forums and requires participation of ACHN entities and their active providers in routine meetings. The Internal ACHN Quality Forum provides a setting for ACHN entities and AMA to pose questions, share ideas and best practices, discuss new evidence-based research and initiatives, and request training or other support. The external quality-related committees, including the Quality Assurance Committee and the Citizen's Advisory Committee, are charged with supporting quality management activities. The Quarterly Quality Collaborative is an AMA-led effort in which the ACHN entities must participate to discuss utilization and management reports and strategies, innovative health care strategies, quality improvement goals and measures, and QIP progress and evaluation, as well as to share program operations and support needs. The Regional Medical Management Committee is the responsibility of the ACHN entities to establish, chaired by their Medical Director and comprised of all actively participating providers. The purpose of this committee is to implement and supervise program initiatives centered around quality measures; to review utilization data with PCPs, as needed, in order to achieve quality goals of the ACHN entities; to review and assist the ACHN entities in implementing and evaluating QIPs; and to discuss and resolve any issues that the PCPs or the ACHN entities encounter in providing care coordination services to their EIs. The Consumer Advisory Committee is designed to advise the ACHN entities on ways they can be more efficient in providing quality care to their enrollees. Lastly, the Medical Care Advisory Committee is a state-established committee to advise on policy development and program administration.

The ACHN program utilizes a value-based purchasing (VBP) strategy that aligns incentives for the state, ACHN, providers, and enrollees to achieve the program's overarching program objectives. AMA offers a quality incentive payment, wherein an ACHN entity may earn an incentive payment of up to 10% of total revenues if the entity meets quality targets set by AMA. There are 11 quality measures used to assess ACHN entity performance, in addition to 8 PCP quality measures that are similar to/align with these measures. **Table 2** and **Table 3** detail these measures.

Table 2: ACHN Quality Measures

Acronym	Description
W15-CH	Well-Child Visits in the First 15 Months of Life
ABA-AD	Adult BMI Assessment
WCC-CH	Child BMI Assessment
CCS-AD	Cervical Cancer Screen
AMR-CH	Asthma Medication Ratio (child measure)
AMR-AD	Asthma Medication Ratio (adult measure)
AMM-AD	Antidepressant Medication Management
LBW-AD	Live Births Less Than 2,500 Grams
CAP-CH	Children and Adolescents' Access to Primary Care Practitioners (four age categories)
PPC-CH	Prenatal and Postpartum: Timeliness of Prenatal Care
IET-AD	Initiation and Engagement of Treatment for AOD (initiation and continuation phases)

ACHN: Alabama Coordinated Health Network; BMI: body mass index; AOD: alcohol and other drugs.

Table 3: PCP Quality Measures

Acronym	Description
AWC	Adolescent Well-Care Visits
W34	Well-Child Visits for Children (Aged 3–6 Years)
CIS	Immunization Status – Child
IMA	Immunization Status – Adolescent
AMM	Antidepressant Medication Management
CDC	HbA1c Test for Diabetic Patients
FUA	Follow-Up After ER Visit for Alcohol and Other Drugs
CHL	Chlamydia Screening in Women

PCP: primary care provider; HbA1c: hemoglobin A1c; ER: emergency room.

At the end of each FY, AMA meets with the ACHN entities to review the quality measures and share best practices. Further, each quarter, AMA meets with each entity to review preliminary data, review measure specifications, plan for data gathering, and share early successes and challenges.

On a monthly and quarterly basis, AMA analyzes all available quality reporting to monitor program performance, evaluating reports not only for compliance with contractual requirements but also for progress toward achieving AMA's program effectiveness goals. Many reporting elements serve as leading indicators for overall program effectiveness. While AMA's first step is to provide technical assistance and learning collaborative opportunities for the ACHN entities, AMA will implement sanctions or corrective action plans (CAPs) to remedy any noncompliance, when necessary.

AMA conducts ongoing monitoring and supervision as required by *Title 42 CFR § 438.66* to determine the ACHN entities' ability to provide services to EIs and resolve any identified operational deficiencies. AMA may require the entity to develop and implement CAPs demonstrating their ability to satisfy the requirements of their contract. ACHN entities are contractually required to submit a variety of reports to AMA on a regular basis, as illustrated in **Table 4**. These reports cover many topics, including those related to enrollee services, provider availability and accessibility, care coordination, quality management, utilization management (including underutilization of care), finance and solvency, and grievances and appeals, among others. In addition, ACHN entities are required to submit accurate and complete case management data monthly. AMA will use the case management data in their monitoring activities, as well as for capitation rate development.

Table 4: ACHN Reporting Requirements

ACHN Report Title	Frequency of Reporting
Consumer Advisory Committee and Governing Board Minutes	Quarterly (alternating)
Care Coordination Data	As required
Cash Flow Flash Report	Monthly
Financial	Quarterly and annually
Fraud and Abuse Activities	As required
Grievances Log	Quarterly
Medical Management Committee Minutes	Quarterly and annually
Outreach and Education Activities	Quarterly
PCP and DHCP List	Quarterly and annually
Performance Reports	Quarterly
Pharmacy	Quarterly
Quality Improvement	Quarterly

ACHN: Alabama Coordinated Health Network; PCP: primary care provider; DHCP: delivering health care provider.

To help confirm that ACHN entities submit reports to AMA that are meaningful and comparable across regions, AMA developed a reporting manual that is made available to the ACHN entities. This reporting manual defines the specifications and formats that entities must use when developing and submitting reports to AMA. When reviewing the ACHN reports, AMA uses standard operating procedures to collect, analyze, and summarize findings for each report. Health system managers also compile report findings across ACHN entities to identify areas of opportunity for discussion at ACHN quarterly meetings and learning collaboratives. As part of the ongoing monitoring phase, each health systems manager is required to conduct a quarterly onsite visit to ensure the entity is meeting the request for proposal (RFP) or other contractual obligations in addition to efficiently and effectively serving the Medicaid population and improving health outcomes. These visits provide insight into day-to-day operations and allow the health systems manager to see and experience workflows and processes that might not be witnessed while offsite.

IPRO's Assessment of the Alabama Medicaid Quality Strategy

Alabama's Medicaid quality strategy aligns with the federal regulations in *Title 42 CFR 438.340(b)*. Assessment of the ACHN program and strategies for improvement are clearly stated, and methods for measuring and monitoring ACHN entity progress toward improving health outcomes incorporate EQR activities. The quality strategy will evolve as the ACHN program continues to grow, as more data become available, and as AMA gathers additional feedback from stakeholders, beneficiaries, providers, and state agencies. In August 2023, AMA updated their quality strategy and submitted the updates to CMS for feedback. The updated quality strategy will be evaluated and included in the RY 2025 ATR.

Recommendations to AMA

- Include in the next iteration of the Medicaid quality strategy quantifiable targets for each quality measure being used to evaluate and incentivize ACHN entities and PCPs. Further, include quantifiable targets for the three clinical focus areas (i.e., adverse birth outcomes, childhood obesity, and SUD).
- Continue to work with the ACHN entities to identify and address access issues faced by EIs, particularly in rural communities.
- Work with providers to understand and mitigate barriers they face in providing care to EIs.
- Evaluate and promote telehealth capabilities of providers.
- Outline the PCP Bonus Payment methodology, as this is not currently specified in the Quality Incentive Payment Methodology section of the quality strategy.
- Define network adequacy standards.

III. Validation of Performance Improvement Projects

Objectives

Title 42 CFR § 438.330(d) establishes that state agencies require contracted MCEs to conduct PIPs that focus on both clinical and nonclinical areas. According to the CMS, the purpose of a PIP is to assess and improve the processes and outcomes of health care provided by these entities.

AMA requires each ACHN entity to develop and implement QIPs to assess and improve processes of care with the desired result of improving outcomes of care. The projects are focused on the health care needs that reflect the demographic characteristics of the ACHN entities' membership, the prevalence of disease, and the potential risks of the disease. QIP topics were selected by AMA. An assessment is conducted for each project upon proposal submission and again for interim and final remeasurement using a tool developed by IPRO and consistent with CMS EQR protocols. Updated reports are provided quarterly and assessed by IPRO and AMA. QIP proposals for the 2019−2022 reporting cycle were submitted November 2019, with resubmissions requested and final review and approval by March 2020. Interim year 1 reports were due June 2021, interim year 2 reports were due June 2022, and final reports were due June 2023.

Beginning October 1, 2019, AMA required each of the ACHN entities to perform one QIP for each of the following topics: adverse birth outcomes, childhood obesity, and substance use disorder. Although the 2019−2022 QIP reports concluded December 31, 2022, AMA continued these topics into the next QIP reporting cycle for 2023−2024. **Tables 7-9** summarize IPRO's validation of the 2019–2022 final measurement year results and proposals for the 2023–2024 QIPs. IPRO will conduct a validation of the 2023 interim year 1 reports in June 2024, with results reported in the RY 2024 annual technical report.

The QIP topics and the ACHN entities carrying them out are displayed in **Table 5.**

Table 5: ACHN Entity QIP Topics

Entity	QIP Topic(s)[1]
ACN Mid-State	Adverse Birth Outcomes Childhood Obesity Substance Use Disorder
ACN Southeast	
Gulf Coast Total Care	
My Care Central	
My Care East	
My Care Northwest	
North Alabama Community Care	

[1] Includes QIPs that started, are ongoing, and/or were completed in the review year.
ACHN: Alabama Coordinated Health Network; QIP: quality improvement project; ACN: Alabama Care Network.

Title 42 CFR § 438.356(a)(1) and *Title 42 CFR § 438.358(b)(1)* establish that state agencies must contract with an EQRO to perform the annual validation of QIPs. To meet these federal regulations, AMA contracted with IPRO to validate the second interim year of the QIPs that were conducted in 2021.

Technical Methods of Data Collection and Analysis

IPRO's validation process begins at the QIP proposal phase and continues through the life of the QIP. As the QIPs are conducted, IPRO provides technical assistance to each ACHN entity.

CMS's *Protocol 1. Validation of Performance Improvement Projects* was used as the framework to assess the quality of each QIP, as well as to score the compliance of each QIP with both federal and state requirements. IPRO's assessment involves the following 10 elements:

1. Review of the selected study topic(s) for relevance of focus and for relevance to the entity's enrollment.
2. Review of the project aims and objectives, ensuring alignment with interventions.
3. Review of the identified study population to ensure it is representative of the entity's enrollment and generalizable to the entity's total population.
4. Review of selected study indicator(s), which should be objective, clear, unambiguous, and meaningful to the focus of the QIP.
5. Review of sampling methods (if sampling used) for validity and proper technique.
6. Review of the data collection procedures to ensure complete and accurate data were collected.
7. Review of the data analysis and interpretation of study results.
8. Assessment of the improvement strategies for appropriateness.
9. Assessment of the likelihood that reported improvement is "real" improvement.
10. Assessment of whether the entity achieved sustained improvement.

Following the review of the listed elements, the review findings are considered to determine whether the QIP outcomes should be accepted as valid and reliable. Specific to Alabama, each QIP requirement is then assessed based on the entity's compliance with elements 1–10. Note that there are also sub-elements reviewed, the details of which are provided in **Tables 7–9**. The element is determined to be "met," "partially met," "not met," or "not applicable." **Table 6** displays the compliance levels and their corresponding definitions.

Table 6: QIP Validation Compliance Levels

Compliance Level	Compliance Level Description
Met	The entity has demonstrated that they have addressed the requirement.
Partially met	The entity has demonstrated that they have addressed the requirement but not in its entirety.
Not met	The entity has not addressed the requirement.
Not applicable	The requirement was not applicable for review.

QIP: quality improvement project.

IPRO provided QIP report templates to each entity for the submission of project proposals and interim updates. All data needed to conduct the validation were obtained through these report submissions and supplemented by quarterly update calls, wherein the entities had the opportunity to discuss their projects.

Upon final reporting, a determination will be made as to the overall credibility of the results of each QIP, with the assignment of 1 of 3 categories:

- There were no validation findings that indicate that the credibility of the QIP results is at risk.
- The validation findings generally indicate that the credibility of the QIP results is not at risk. Results must be interpreted with some caution.
- There are one or more validation findings that indicate a bias in the QIP results.

IPRO's assessment of indicator performance will be based on four categories upon final reporting:

- Target met (or exceeded), and performance improvement demonstrated.

- Target not met, but performance improvement demonstrated.
- Target not met, and performance decline demonstrated.
- Unable to evaluate performance at this time.

Description of Data Obtained

Information obtained throughout the reporting period included project rationale, aims and goals, target population, performance indicator descriptions, performance indicator rates (baseline and interim), methods for performance measure calculations, targets, benchmarks, barriers, interventions (planned and executed), tracking measures and rates, and limitations.

Conclusions and Comparative Findings

2019-2022 QIP Findings

Final QIP validation results for measurement year 2022 for each ACHN entity are presented in **Tables 7–9.**

Table 7: Adverse Birth Outcomes QIP – Final (MY 2022) Validation Results

Validation Elements	ACNM	ACNS	GCTC	MCA-C	MCA-E	MCA-NW	NACC
Project topic							
1. Attestation signed and project identifiers completed	M	M	M	M	M	M	M
2. Project topic impacts the maximum proportion of EIs that is feasible	M	M	M	M	M	M	M
3. Potential for meaningful impact on EI health, functional status, or satisfaction	M	M	M	M	M	M	M
4. Topic reflects high-volume or high risk-conditions	M	M	M	M	M	M	M
5. Topic supported by ACHN EI data (e.g., historical data related to disease prevalence)	M	M	M	M	M	M	M
6. Aims, objectives, and interventions are in alignment	M	M	M	M	M	M	M
7. Goal sets a target improvement rate that is bold, feasible, and based upon baseline data and strength of interventions. The rationale for target rate is provided.	M	M	M	M	M	M	M
Methodology							
8. Study uses objective, clearly defined, measurable, time-specific indicators to track performance and improvement outcomes	M	M	M	M	M	M	M
9. Performance indicators are measured consistently over time	M	M	M	M	M	M	M
10. Performance indicators measure changes in health status, functional status, satisfaction, or processes of care with strong associations with improved outcomes	M	M	M	M	M	M	M
11. Eligible population (i.e., Medicaid enrollees to whom the QIP is relevant) is clearly defined	M	M	M	M	M	M	M
12. If sampling was used, the ACHN identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.	N/A	M	N/A	N/A	M	M	N/A

Validation Elements	ACNM	ACNS	GCTC	MCA-C	MCA-E	MCA-NW	NACC
13. Data collection procedures to ensure that data are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	M	M	M	M	M	M	M
14. Data analysis procedures indicate a) the entity will interpret improvement in terms of achieving target rates and b) the entity will monitor intervention tracking measures (ITMs) so that stagnating or worsening quarterly ITM trends will trigger barrier/root cause analysis, with findings used to inform modifications to interventions. If ACHN cited statistical techniques, are they appropriate? (Note that hypothesis testing should only be used to test significant differences between independent samples.)	M	M	M	M	M	M	M
15. Procedures indicate data source, hybrid vs. administrative, reliability (e.g., Inter-Rater Reliability [IRR])	M	M	M	M	M	M	M
16. Timeline specifies baseline, interim and final measurement time periods, start date for interventions, and QIP report due dates	M	M	M	M	M	M	M
Barrier analysis, interventions, and monitoring							
17. Barriers to improvement identified through data analysis and quality improvement processes (e.g., fishbone diagram, provider/EI input at focus groups or quality meetings, claims data stratified by clinical/demographic characteristics to identify susceptible subpopulations)	M	M	M	M	M	M	M
18. Robust EI and provider interventions (e.g., active EI outreach and engagement and active provider outreach and education) undertaken to address identified causes/barriers	M	M	M	PM	M	M	M
19. Interventions are new or enhanced, starting after baseline period	M	M	M	M	M	M	M
20. Interventions have corresponding monthly or quarterly ITMs, with numerator/denominator (specified in proposal and baseline QIP reports, with actual data reported in interim and final QIP reports)	M	M	M	M	M	M	M
21. Interventions were modified and/or successes spread as informed by interpretation of ITMs	M	M	M	M	M	M	M

Validation Elements	ACNM	ACNS	GCTC	MCA-C	MCA-E	MCA-NW	NACC
Results							
22. In the Results Table, the numerators, denominators, and rates of the annual performance indicators are correctly reported	M	M	M	M	M	M	M
23. Target rates are reported in the Results Table. If target rates are achieved during the interim period, the entity adjusts the target rate for incremental improvement.	M	M	M	M	M	M	M
24. Improvement shown in annual performance indicators or quarterly ITMs?	PM	M	PM	PM	PM	PM	PM
25. The ACHN adhered to the statistical techniques outlined in the data analysis plan (note that hypothesis testing should only be used to test significant differences between independent samples)	M	M	M	M	M	M	M
Discussion							
26. Interpretation of extent to which QIP is successful, and the factors associated with success (e.g., performance indicator relative to target rates, interventions, with interpretation of ITMs, barriers addressed)	M	M	M	M	M	M	M
27. Identification of study limitations, (i.e., factors that threaten internal/external validity)	M	M	M	N/A	M	M	M
Next steps							
28. Lessons learned are documented and follow-up activities have been planned as a result	M	M	M	M	M	M	M
Validity and reliability of QIP results							
29. Sustained improvement of performance indicators was demonstrated from baseline to final measurement	M	PM	PM	PM	N/A	N/A	PM
30. The reported improvement in performance has “face” validity (i.e., the intervention appears to have been successful in improving performance)	M	M	M	M	M	M	M
31. Overall credibility of results	M	M	M	M	M	N/A	M

M: Met; PM: Partially Met; NM: Not Met; MY: measurement year; QIP: quality improvement project; ACNM: Alabama Care Network Mid-State; ACNS; Alabama Care Network Southeast; GCTC: Gulf Coast Total Care; MCA-C: My Care Alabama Central; MCA-E: My Care Alabama East; MCA-NW: My Care Alabama Northwest; NACC: North Alabama Community Care; EI: eligible individual; ACHN: Alabama Coordinated Health Network; ITM: intervention tracking measure; N/A: not applicable.

Table 8: Childhood Obesity QIP – Final (MY 2022) Validation Results

Validation Elements	ACNM	ACNS	GCTC	MCA-C	MCA-E	MCA-NW	NACC
Project topic							
1. Attestation signed and project identifiers completed	M	M	M	M	M	M	M
2. Project topic impacts the maximum proportion of EIs that is feasible	M	M	M	M	M	M	M
3. Potential for meaningful impact on EI health, functional status, or satisfaction	M	M	M	M	M	M	M
4. Topic reflects high-volume or high risk-conditions	M	M	M	M	M	M	M
5. Topic supported by ACHN EI data (e.g., historical data related to disease prevalence)	M	M	M	M	M	M	M
6. Aims, objectives, and interventions are in alignment	M	M	M	M	M	M	M
7. Goal sets a target improvement rate that is bold, feasible, and based upon baseline data and strength of interventions. The rationale for target rate is provided.	M	M	M	M	M	M	M
Methodology							
8. Study uses objective, clearly defined, measurable, time-specific indicators to track performance and improvement outcomes	M	M	M	M	M	M	M
9. Performance indicators are measured consistently over time	M	M	M	M	M	M	M
10. Performance indicators measure changes in health status, functional status, satisfaction, or processes of care with strong associations with improved outcomes	M	M	M	M	M	M	M
11. Eligible population (i.e., Medicaid enrollees to whom the QIP is relevant) is clearly defined	M	M	M	M	M	M	M
12. If sampling was used, the ACHN identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.	N/A	M	N/A	N/A	M	M	N/A
13. Data collection procedures to ensure that data are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	M	M	M	M	M	M	M
14. Data analysis procedures indicate a) the entity will interpret improvement in terms of achieving target rates and b) the entity will monitor intervention tracking measures	M	M	M	M	M	M	M

Validation Elements	ACNM	ACNS	GCTC	MCA-C	MCA-E	MCA-NW	NACC
(ITMs) so that stagnating or worsening quarterly ITM trends will trigger barrier/root cause analysis, with findings used to inform modifications to interventions. If ACHN cited statistical techniques, are they appropriate? (Note that hypothesis testing should only be used to test significant differences between independent samples.)							
15. Procedures indicate data source, hybrid vs. administrative, reliability (e.g., Inter-Rater Reliability [IRR])	M	M	M	M	M	M	M
16. Timeline specifies baseline, interim and final measurement time periods, start date for interventions, and QIP report due dates	M	M	M	M	M	M	M
Barrier analysis, interventions, and monitoring							
17. Barriers to improvement identified through data analysis and quality improvement processes (e.g., fishbone diagram, provider/EI input at focus groups or quality meetings, claims data stratified by clinical/demographic characteristics to identify susceptible subpopulations)	M	M	M	M	M	M	M
18. Robust EI and provider interventions (e.g., active EI outreach and engagement and active provider outreach and education) undertaken to address identified causes/barriers	M	M	M	M	M	M	M
19. Interventions are new or enhanced, starting after baseline period	M	M	PM	M	M	M	M
20. Interventions have corresponding monthly or quarterly ITMs, with numerator/denominator (specified in proposal and baseline QIP reports, with actual data reported in interim and final QIP reports)	M	M	M	M	M	M	M
21. Interventions were modified and/or successes spread as informed by interpretation of ITMs	M	M	PM	M	M	M	M
Results							
22. In the Results Table, the numerators, denominators, and rates of the annual performance indicators are correctly reported	M	M	M	M	M	M	M

Validation Elements	ACNM	ACNS	GCTC	MCA-C	MCA-E	MCA-NW	NACC
23. Target rates are reported in the Results Table. If target rates are achieved during the Interim Period, the entity adjusts the target rate for incremental improvement.	M	M	M	M	M	M	M
24. Improvement shown in annual performance indicators or quarterly ITMs?	PM	NM	PM	PM	M	M	PM
25. The ACHN adhered to the statistical techniques outlined in the data analysis plan (note that hypothesis testing should only be used to test significant differences between independent samples)	M	M	M	M	M	M	M
Discussion							
26. Interpretation of extent to which QIP is successful, and the factors associated with success (e.g., performance indicator relative to target rates, interventions, with interpretation of ITMs, barriers addressed)	M	M	M	M	M	M	M
27. Identification of study limitations (i.e., factors that threaten internal/external validity)	M	M	M	M	M	M	M
Next steps							
28. Lessons learned are documented and follow-up activities have been planned as a result	M	M	M	M	M	M	M
Validity and reliability of QIP results							
29. Sustained improvement of performance indicators was demonstrated from baseline to final measurement	N/A	PM	PM	N/A	M	M	N/A
30. The reported improvement in performance has “face” validity (i.e., the intervention appears to have been successful in improving performance)	M	M	M	M	M	M	M
31. Overall credibility of results	M	M	M	M	M	M	M

M: Met; PM: Partially Met; NM: Not Met; MY: measurement year; QIP: quality improvement project; ACNM: Alabama Care Network Mid-State; ACNS; Alabama Care Network Southeast; GCTC: Gulf Coast Total Care; MCA-C: My Care Alabama Central; MCA-E: My Care Alabama East; MCA-NW: My Care Alabama Northwest; NACC: North Alabama Community Care; EI: eligible individual; ACHN: Alabama Coordinated Health Network; ITM: intervention tracking measure; N/A: not applicable.

Table 9: Substance Use Disorder QIP – Final (MY 2022) Validation Results

Validation Elements	ACNM	ACNS	GCTC	MCA-C	MCA-E	MCA-NW	NACC
Project topic							
1. Attestation signed and project identifiers completed	M	M	M	M	M	M	M
2. Project topic impacts the maximum proportion of EIs that is feasible	M	M	M	M	M	M	M
3. Potential for meaningful impact on EI health, functional status, or satisfaction	M	M	M	M	M	M	M
4. Topic reflects high-volume or high risk-conditions	M	M	M	M	M	M	M
5. Topic supported by ACHN EI data (e.g., historical data related to disease prevalence)	M	M	M	M	M	M	M
6. Aims, objectives, and interventions are in alignment	M	M	M	M	M	M	M
7. Goal sets a target improvement rate that is bold, feasible, and based upon baseline data and strength of interventions. The rationale for target rate is provided.	M	M	M	M	M	PM	M
Methodology							
8. Study uses objective, clearly defined, measurable, time-specific indicators to track performance and improvement outcomes	M	M	M	M	M	M	M
9. Performance indicators are measured consistently over time	M	M	M	M	M	M	PM
10. Performance indicators measure changes in health status, functional status, satisfaction, or processes of care with strong associations with improved outcomes	M	M	M	M	M	M	M
11. Eligible population (i.e., Medicaid enrollees to whom the QIP is relevant) is clearly defined	M	M	M	M	M	M	M
12. If sampling was used, the ACHN identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.	N/A	N/A	N/A	N/A	M	M	N/A
13. Data collection procedures to ensure that data are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	M	M	M	M	M	M	M
14. Data analysis procedures indicate a) the entity will interpret improvement in terms of achieving target rates and b) the entity will monitor intervention tracking measures	M	M	M	M	M	M	M

Validation Elements	ACNM	ACNS	GCTC	MCA-C	MCA-E	MCA-NW	NACC
(ITMs) so that stagnating or worsening quarterly ITM trends will trigger barrier/root cause analysis, with findings used to inform modifications to interventions. If ACHN cited statistical techniques, are they appropriate? (Note that hypothesis testing should only be used to test significant differences between independent samples.)							
15. Procedures indicate data source, hybrid vs. administrative, reliability (e.g., Inter-Rater Reliability [IRR])	M	M	M	M	M	M	M
16. Timeline specifies baseline, interim and final measurement time periods, start date for interventions, and QIP report due dates	M	M	M	M	M	M	M
Barrier analysis, interventions, and monitoring							
17. Barriers to improvement identified through data analysis and quality improvement processes (e.g., fishbone diagram, provider/EI input at focus groups or quality meetings, claims data stratified by clinical/demographic characteristics to identify susceptible subpopulations)	M	M	M	M	M	M	M
18. Robust EI and provider interventions (e.g., active EI outreach and engagement and active provider outreach and education) undertaken to address identified causes/barriers	M	M	M	M	M	M	M
19. Interventions are new or enhanced, starting after baseline period	M	M	M	M	M	M	M
20. Interventions have corresponding monthly or quarterly ITMs, with numerator/denominator (specified in proposal and baseline QIP reports, with actual data reported in interim and final QIP reports)	M	M	M	M	M	M	M
21. Interventions were modified and/or successes spread as informed by interpretation of ITMs	M	M	M	M	M	M	M
Results							
22. In the Results Table, the numerators, denominators, and rates of the annual performance indicators are correctly reported	M	M	M	M	M	M	PM

Validation Elements	ACNM	ACNS	GCTC	MCA-C	MCA-E	MCA-NW	NACC
23. Target rates are reported in the Results Table. If target rates are achieved during the interim period, the entity adjusts the target rate for incremental improvement.	M	M	PM	M	M	M	M
24. Improvement shown in annual performance indicators or quarterly ITMs?	PM	PM	PM	PM	M	PM	PM
25. The ACHN adhered to the statistical techniques outlined in the data analysis plan (note that hypothesis testing should only be used to test significant differences between independent samples)	M	M	M	M	M	M	M
Discussion							
26. Interpretation of extent to which QIP is successful, and the factors associated with success (e.g., performance indicator relative to target rates, interventions, with interpretation of ITMs, barriers addressed)	M	M	M	M	M	M	PM
27. Identification of study limitations (i.e., factors that threaten internal/external validity)	M	M	M	M	M	M	M
Next steps							
28. Lessons learned are documented and follow-up activities have been planned as a result	M	M	M	M	M	M	M
Validity and reliability of QIP results							
29. Sustained improvement of performance indicators was demonstrated from baseline to final measurement	PM	NM	N/A	N/A	M	PM	PM
30. The reported improvement in performance has “face” validity (i.e., the intervention appears to have been successful in improving performance)	M	PM	M	M	M	M	PM
31. Overall credibility of results	M	M	M	M	M	M	M

M: Met; PM: Partially Met; NM: Not Met; MY: measurement year; QIP: quality improvement project; ACNM: Alabama Care Network Mid-State; ACNS; Alabama Care Network Southeast; GCTC: Gulf Coast Total Care; MCA-C: My Care Alabama Central; MCA-E: My Care Alabama East; MCA-NW: My Care Alabama Northwest; NACC: North Alabama Community Care; EI: eligible individual; ACHN: Alabama Coordinated Health Network; ITM: intervention tracking measure; N/A: not applicable.

Adverse Birth Outcomes

Through the validation process, IPRO determined that the review elements shown in **Table 10** did not achieve full compliance in the measurement year 2022 Adverse Birth Outcomes QIP.

Table 10: Adverse Birth Outcomes QIP – MY 2022 Deficient Review Elements

Section	Review Element	Review Determination	Review Comments
Alabama Care Network Mid-State			
Results	24. Improvement shown in annual performance indicators or quarterly ITMs?	Partially met	Improvement was not demonstrated from baseline to final periods for the performance indicator. The performance indicator did not meet the target rate.
Alabama Care Network Southeast			
Validity and reliability of QIP results	29. Sustained improvement of performance indicators was demonstrated from baseline to final measurement.	Partially met	While improvement was observed in some indicators, success was not sustained throughout the project.
Gulf Coast Total Care			
Results	24. Improvement shown in annual performance indicators or quarterly ITMs?	Partially met	Improvement was shown in one annual performance indicator (Indicator 3). Indicator 1 and 2 both had a decrease in performance. Two of the four quarterly ITMs showed an overall improvement. One ITM had a decreased performance and one remained relatively constant.
Validity and reliability of QIP results	29. Sustained improvement of performance indicators was demonstrated from baseline to final measurement.	Partially met	Indicator 3 had an improved performance, and this continued from baseline to final measurement. Indicator 2 showed some improvement in interim period 2 but this was not sustained. Indicator 1 did not show improvement.
My Care Alabama Central			
Barrier analysis, interventions, and monitoring	18. Robust EI and provider interventions (e.g., active EI outreach and engagement and active provider outreach and education) undertaken to address identified causes/barriers.	Partially met	Two interventions related to cervical cancer/STI screenings and contraception use were discontinued and not replaced. Interventions were limited to school-based reproductive education. School-based reproductive education was expanded from high school only to include middle schools.
Results	24. Improvement shown in annual performance indicators or quarterly ITMs?	Partially met	Indicator 1 showed an overall decrease in performance (higher is better). Improvement cannot be assessed for Indicators 2 and 3 as they were new in 2022.

Section	Review Element	Review Determination	Review Comments
			ITM 1a was consistent over the PIP. ITMs 1b, 2a, and 2b showed overall improvement.
Validity and reliability of QIP results	29. Sustained improvement of performance indicators was demonstrated from baseline to final measurement.	Partially met	One indicator had an overall decrease in performance and two were too new to assess for impact/sustainability.
My Care Alabama East			
Results	24. Improvement shown in annual performance indicators or quarterly ITMs?	Partially met	Indicator 1 showed an improvement from baseline to final measurement periods in decreasing the percentage of pregnant women who smoke in pregnancy. Indicators 2 and 3 did not show an improvement from baseline to final measurement periods.
My Care Alabama Northwest			
Results	24. Improvement shown in annual performance indicators or quarterly ITMs?	Partially met	Improvement was seen in Indicator 1 and Indicator 2 from baseline to final measurement period. Indicator 3 showed a slight decline in improvement.
North Alabama Community Care			
Results	24. Improvement shown in annual performance indicators or quarterly ITMs?	Partially met	While significant improvement was observed in Indicators 2 and 3 from baseline to final measurement, a decline was observed in Indicator 1.
Validity and reliability of QIP results	29. Sustained improvement of performance indicators was demonstrated from baseline to final measurement.	Partially met	While annual performance Indicator 2 showed improved performance, Indicator 1 did not reach its target and Indicator 3 showed a decline in the final measurement period. Performance indicators may be influenced by multiple factors outside the scope of the QIP. The interventions were implemented, and the entity responded appropriately to barriers by modifying processes throughout the PIP process.

QIP: quality improvement project; MY: measurement year; ITM: interventions tracking measure; EI: eligible individual; STI: sexually transmitted infection; PIP: performance improvement project.

Childhood Obesity

Through the validation process, IPRO determined that the review elements shown in **Table 11** did not achieve full compliance in the measurement year 2022 Childhood Obesity QIP. MCA-E and MCA-NW were fully compliant with all review elements.

Table 11: Childhood Obesity QIP – MY 2022 Deficient Review Elements

Section	Review Element	Review Determination	Review Comments
Alabama Care Network Mid-State			
Results	24. Improvement shown in annual performance indicators or quarterly ITMs?	Partially met	Improvement was shown in half of the indicators: Although Indicator 1 demonstrated an improvement in rates from baseline to final measurement year, the target rate of 70% was not achieved. Indicator 2 demonstrated an improvement throughout each period ending with a 68.3% rate surpassing the target rate of 66.7%. Indicator 3 demonstrated an improvement in rates from baseline to the final measurement year but did not meet the target rate of 78.6%. Indicator 4: Percentage of EIs, age 3–11 with diagnosis of overweight or obese target rate was 34.1% and shows ending rate of 1% reduction. This indicator was discussed/explained that the 22 days in 2022 challenge was a modification to the 2021 interventions. Although the challenge took some time to become implemented, there were many children who were able to be reached.
Alabama Care Network Southeast			
Results	24. Improvement shown in annual performance indicators or quarterly ITMs?	Not met	Improvement was not seen in the annual performance indicators, and, while quarterly ITMs showed some improvement at times throughout the QIP, improvement was not consistent.

Section	Review Element	Review Determination	Review Comments
Validity and reliability of QIP results	29. Sustained improvement of performance indicators was demonstrated from baseline to final measurement.	Partially met	While some performance indicators demonstrated an improvement between the 2nd interim period to the final measurement period there was an overall decline in rates from baseline and no rates met the target rates.
Gulf Coast Total Care			
Barrier analysis, interventions, and monitoring	19. Interventions are new or enhanced, starting after baseline period.	Partially met	The interventions center around the step challenge. Additional interventions for care coordination were discontinued during the PIP and not replaced.
Barrier analysis, interventions, and monitoring	21. Interventions were modified and/or successes spread as informed by interpretation of ITMs	Partially met	ACHN was recommended to expand current interventions, this was not done. As noted above, some interventions were discontinued and not replaced.
Results	24. Improvement shown in annual performance indicators or quarterly ITMs?	Partially met	Indicator 1 showed improvement. Indicator 2 had a change in the codes included, making it difficult to note a trend over time. Indicator 3 showed decreased performance over the QIP. ITM 2b showed some improvements over the course of the QIP but the performance declined in the final reporting period.
Validity and reliability of QIP results	29. Sustained improvement of performance indicators was demonstrated from baseline to final measurement.	Partially met	Performance indicators that did not show improvement may be influenced by multiple factors outside the scope of the PIP. Improvement was reported in one indicator in the last measurement year, precluding assessment of sustainability. The other indicators did not demonstrate improvement.
My Care Alabama Central			
Results	24. Improvement shown in annual performance indicators or quarterly ITMs?	Partially met	Indicator 1 and 2 decreased in each year and overall performance. Indicator 3 was new in the last measurement period and there is no baseline data available. Improvement cannot be assessed. The target for indicator 3 was not reached. ITMs 1a and 1b showed overall improvement trend over the duration of the project. ITM 2a showed overall decrease in performance over the duration of the project. The intervention began as a telehealth intervention and changed to face-to-face

Section	Review Element	Review Determination	Review Comments
			at the end of the project, potentially affecting the rate. ITMs 3a and 3b were new in the last year of the project. ITM 3a showed an overall increase in performance while 3b was stable without significant improvement or decline noted.
North Alabama Community Care			
Results	24. Improvement shown in annual performance indicators or quarterly ITMs?	Partially met	After an initial decline, performance indicator targets 1 and 2 were reached and targets adjusted accordingly. Indicator 3 showed improvement but did not meet the target. ITMs showed mixed results during the final year of the QIP.

QIP: quality improvement project; MY: measurement year; ITM: intervention tracking measure; EI: eligible individual; PIP: performance improvement project.

Substance Use Disorder

Through the validation process, IPRO determined that the review elements shown in **Table 12** did not achieve full compliance in the measurement year 2022 Substance Use Disorder QIP. MCA-E was fully compliant with all review elements.

Table 12: Substance Use Disorder QIP – MY 2022 Deficient Review Elements

Section	Review Element	Review Determination	Review Comments
Alabama Care Network Mid-State			
Results	24. Improvement shown in annual performance indicators or quarterly ITMs?	Partially met	The performance indicator demonstrated an improvement from the baseline to final reporting period. There was decline in improvement with some of the quarterly ITMs. Additionally due to the lack of reported data for some of the ITMs a determination of improvement could not be made with some of the interventions.
Validity and reliability of QIP Results	29. Sustained improvement of performance indicators was demonstrated from baseline to final measurement.	Partially met	Although there was an improvement in rates from the baseline to final periods, there was a decline in performance during the interim periods and the target rate was not met.
Alabama Care Network Southeast			
results	24. Improvement shown in annual performance indicators or quarterly ITMs?	Partially met	There was a decline in performance in the annual performance indicator over the first two measurement periods, after which the target rate was lowered to 10%.

Section	Review Element	Review Determination	Review Comments
			This allowed the entity to surpass the target in the final measurement period. In addition, while one of the ITMs showed improvement over the last year of the project, the other showed a decline over the last year.
Validity and reliability of QIP results	29. Sustained improvement of performance indicators was demonstrated from baseline to final measurement.	Not met	While the (new) target of 10% was met, the annual performance indicator showed a decline in performance over the first two measurement periods.
Validity and reliability of QIP results	30. The reported improvement in performance has "face" validity (i.e., the intervention appears to have been successful in improving performance).	Partially met	It is unclear whether the interventions, which were implemented late in the QIP, could have helped the entity reach the target in the last measurement period.
Gulf Coast Total Care			
Results	23. Target rates are reported in the Results Table. If target rates are achieved during the interim period, the entity adjusts the target rate for incremental improvement.	Partially met	Due to changes in the performance indicators, the entity did not have baseline or interim period 1 rates. Therefore, a target rate that is far-reaching, yet attainable could not be selected. The target rate was achieved in interim period 2 for Indicator 3 but the entity did not adjust the target rate.
Results	24. Improvement shown in annual performance indicators or quarterly ITMs?	Partially met	Indicators 1 and 3 had a decline in performance and did not meet the target rates. Indicator 2 had an improvement in performance from Interim 2 to final reporting period.
My Care Alabama Central			
Results	24. Improvement shown in annual performance indicators or quarterly ITMs?	Partially met	Indicator 1 showed some improvement in CY 2021, but this was not maintained. The PIP ended with the indicator similar to baseline. Indicator 2 showed a slight increase but did not meet target. Indicator 3 was new in CY 2022 and does not have data to compare/trend. ITM 1 had inconsistent rates with a low denominator, making a meaningful assessment of improvement difficult. ITM 2 also had low denominators but maintained a steady level of performance. ITM 3a and 3b were started in the

Section	Review Element	Review Determination	Review Comments
			last quarter of the PIP. Improvement cannot be assessed without comparable/historical data.
My Care Alabama Northwest			
Project topic	7. Goal sets a target improvement rate that is bold, feasible, and based upon baseline data and strength of interventions. The rationale for target rate is provided.	Partially met	The goal for Indicator 1 is the same as baseline and does not reflect an improvement. In the QIP report, Table 6 lists the goal for Indicator 2 as lower than baseline and does not reflect an improvement.
Results	24. Improvement shown in annual performance indicators or quarterly ITMs?	Partially met	Indicator 2 showed an improvement from baseline to final measurement year and surpassed the target rate. Indicator 1 slightly decreased from baseline to final period.
Validity and reliability of QIP results	29. Sustained improvement of performance indicators was demonstrated from baseline to final measurement.	Partially met	Indicator 2 showed an improvement from baseline to final measurement year and surpassed the target rate. There was some fluctuation, but overall, an improvement. Indicator 1 stayed at about the same rate throughout the PIP and decreased from baseline to final.
North Alabama Community Care			
Methodology	9. Performance indicators are measured consistently over time.	Partially met	The ACHN states that diagnosis codes that were used for EI selection included "in remission" cases and were inflating the denominator. Data was re-pulled to include only non-remission cases. As a result, there were only two measurements taken: a baseline (which also served as the interim) and a final, which was on a different scale and not comparable to the baseline.
Results	22. In the Results Table, the numerators, denominators, and rates of the annual performance indicators are correctly reported.	Partially met	Baseline measurement year was 2021, thus there were no interim period 1 or 2 measurements taken.
Results	24. Improvement shown in annual performance indicators or quarterly ITMs?	Partially met	Two of three remaining ITMs showed improvement. The third showed a slight decrease.

QIP: quality improvement project; MY: measurement year; EI: eligible individual; ITM: intervention tracking measure; ACHN: Alabama Coordinated Health Network; CY: calendar year; PIP: performance improvement project.

QIP Summaries

Measurement year 2022 QIP summaries, including aim, interventions, and overall performance, are reported in **Tables 13–19** for each ACHN entity.

Table 13: ACN Mid-State QIP Summaries, MY 2022

ACN Mid-State QIP Summaries
QIP 1: Adverse Birth Outcomes Validation Summary: There were no validation findings that indicate the credibility of the QIP results is at risk.
Aim ACN Mid-State will continue the in-house hypertension/diabetes monitoring program for pregnant EIs and nonpregnant EIs aged 18−44 years diagnosed with hypertension/diabetes to improve the percentage of live deliveries with low birth weight from baseline to final measurement. Also, ACN Mid-State will implement an education video series to promote healthy birth outcomes and decrease infant mortality. **Interventions in 2022** • Implemented the use of hypertension/diabetes monitoring for management of diabetes and hypertension for EIs identified as childbearing aged 18–44 years who are not pregnant. • Implemented the use of hypertension/diabetes monitoring for management of diabetes and hypertension for pregnant EIs. • Implemented the use of hypertension education and self-monitoring for management of hypertension for EIs identified as childbearing age (18–44) who are either pregnant or not pregnant. Provided written materials and blood pressure monitors for home use. • Outreached to EIs who deliver a low-weight baby (< 2,500 grams) to complete social determinants of health screening. • Maternity Care Coordinators completed a Social Determinants of Health (SDoH) screening at initial assessment of all new pregnant EIs. • Referred postpartum EIs to family planning. • Referred enrolled pregnant EIs to view Healthy Baby, Healthy Mom video series on ACNM website to promote healthy birth outcomes. Topics include but are not limited to: Breastfeeding, Count the Kicks, Safe Sleep, and Family Planning. **Performance Improvement Summary** ACN Mid-State demonstrated a decline in performance for the adverse birth outcomes performance indicator from baseline (2019) to the final measurement period (2022). The performance indicator also did not meet the target rate of 9.5%.
QIP 2: Childhood Obesity Validation Summary: There were no validation findings that indicate the credibility of the QIP results is at risk.
Aim ACN Mid-State will continue implementing Eating Smart Being Active and assist EIs in scheduling well visits with an emphasis on good nutrition/physical activity for those EIs with BMI > 85th percentile to improve the percentage of EIs aged 3−11 years with a diagnosis of being overweight or obese from baseline to final measurement. In addition, ACN Mid-State will implement USDA Grow It, Try It, Like It for preschool children aged 3−5 years to improve children's lifelong eating and physical activity habits through nutrition education.

ACN Mid-State QIP Summaries

Interventions in 2022

- Mid-State identified EIs from the top 5 PCP provider groups, aged 3–11 without a well visit who have a BMI > 85th percentile and made outreach attempts to explain the importance of well visit and assist with scheduling a visit with PCP. PCP groups included are as follows: Pediatrics East, Pediatrics West, Primary Care Clinic, Metro Pediatrics, and Greenvale Pediatrics.
- Provided the 22 Days in 2022 Healthy Lifestyle Challenge. Challenge includes Healthy Lifestyle Kit materials for nutrition education, enhancing steps, and promoting physical activity such as portion control devices, fitness trackers, and exercise equipment.

Performance Improvement Summary

ACN Mid-State demonstrated improvement in all childhood obesity performance indicators from baseline (2019) to the final measurement period (2022). Two of the four performance indicators exceeded the target rate.

QIP 3: Substance Use Disorder

Validation Summary: There were no validation findings that indicate the credibility of the QIP results is at risk.

Aim

ACN Mid-State will implement a peer specialist and wraparound support service for EIs prescribed medication-assisted therapy (MAT) for the first time (within 6 months) or are pregnant EIs with a history of or active SUD to improve the percentage of EIs engaged with peer specialist or wraparound support services for primary/mental health care or community resources to increase patient engagement and retention in SUD treatment from baseline to final measurement. Also, ACN Mid-State will implement a school-based substance use prevention program for middle and high school students to reduce the prevalence of substance use among adolescents.

Interventions in 2022

- Use AMA pharmacy claims data to contact EIs who had new MAT prescription to offer Care Coordination services for assistance with primary care, mental health care, or community resources.
- Used AMA data to outreach EIs with SUD to refer to peer support specialist.
- Referred pregnant EIs identified at assessment by maternal care coordinator with history of/active SUD to peer support specialist.
- Recovery Resource Center referred EIs for Care Coordination services to improve level of support for EIs in recovery process.
- Provide Continuing Medical Education (CME) for Providers.

Performance Improvement Summary

ACN Mid-State demonstrated an improvement for the SUD performance indicator from baseline (2019) to the final measurement period (2022).

ACN: Alabama Care Network; QIP: quality improvement project; EI: eligible individual; BMI: body mass index; AMA: Alabama Medicaid Agency; SUD: substance use disorder; USDA: United State Department of Agriculture; MY: measurement year; ACNM: Alabama Care Network Mid-State; PCP: primary care provider.

Table 14: ACN Southeast QIP Summaries, MY 2022

ACN Southeast QIP Summaries
QIP 1: Adverse Birth Outcomes Validation Summary: There were no validation findings that indicate the credibility of the QIP results is at risk.
Aim ACN Southeast aims to improve the rate of pregnant EIs who have a prenatal visit in the first trimester from 64.9% to 67.5%, decrease the number of live births < 2,500 grams from baseline of 9.5% to 9.1%, and increase the percentage of well-child visits in the first 15 months of life from 64.2% to 65%. **Interventions in 2022** • Implemented processes with DHCP offices to schedule initial visit within the first trimester to improve the rate of pregnant EIs who have a prenatal visit in the first trimester. • Provided an incentive care package at delivery for EIs who attend 80% of prenatal visits, all care coordination visits, and postpartum visits. • Implemented a biomonitoring program for pregnant EIs with hypertension or diabetes to decrease live births < 2500 grams. • Distributed safe sleep information to caregivers of EIs aged 0−6 months during case management services. • Targeted case management of EIs aged 0−15 months. **Performance Improvement Summary** ACN Southeast demonstrated an improvement in performance in two of three adverse birth outcomes performance indicators from baseline (2019) to the final measurement period (2022). Two of the three performance indicators exceeded the target rates.
QIP 2: Childhood Obesity Validation Summary: There were no validation findings that indicate the credibility of the QIP results is at risk.
Aim ACN Southeast aims to increase the percentage of children aged 3−6 years who have a well-child visit in the measurement year. They also aim to increase the percentage of children aged 3−6 years with a BMI from 5th percentile to < 85th percentile. **Interventions in 2022** • Provided gardening materials to children in pre-k, kindergarten, and first grade to provide augmented education on healthy eating. • Provided education and support to encourage breastfeeding in infants up to 3 months of age. • Provided physical activity equipment (jump ropes) to elementary and middle schools in Southeast region. • Provided physical activity equipment (jump ropes) to Auburn Community Extension Programs in Southeast region. **Performance Improvement Summary** ACN Southeast demonstrated an improvement in performance in one of two childhood obesity performance indicators from baseline (2019) to the final measurement period (2022).

ACN Southeast QIP Summaries
QIP 3: Substance Use Disorder Validation Summary: There were no validation findings that indicate the credibility of the QIP results is at risk.
Aim ACN Southeast aims to develop an infrastructure within ACN Southeast to increase the percentage of EIs who initiate SUD treatment within 14 days of a new episode diagnosis from 39.6% to 40.2% and continue in treatment with at least two AOD services within 34 days from 5.6% to 6.5%, in addition to supporting existing EIs with SUD to enroll into treatment. ACN Southeast has partnered with SpectraCare in southeast Alabama to financially support dedicated staff members to assess EIs with SUD for treatment options in Region G. **Interventions in 2022** • Provided funding for residential housing costs for EIs who participate in recovery programs at non-billing SUD programs. • Partnered with SpectraCare Mental Health in Dothan (Houston County) to financially support dedicated SUD staff members in Region G. • Provided education to area schools regarding substance use prevention educational materials. **Performance Improvement Summary** ACN Southeast demonstrated an improvement in performance for the SUD performance indicator from baseline (2019) to the final measurement period (2022).

ACN: Alabama Care Network; QIP: quality improvement project; BMI: body mass index; EI: eligible individual; DHCP: delivering healthcare professionals; SUD: substance use disorder; AOD: alcohol and other drug; MY: measurement year.

Table 15: GCTC QIP Summaries, MY 2022

GCTC QIP Summaries
QIP 1: Adverse Birth Outcomes Validation Summary: There were no validation findings that indicate the credibility of the QIP results is at risk.
Aim GCTC will implement a critical care protocol to specifically target EIs that are at additional risk for preterm delivery. Additionally, GCTC will grow opportunities for pregnant EIs to enter prenatal care in the first trimester. These interventions will decrease the infant mortality rate by one in the southwest region. **Interventions in 2022** • Identified EIs through psychosocial assessment with one of the critical risk diagnoses (hypertension, diabetes, or previous preterm delivery) and enrolled them in biomonitoring. • Improved EI knowledge regarding critical risk diagnosis and care plan adherence through biomonitoring activities. **Performance Improvement Summary** GCTC demonstrated an improvement in performance for one of three adverse birth outcomes performance indicators from baseline (2019) to the final measurement period (2022). One of three performance indicators exceeded the target rate.
QIP 2: Childhood Obesity Validation Summary: There were no validation findings that indicate the credibility of the QIP results is at risk.
Aim GCTC will assist EIs in enrolling in the 14,000 Steps Challenge to help reduce the number of overweight and obese children in the southwest region by 1%. **Interventions in 2022** • Used AMA data to target EIs 7–11 years of age with Z68.53 diagnosis code. • Promoted increased physical activity through implementing the 14,000 Steps Challenge. **Performance Improvement Summary** GCTC demonstrated an improvement in performance in one of three childhood obesity performance indicators from baseline (2019) to the final measurement period (2022).
QIP 3: Substance Use Disorder Validation Summary: There were no validation findings that indicate the credibility of the QIP results is at risk.
Aim GCTC will increase by 2% the number of EIs aged 18 and older with a new episode of AOD abuse or dependence that initiate and continue treatment. GCTC will focus their efforts on EIs with a new episode of Opioid Use Disorder (OUD) and EIs with first Medication Assisted Treatment (MAT) prescription fill. GCTC will assist with referrals to People Engaged in Recovery (PEIR) or other community treatment agencies.

GCTC QIP Summaries
Interventions in 2022 • Identified EIs 18 years of age and older with new AOD diagnosis, specifically OUD. • Connected EIs with an OUD and receiving MAT to PEIR to help facilitate the incorporation of counseling and behavioral therapies into treatment plan and access other available community resources. • Provided educational outreach to increase the comfort level of primary providers in managing EIs with an OUD. The medical director, pharmacy manager and/or quality manager provided training on pathophysiology of OUD, prescribing guidelines, MAT options, quality measures, and community resources. **Performance Improvement Summary** GCTC demonstrated an improvement in performance for two of three SUD performance indicators from interim period (2021) to the final measurement period (2022). GCTC did not have baseline (2019) or interim period (2020) rates reported. Indicators were modified during the QIP limiting the number of data points available for assessment.

QIP: quality improvement project; GCTC: Gulf Coast Total Care; EI: eligible individual; AOD: alcohol and other drugs; AMA: Alabama Medicaid Agency; OUD: opioid use disorder; MAT: medication-assisted therapy; MY: measurement year.

Table 16: MCA-C QIP Summaries, MY 2022

MCA-C QIP Summaries
QIP 1: Adverse Birth Outcomes Validation Summary: There were no validation findings that indicate the credibility of the QIP results is at risk.
Aim MCA-C aims to implement school-based education programs to improve preconception wellness among Medicaid-eligible youth of childbearing age. This focus will be reducing the prevalence of sexually transmitted infections (STIs) and improving avoidance of teen pregnancy through the use of comprehensive sexual health curriculum for high school and an abstinence-based curriculum for middle school. **Interventions in 2022** • MCA-C initiated an evidence-based sexual/reproductive health curriculum in a high school that is embedded in health/science class. • MCA-C initiated an evidence-based abstinence curriculum in a middle school that is embedded in science/health classes. **Performance Improvement Summary** MCA-C demonstrated a decline in performance for one of three adverse birth outcomes performance indicators from interim period (2021) to the final measurement period (2022). Two of three performance indicators were added to the report during interim period (2021) but there were no rates reported, therefore an assessment on performance could not be made with only the final measurement period (2022) rates.
QIP 2: Childhood Obesity Validation Summary: There were no validation findings that indicate the credibility of the QIP results is at risk.
Aim MCA-C aims to improve childhood obesity by behavioral modification in the mother by increasing education, breastfeeding, early access to WIC, and AAP feeding guidelines. **Interventions in 2022** • QIP nurses provided in home breastfeeding education and support the initiation of breastfeeding in hospital. • Increased in early prenatal (less than 28 weeks) access into WIC due to support and education from QIP nurse. • Increased the number of mothers receiving support and education by the QIP nurses on use of breast pump to maintain breast milk for infants at 2 months of age. • Increased the number of Strong Mommas receiving electric breast pumps from WIC with support and education by the QIP nurses. **Performance Improvement Summary** MCA-C demonstrated an improvement in performance for one of three childhood obesity performance indicators from baseline (2019) to the final measurement period (2022). One of three performance indicators demonstrated a decline in performance from interim period (2020) to the final measurement period (2022). There was one performance indicator that was added to the report during interim period (2021) but there were no rates reported therefore an assessment on performance could not be made with only the final measurement period (2022) rates.

MCA-C QIP Summaries
QIP 3: Substance Use Disorder Validation Summary: There were no validation findings that indicate the credibility of the QIP results is at risk.
Aim MCA-C aims to provide SUD EIs with the increased opportunity to receive SUD treatment within a timely manner. **Interventions in 2022** • Increase in ability of a mental health professional to initiate treatment after a diagnosis of an EI by providing APA in the targeted county. • Increase in support for Els who initiated treatment and had 2 or more AOD/MAT services within 30 days due to transportation support by PSS. • Initiate Operation Prevention program in regional high schools by having QIP staff that is embedded in health/science classes. **Performance Improvement Summary** MCA-C demonstrated an improvement in performance for two of three SUD performance indicators from baseline (2019) to the final measurement period (2022). One of three performance indicators was added to the report during the final measurement period (2022) and therefore an assessment on performance could not be made.

MCA-C: My Alabama Care Central; QIP: quality improvement project STI: sexually transmitted infection; EI: eligible individual; WIC: Special Supplemental Nutrition Program for Women, Infants, and Children; AAP: American Academy of Pediatrics; SUD: substance use disorder; APA: adult placement assessment; AOD: alcohol and other drugs; MAT: medication-assisted treatment; MY: measurement year.

Table 17: MCA-E QIP Summaries, MY 2022

MCA-E QIP Summaries
QIP 1: Adverse Birth Outcomes Validation Summary: There were no validation findings that indicate the credibility of the QIP results is at risk.
Aim MCA-E aims to implement the use of a smoking cessation application by incentivizing EIs to complete the smoking cessation program via the mobile application, which will focus on behavioral change versus drug therapy to improve quit rates for pregnant EIs from baseline to final measurement. They also aim to implement the process of incentivizing for EIs attendance of prenatal and postpartum visits to improve risks during pregnancy and increase the chance of a safe and healthy delivery and health in the future from baseline to final measurement. **Interventions in 2022** • Increased support, resources, and education for EIs through completion of smoking cessation program for pregnant women via the mobile application, Quit Genius. • Incentivized EIs to attend prenatal and postpartum appointments to increase appointment compliance and education of pregnancy resources. **Performance Improvement Summary** MCA-E demonstrated an improvement in performance for one of three adverse birth outcomes performance indicators from baseline (2019) to the final measurement period (2022). Two of three performance indicators declined in performance from baseline (2019) to the final measurement period (2022).
QIP 2: Childhood Obesity Validation Summary: There were no validation findings that indicate the credibility of the QIP results is at risk.
Aim MCA-E aims to implement a program to incentivize EIs parents for attendance of BMI assessment well-child visits for children and adolescents aged 3−11 years and aged 12−17 years with nutrition and physical activity counseling to improve child access to care, as well as BMI assessment from baseline to final measurement. They also aim to implement the HEAL (Healthy Eating, Active Living) program curriculum in physical education classes for two elementary schools in the MCA-E region, increased to three schools in 2021, as well as to implement a pilot program providing telehealth nutrition, physical activity, and behavior change by a registered dietician nutritionist for children aged 6−12 years who meet criteria with BMI > 85th percentile. **Interventions in 2022** • Provided incentives for EIs who attended well-child visits and participated in nutrition and physical activity counseling. • Implemented the HEAL Program curriculum in physical education classes for two Title I elementary schools in the MCA-E region. • Provided telehealth nutrition, physical activity, and behavior change by a UAB registered dietician nutritionist for children 6–12 years of age with a BMI > 85th percentile. EIs were provided $25 incentives for attending 80% of classes.

MCA-E QIP Summaries
Performance Improvement Summary MCA-E demonstrated an improvement in performance for both childhood obesity performance indicators from baseline (2019) to the final measurement period (2022).
QIP 3: Substance Use Disorder Validation Summary: There were no validation findings that indicate the credibility of the QIP results is at risk.
Aim MCA-E aims to implement the use of peer support specialists (PSSs) to improve the percentage of initiation and engagement of treatment for AOD. They also aim to implement the use of MCA-E's master's-level social workers to conduct timely adult placement assessments to improve entry into substance treatment facilities after detox and create a substance use disorder task force to improve community capacity to identify and connect recipients to substance use resources in St. Clair and Talladega counties from baseline to final measurement. **Interventions in 2022** • Implemented the use of PSSs to improve the percentage of initiation and engagement of treatment for alcohol and other drugs among EIs. • Implemented the use of MCA-E's master's-level social workers to conduct timely adult placement assessments to improve entry into substance treatment facilities after detox. **Performance Improvement Summary** MCA-E demonstrated an improvement in performance for both SUD performance indicators from baseline (2019) to the final measurement period (2022).

MCA-E: My Care Alabama East; QIP: quality improvement project; EI: eligible individual; BMI: body mass index; HEAL: Healthy Eating, Active Living; UAB: University of Alabama Birmingham; PSS: peer support specialist; AOD: alcohol and other drugs; SUD: substance use disorder; MY: measurement year.

Table 18: MCA-NW QIP Summaries, MY 2022

MCA-NW QIP Summaries
QIP 1: Adverse Birth Outcomes Validation Summary: There were no validation findings that indicate the credibility of the QIP results is at risk.
Aim MCA-NW aims to positively impact EI health outcomes and experiences of care by incentivizing the following programs: enrollment into a smoking cessation program via mobile application (app), enrolling into She Recovers at the prenatal stage, and continued treatment after delivery. **Interventions in 2022** • MCA-NW will refer all pregnant EIs from Walker Women Specialists, with a positive SBIRT screening, to She Recovers for enrollment and to receive education, resources, and treatment. • Increasing support, resources, and education through EIs for completion of the Smoking Cessation Program for Pregnant Women via mobile-Quit Genius. **Performance Improvement Summary** MCA-NW demonstrated an improvement in performance for two of three adverse birth outcomes performance indicators from baseline (2019) to the final measurement period (2022).
QIP 2: Childhood Obesity Validation Summary: There were no validation findings that indicate the credibility of the QIP results is at risk.
Aim MCA-NW aims to implement the following initiatives to address childhood obesity: identify and enroll EIs in care coordination who had a sick visit to UMC without a well-child visit in the past 12 months with a BMI of 95% or greater; identify EIs who completed the initial nutritional assessment visit with UMC; identify EIs who completed an initial assessment with the UMC nutritionist to complete a 30-day follow-up; and incentivize EIs to attend the initial visit with the UMC nutritionist to complete education and nutritional assessment. **Interventions in 2022** • UMC provided nutritional and activity counseling to EIs (aged 3–17 years) who had a sick visit without a well-child visit in the last 12 months and with a BMI of 95% or greater. **Performance Improvement Summary** MCA-NW demonstrated an improvement in performance for the childhood obesity performance indicator from baseline (2019) to the final measurement period (2022).

MCA-NW QIP Summaries
QIP 3: Substance Use Disorder Validation Summary: There were no validation findings that indicate the credibility of the QIP results is at risk.
Aim MCA-NW aims to implement the following initiatives to address substance use disorders: provide PSSs to improve initiation and engagement of treatment for AOD SUDs from baseline to the final measurement; track EIs connected to a PSS that entered into treatment in Bibb and Tuscaloosa counties; outreach to PCPs, DHCPs, and rehabilitation facilities from baseline to final measurement; provide transportation to treatment services; and enroll EIs into care coordination services from the Naloxone Distribution list to assist with referrals to treatment. **Interventions in 2022** • Used PSSs to improve the percentage of initiation and engagement of treatment for AOD. • Used Naloxone Distribution list to assist with enrolling EIs into care coordination services and referring them for SUD treatment. • Had PSS provided EIs with transportation to SUD treatment in Bibb and Tuscaloosa. **Performance Improvement Summary** MCA-NW demonstrated an improvement in performance for one of two SUD performance indicators from baseline (2019) to the final measurement period (2022).

MCA-NW: My Care Alabama Northwest; QIP: quality improvement project; EI: eligible individual; UMC: University Medical Center; BMI: body mass index; AOD: alcohol and other drugs; PSS: peer support specialist; SUD: substance use disorder; SBIRT: Screening, Brief Intervention, and Referral to Treatment; MY: measurement year.

Table 19: NACC QIP Summaries, MY 2022

NACC QIP Summaries
QIP 1: Adverse Birth Outcomes Validation Summary: There were no validation findings that indicate the credibility of the QIP results is at risk.
Aim NACC aims to decrease the rate of adverse birth outcomes in the northeast Alabama region by managing maternal obesity and failed GTTs during pregnancy. NACC aims to achieve this by increasing the amount of EIs with maternal obesity and failed GTTs that receive nutritional and healthy lifestyle counseling during their pregnancy. **Interventions in 2022** • Provided nutritional counseling from a NACC registered dietitian to educate and encourage EIs with a BMI greater than or equal to 30.0 at their initial visit to maintain a healthy weight throughout the pregnancy. • Provided nutritional counseling from a NACC registered dietitian to educate and encourage EIs that failed their GTT to maintain a healthy weight throughout the pregnancy. • Provided education to pregnant EIs with a BMI greater than or equal to 30.0 on the benefits to the EI and unborn infant of participating in physician-approved physical activities, smoking cessation, and breastfeeding, using educational materials and motivational interviewing at each appointment with NACC staff. • Provided education to pregnant EIs that failed their GTT on the benefits to the EI and unborn infant of participating in physician-approved physical activities, smoking cessation, and breastfeeding, using educational materials and motivational interviewing at each appointment with NACC staff. • Promoted interconception care by referring EIs with a BMI greater than or equal to 30.0 at their initial prenatal visit for enrollment in Family Planning services. • Promoted interconception care by referring EIs that failed their GTT for enrollment in Family Planning services. **Performance Improvement Summary** NACC demonstrated an improvement in performance for all three adverse birth outcomes performance indicators from baseline (2019) to the final measurement period (2022).
QIP 2: Childhood Obesity Validation Summary: There were no validation findings that indicate the credibility of the QIP results is at risk.
Aim NACC aims to prevent childhood obesity in the northeast Alabama region by increasing the number of EIs aged 3−6 years with documentation of BMI in their medical record and increasing the percentage of EIs aged 3−6 years with a BMI between 85%−94% receiving nutritional and healthy lifestyle counseling. **Interventions in 2022** • Educated PCPs and pediatricians on the correct collection of BMI and reporting BMI on claims submissions.

NACC QIP Summaries
• Had PCPs and pediatricians refer EIs 3–6 years of age with BMIs between 85%−94% to NACC for counseling. • Implemented case management by NACC for EIs aged 3−6 years with BMIs between 85%−94% that assesses the EI's readiness for change. • Implemented food box distribution for EIs aged 3−6 years with BMIs between 85%−94%, which focuses on promoting child nutrition, increasing physical activity, and reducing screen time. • Provided education by NACC maternity care coordinators to discuss the benefits of breastfeeding with first time pregnant EIs. **Performance Improvement Summary** NACC demonstrated an improvement in performance for all three childhood obesity performance indicators from baseline (2019) to the final measurement period (2022).
QIP 3: Substance Use Disorder Validation Summary: The validation findings generally indicate that the credibility of the QIP results is not at risk. Results must be interpreted with some caution.
Aim NACC aims to decrease the rate of adverse health outcomes related to substance use disorders in the northeast Alabama Medicaid population by increasing the percentage of EIs with substance use disorders receiving treatment. **Interventions in 2022** • Incentivized physicians to become MAT-certified by reimbursing physicians for the time spent completing certification. • Held provider group training sessions and onsite education at providers' offices on the referral process to identify EIs in need of brief intervention for substance use. Brief interventions were completed by NACC staff to educate EIs on the consequences of substance use and to encourage substance use free and healthy lifestyle choices. • Coordination of 8–5 support with R.O.S.S. to address the support needs of EIs with a substance use disorder diagnosis and complete referrals to residential facilities for substance use disorder treatment. **Performance Improvement Summary** An assessment of performance could not be done for the SUD performance indicator due to data collection issues. The final measurement period (2022) rates could not be evaluated because the result could not be compared to the baseline (2019) or the interim year measurement periods (2020 and 2021).

NACC: North Alabama Community Care; QIP: quality improvement project; GTT: glucose tolerance test; EI: eligible individual; BMI: body mass index; PCP: primary care provider; SUD: substance use disorder; MAT: medication-assisted treatment; ROSS: Recovery Organization of Support Specialists; MY: measurement year.

Results of MY 2019–2022 QIPs

Table 20 displays a summary of IPRO's improvement assessment of indicator performance from baseline (2019) to the final measurement (2022) for each entity and QIP topic. Improvement in performance demonstrated is denoted in green, a decline in performance is denoted in red. Gray indicates the inability to evaluate performance at this time or that the performance remained constant.

Table 20: Assessment of ACHN Entity QIP Indicator Performance

ACHN Entity[1]	Indicator Number[2]	Indicator Description[3]	Assessment of Performance, Baseline (2019) to Final (2022)
QIP 1: Adverse Birth Outcomes			
ACN Mid-State	1	Percentage of live deliveries with low birth weight **Baseline: 9.71%; Interim Y1: 11.3%; Interim Y2: 11.7%; Final: 11.9%; Target: 9.5%**	Decline
ACN Southeast	1	Percentage of pregnant EIs who had a prenatal visit in the first trimester **Baseline: 64.9%; Interim Y1: 76.5%; Interim Y2: 77.2%; Final: 76.9%; Target: 73.5%**	Improvement
	2	Percentage of live births less than 2,500 grams **Baseline: 9.5%; Interim Y1: 9.7%; Interim Y2: 10.3%; Final: 10.2%; Target: 8.9%**	Decline
	3	Percentage of infants aged 0–15 months with ≥ 6 well-child visits **Baseline: 64.2%; Interim Y1: 60.2%; Interim Y2: 63.0%; Final: 66.6%; Target: 65.0%**	Improvement
Gulf Coast Total Care	1	Percentage of live births weighing less than 2,500 grams **Baseline: 10.4%; Interim Y1: 12.3%; Interim Y2: 12.3%; Final: 14.9; Target: 9.7%**	Decline
	2	Percentage of pregnant EIs that received prenatal care in the first trimester **Baseline: 70.5%; Interim Y1: 64.2%; Interim Y2: 80.2%; Final: 60.2%; Target: 74.2%**	Decline
	3	Percentage of EIs defined as critical risk who completed 37 weeks of gestation **Baseline: NA; Interim Y1: 54.3%; Interim Y2: 62.6%; Final: 70.6%; Target: 50.0%**	Improvement
My Care Alabama Central	1	Percentage of students enrolled in the targeted high school that completed the Making Proud Choices curriculum **Baseline: 0.0%; Interim Y1: 84.0%; Interim Y2: 78.0%; Final: 77.0%; Target: 90.0%**	Improvement
	2	Percentage of students enrolled in the targeted middle school that completed the curriculum **Baseline: 0.0%; Interim Y1: NA; Interim Y2: NA; Final: 97.0%; Target: 90.0%**	Unable to evaluate performance at this time
	3	Percentage of teenage pregnancies in targeted school ZIP codes (from AMA claims) **Baseline: 0.0%; Interim Y1: NA; Interim Y2: NA; Final: 45.5%; Target: 27.0%%**	Unable to evaluate performance at this time
My Care Alabama East	1	Percentage of pregnant women who smoked during pregnancy **Baseline: 26.4%; Interim Y1: 15.4%; Interim Y2: 16.0%; Final: 17.7%; Target: 15.0%**	Improvement
	2	Percentage of live births that weighed < 2,500 grams during the reporting period **Baseline: 8.8%; Interim Y1: 7.5%; Interim Y2: 8.5%; Final: 10.1%; Target: 8.7%**	Decline

ACHN Entity[1]	Indicator Number[2]	Indicator Description[3]	Assessment of Performance, Baseline (2019) to Final (2022)
	3	Percentage of live births on or between November 6 of the year prior to the MY and November 5 of the MY that had a postpartum visit between 21–56 days after delivery **Baseline: 64.9%; Interim Y1: 31.6%; Interim Y2: 54.1%; Final: 48.9%; Target: 74.8%**	Decline
My Care Alabama Northwest	1	Prenatal and Postpartum: The Timeliness of Prenatal Care **Baseline: 61.7%; Interim Y1: 55.8%; Interim Y2: 61.7%; Final: 74.5%; Target: 68.9%**	Improvement
	2	Pregnant women who smoke during pregnancy **Baseline: 24.8%; Interim Y1: 10.9%; Interim Y2: 22.7%; Final: 17.0%; Target: 22.2%**	Improvement
	3	Live births less than 2500 grams (LBW-CH) Percentage of live births that weighed less than 2,500 grams in the state during the reporting period **Baseline: 11.0%; Interim Y1: 12.1%; Interim Y2: 11.3%; Final: 11.7%; Target: 11.7%**	Decline
North Alabama Community Care	1	Percentage of pregnant EIs identified as having a BMI greater than or equal to 30.0 at their first prenatal visit receiving nutritional and healthy lifestyle counseling **Baseline: 91.1%; Interim Y1: 91.1%; Interim Y2: 90.5%; Final: 91.4%; Target: 93.0%**	Improvement
	2	Percentage of pregnant EIs that failed their GTT receiving nutritional and healthy lifestyle counseling **Baseline: 80.4%; Interim Y1: 80.4%; Interim Y2: 93.5%; Final: 100.0%; Target: 98.0%**	Improvement
	3	Percentage of pregnant EIs with a BMI greater than or equal to 30.0 at their first prenatal visit and/or EIs that failed their GTT enrolling in Plan First services after delivery **Baseline: 6.78%; Interim Y1: 6.8%; Interim Y2: 23.8%; Final: 23.05; Target: 50.0%**	Improvement
QIP 2: Childhood Obesity			
ACN Mid-State	1	Percentage of annual BMI assessments completed for EIs aged 3–19 years during the MY **Baseline: 8.6%; Interim Y1: 59.9%; Interim Y2: 64.6%; Final: 61.3%; Target: 70.0%**	Improvement
	2	Percentage of EIs aged 3–6 years that had an annual well visit during the MY **Baseline: 61.1%; Interim Y1: 52.7%; Interim Y2: 56.9%; Final: 68.3%; Target: 66.7%**	Improvement
	3	Percentage of EIs aged 7–11 years that had an annual well visit during the MY **Baseline: 74.9%; Interim Y1: 42.4%; Interim Y2: 46.6%; Final: 66.0%; Target: 78.6%**	Decline
	4	Percentage of EIs aged 3–11 years with diagnosis of being overweight or obese during the MY **Baseline: 35.1%; Interim Y1: 41.8%; Interim Y2: 40.2%; Final: 37.4%; Target: 34.1%**	Decline
ACN Southeast	1	Percentage of EIs aged 3–6 years who had a well-child visit in the MY **Baseline: 61.6%; Interim Y1: 58.3%; Interim Y2: 55.3%; Final: 58.4%; Target: 66.7%**	Decline

ACHN Entity[1]	Indicator Number[2]	Indicator Description[3]	Assessment of Performance, Baseline (2019) to Final (2022)
	2	Percentage of EIs aged 3–6 years with a BMI > 85th percentile **Baseline: 13.1%; Interim Y1: NA; Interim Y2: 32.2%; Final: No rate reported due to the indicator ending after Interim Y2; Target: 25.7%**	Unable to evaluate performance at this time
	3	Percentage of EIs aged 3– 6 years with a BMI between 5th and 85th percentile **Baseline: NA; Interim Y1: NA; Interim Y2: 62.8% new in 2021; Final: 65.3%; Target: 64.0%**	Improvement
Gulf Coast Total Care	1	Percentage of EIs aged 3–17 years who had an annual BMI assessment completed **Baseline: 62.3%; Interim Y1: 93.8%; Interim Y2: 94.3%; Final: 95.8%; Target: 95.0%**	Improvement
	2	Percentage of EIs aged 7–11 years with a diagnosis code of overweight (ICD-10 Z68.53) **Baseline: 44.9%; Interim Y1: 47.9%; Interim Y2: 22.7%; Final: 23.7%; Target: 41.8%**	Decline
	3	Percentage of EIs aged 7−11 years that had an annual PCP visit **Baseline: 89.1%; Interim Y1: 86.0%; Interim Y2: 81.7%; Final: 67.3%; Target: 90.3%**	Decline
My Care Alabama Central	1	Percentage of initiation of breastfeeding; baby placed on the breast during hospital stay **Baseline: NA; Interim Y1: 80.0%; Interim Y2: 77.0%; Final: 45.0%; Target: 81.9%**	Decline
	2	Percentage of pregnant EIs enrolled in WIC during the prenatal period, first trimester **Baseline: 46.0%; Interim Y1: 72.0%; Interim Y2: 60.0%; Final: 55.0%; Target: 59.1%**	Improvement
	3	Percentage increase in well-child visits during first 15 months of life, 6 or more **Baseline: NA; Interim Y1: NA; Interim Y2: NA; Final: 31.0%; Target: 61.8%**	Unable to evaluate performance at this time
My Care Alabama East	1	Percentage of children aged 3–17 years who had an outpatient visit with a PCP or ob/gyn and had evidence of BMI documentation during the MY **Baseline: 15.3%; Interim Y1: 69.2%; Interim Y2: 95.6%; Final: 95.8%; Target: 96.0%**	Improvement
	2	Percentage of children aged 3−17 years with a diagnosis of being overweight or obese in east region **Baseline: 31.8%; Interim Y1: 37.3%; Interim Y2: 45.8%; Final: 53.2%; Target: 38.5%**	Improvement
My Care Alabama Northwest	1	Percentage of children aged 3−17 years who had a visit with PCP or ob/gyn and who had evidence of BMI documentation during the MY **Baseline: 11.7%; Interim Y1: 62.7%; Interim Y2: 91.9%; Final: 95.8%; Target: 91.9%**	Improvement
North Alabama Community Care	1	Percentage of EIs aged 3–6 years with documentation of BMI in their medical record **Baseline: 89.5%; Interim Y1: 78.9%; Interim Y2: 72.1%; Final: 80.1%; Target: 73.0%**	Improvement
	2	Percentage of EIs aged 3–6 years with a BMI between 85% and 94% **Baseline: 16.01%; Interim Y1: 15.4%; Interim Y2: 14.7%; Final: 12.0%; Target: 14.0%**	Improvement

ACHN Entity[1]	Indicator Number[2]	Indicator Description[3]	Assessment of Performance, Baseline (2019) to Final (2022)
	3	Percentage of first-time pregnant EIs that were breastfeeding at postpartum visit **Baseline: 31.3%; Interim Y1: 27.6%; Interim Y2: 45.6%; Final: 35.6%; Target: 46.0%**	Improvement
QIP 3: Substance Use Disorder			
ACN Mid-State	1	Percentage of EIs aged 18–64 years with a new episode of AOD abuse or dependence who engaged in AOD treatment **Baseline: 1.4%; Interim Y1: 12.5%; Interim Y2: 8.5%; Final: 40.2%; Target: 41.1%**	Improvement
ACN Southeast	1	Percentage of EIs with an SUD diagnosis who received treatment during the MY **Baseline: 13.6%; Interim Y1: 12.6%; Interim Y2: 7.9%; Final: 11.8%; Target: 10.0%**	Improvement
Gulf Coast Total Care[4]	1	Percentage of EIs aged 18 years and older with a new episode of opioid-related disorders (ICD-10 F-11) that enrolled in care coordination **Baseline: NA; Interim Y1: NA; Interim Y2: 23.6%; Final: 15.4%; Target: 25.6%**	Decline
	2	Percentage of EIs 18 and older with an OUD and first MAT prescription filled (no prior claim in past 60 days) and agreed P.E.I.R. or another community treatment agency referral **Baseline: NA; Interim Y1: NA; Interim Y2: 15.5%; Final: 37.2%; Target: 20.0%**	Improvement
	3	Percentage of eligible providers who completed the Opioid Use Disorder Educational Outreach and Survey and increased knowledge/understanding of OUD, prescribing guidelines, treatment options, and community resources **Baseline: NA; Interim Y1: NA; Interim Y2: 100.0%; Final: 88.9%; Target: 75.0%**	Improvement
My Care Alabama Central	1	Percentage of beneficiaries who initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication treatment within 14 days of the diagnosis **Baseline: 32.2%; Interim Y1: 32.3%; Interim Y2: 35.8%; Final: 33.0%; Target: 37.4%**	Improvement
	2	Number of EIs who initiated treatment and had two or more additional services within 30 days of initiation visit **Baseline: 2.9%; Interim Y1: 3.6%; Interim Y2: 4.3%; Final: 4.4%; Target: 5.2%**	Improvement
	3	Percentage of students enrolled in the targeted high schools that completed the curriculum, Operation Prevention **Baseline: 0.0%; Interim Y1: 0.0%; Interim Y2: 0.0%; Final: 80.0%; Target: 90.0%**	Unable to evaluate performance at this time
My Care Alabama East	1	Percentage of beneficiaries aged 18 years and over with a new episode of AOD abuse or dependence who initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or MAT within 14 days of the diagnosis **Baseline: 29.6%; Interim Y1: 33.5%; Interim Y2: 28.7%; Final: 30.1%; Target: 37.8%**	Improvement

ACHN Entity[1]	Indicator Number[2]	Indicator Description[3]	Assessment of Performance, Baseline (2019) to Final (2022)
	2	Percentage of beneficiaries aged 18 years and over with a new episode of AOD abuse or dependence who initiated treatment and who had two or more additional AOD services or MAT within 34 days of the initiation visit **Baseline: 2.8%; Interim Y1: 4.4%; Interim Y2: 2.8%; Final: 10.0%; Target: 7.7%**	Improvement
My Care Alabama Northwest	1	Percentage of EIs aged 18 years and over with a new episode of AOD abuse or dependence who initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or MAT within 14 days of the diagnosis **Baseline: 41.0%; Interim Y1: 41.2; Interim Y2: 40.7%; Final: 39.4%; Target: 41.1%**	Decline
	2	Percentage of EIs aged 18 years and over with a new episode of AOD abuse or dependence who initiated treatment and who had two or more additional AOD services or MAT within 34 days of the initiation visit **Baseline: 13.3%; Interim Y1: 20.7%; Interim Y2: 18.8%; Final: 22.1%; Target: 20.6%**	Improvement
North Alabama Community Care	1	Percentage of EIs aged 13 years and over with a new episode of SUD receiving SUD treatment[5] **Baseline: 4.6%; Interim Y1: 4.6%; Interim Y2: NA; Final: NA; Target: 4.8%**	Unable to evaluate performance at this time

[1] Improvement in performance demonstrated is denoted in green; a decline in performance is denoted in red. Gray indicates the inability to evaluate performance at this time or that the performance remained constant.
[2] Indicators are numbered as they are in the entity's QIPs proposal submissions.
[3] Rates presented in this table may differ from the rates presented in the ACHN performance measure validation tables due to the availability of data at the time of the QIP report submissions.
[4] Gulf Coast Total Care's indicators for the Substance Use Disorder QIP were all new in interim year 2 and did not have baseline data available.
[5] The ACHN states that diagnosis codes that were used for EI selection included "in remission" cases and was inflating the denominator. Data was re-pulled to include only non-remission cases. As a result, there were only two measurements taken: a baseline (which also served as the interim) and a final, which was on a different scale and not comparable to the baseline.
ACHN: Alabama Coordinated Health Network; QIP: quality improvement project; ACN: Alabama Care Network; Y1: year 1; Y2: year 2; EI: eligible individual; ZIP: zone improvement plan; NA: not available; AMA: Alabama Medicaid Agency; MY: measurement year; GTT: glucose tolerance test; BMI: body mass index; ICD-10: International Classification of Diseases, 10th Revision; PCP: primary care provider; WIC: Special Supplemental Nutrition Program for Women, Infants, and Children; ob/gyn: obstetrician/gynecologist; AOD: alcohol and other drugs; SUD: substance use disorder; OUD: opioid use disorder; MAT: medication-assisted therapy; PEIR: People Engaged in Recovery.

2023-2024 QIP Findings

In measurement year 2023, ACHN entities proposed new QIP reports on adverse birth outcomes, childhood obesity, and substance use disorder. Validation results for these proposals are presented in **Tables 21–23**. An assessment of interventions, indicator results, and performance will be completed in June 2024 and reported in the RY 2025 ATR.

Table 21: Adverse Birth Outcomes QIP – MY 2023 Validation Results

Validation Elements	ACNM	ACNS	GCTC	MCA-C	MCA-E	MCA-NW	NACC
Topic/Rationale							
1a. Attestation signed and project identifiers completed	M	M	M	M	M	M	M
1b. Supported with entity-level data (e.g., historical data related to disease prevalence or screening rates)	M	M	PM	M	M	M	M
Aim							
2a. Aims described for all performance indicators and include corresponding goals	M	M	M	M	PM	M	M
2b. Goal sets a target improvement rate that is bold, feasible, and based upon baseline data and strength of interventions, with rationale (e.g., benchmark)	M	M	M	M	M	M	M
2c. Vision statement aligns with aim, goals, and interventions	M	M	PM	PM	M	M	M
Methodology							
3a. Performance indicators are clearly defined and measurable (specifying numerator and denominator criteria with clearly defined timeframe)	M	M	PM	M	PM	M	M
3b. Performance indicators measure changes in health status, functional status, satisfaction, or processes of care with strong associations with improved outcomes	M	M	M	M	M	M	M
3c. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly and consistently defined	M	M	M	M	PM	M	M
3d. Procedures indicate data source, hybrid vs. administrative, reliability (e.g., Inter-Rater Reliability [IRR])	M	M	M	M	M	M	M
3e. If sampling was used, the entity identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.	N/A	M	N/A	N/A	N/A	N/A	N/A

Validation Elements	ACNM	ACNS	GCTC	MCA-C	MCA-E	MCA-NW	NACC
3f. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	M	M	M	M	PM	M	M
3g. Study design specifies data analysis procedures with a corresponding timeline	M	M	M	M	M	M	M
Population analysis and stratification of performance indicator(s)							
4a. Entity provides a description of their population and its characteristics	M	M	M	PM	PM	M	M
4b. Stratifies results for at least one performance indicator across subgroups	M	M	PM	PM	PM	PM	M
Barrier analysis							
5a. Barriers listed represent obstacles to achieving improved rates on performance indicators	M	M	M	M	M	M	M
5b. Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or entity. Entity uses two or more of the methodologies in parentheses, at least one of which is directly from providers or members (e.g., member complaint data, member or provider survey, member advisory committee, member input at focus groups and/or Quality Meetings, from CM outreach, member complaint data, member surveys, and/or member advisory committee, provider input at focus groups, Quality Meetings, provider survey, literature review). IPRO strongly suggests combining qualitative and quantitative data for barrier analysis to understand why there are patterns in the data that you see.	M	M	M	M	M	M	M
5c. There is at least one barrier corresponding to each performance indicator	M	M	M	M	M	M	M
5d. Barrier analysis reflects additional knowledge gained throughout course of PIP (interim and final reports)	N/A	N/A	N/A	M	N/A	N/A	N/A
Robust interventions							
6a. All performance indicators addressed by at least one intervention	M	M	M	M	M	M	M
6b. Interventions are active and clearly defined	M	M	M	M	M	M	M
6c. Interventions are informed by barrier analysis	M	M	M	M	M	M	NM
6d. Interventions involve actions that target a mix of member, provider, community, system, and entity	M	M	M	M	M	M	M

Validation Elements	ACNM	ACNS	GCTC	MCA-C	MCA-E	MCA-NW	NACC
6e. New or enhanced, starting after baseline year	M	PM	M	M	PM	M	M
6f. All interventions have corresponding intervention tracking measures (generally monthly or quarterly), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in First Remeasurement Period and Second Remeasurement Period/Final PIP Reports)	M	M	M	M	M	M	M

MY: measurement year; QIP: quality improvement project; ACNM: Alabama Care Network Mid-State; ACNS; Alabama Care Network Southeast; GCTC: Gulf Coast Total Care; MCA-C: My Care Alabama Central; MCA-E: My Care Alabama East; MCA-NW: My Care Alabama Northwest; NACC: North Alabama Community Care; N/A: not applicable; M: met; PM: partially met; NM: not met; PIP: performance improvement project; CM: care management.

Table 22: Childhood Obesity QIP – MY 2023 Validation Results

Validation Element	ACNM	ACNS	GCTC	MCA-C	MCA-E	MCA-NW	NACC
Topic/Rationale							
1a. Attestation signed and project identifiers completed	M	M	M	M	M	M	M
1b. Supported with entity-level data (e.g., historical data related to disease prevalence or screening rates)	M	M	M	M	M	M	M
Aim							
2a. Aims described for all performance indicators and include corresponding goals	M	M	M	M	PM	M	M
2b. Goal sets a target improvement rate that is bold, feasible, and based upon baseline data and strength of interventions, with rationale (e.g., benchmark)	M	M	M	PM	PM	M	M
2c. Vision statement aligns with aim, goals, and interventions	M	M	M	M	M	M	M
Methodology							
3a. Performance indicators are clearly defined and measurable (specifying numerator and denominator criteria with clearly defined timeframe)	M	M	M	M	M	M	M
3b. Performance indicators measure changes in health status, functional status, satisfaction, or processes of care with strong associations with improved outcomes	M	M	M	M	M	M	M
3c. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly and consistently defined	M	M	M	M	M	M	M
3d. Procedures indicate data source, hybrid vs. administrative, reliability (e.g., Inter-Rater Reliability [IRR])	M	M	M	M	M	M	M

Validation Element	ACNM	ACNS	GCTC	MCA-C	MCA-E	MCA-NW	NACC
3e. If sampling was used, the entity identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.	N/A	M	N/A	N/A	N/A	N/A	N/A
3f. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	M	M	M	M	M	M	M
3g. Study design specifies data analysis procedures with a corresponding timeline	M	M	M	M	M	M	M
Population analysis and stratification of performance indicator(s)							
4a. Entity provides a description of their population and its characteristics	M	M	M	PM	NM	NM	M
4b. Stratifies results for at least one performance indicator across subgroups	M	M	PM	M	NM	M	M
Barrier analysis							
5a. Barriers listed represent obstacles to achieving improved rates on performance indicators	M	M	PM	M	M	M	M
5b. Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or entity. Entity uses two or more of the methodologies in parentheses, at least one of which is directly from providers or members (e.g., member complaint data, member or provider survey, member advisory committee, member input at focus groups and/or Quality Meetings, from CM outreach, member complaint data, member surveys, and/or member advisory committee, provider input at focus groups, Quality Meetings, provider survey, literature review). IPRO strongly suggests combining qualitative and quantitative data for barrier analysis to understand why there are patterns in the data that you see.	M	M	PM	M	M	PM	M
5c. There is at least one barrier corresponding to each performance indicator	M	M	M	M	PM	M	M
5d. Barrier analysis reflects additional knowledge gained throughout course of PIP (interim and final reports)	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Robust interventions							
6a. All performance indicators addressed by at least one intervention	M	M	M	M	PM	M	M

Validation Element	ACNM	ACNS	GCTC	MCA-C	MCA-E	MCA-NW	NACC
6b. Interventions are active and clearly defined	M	M	M	M	M	M	M
6c. Interventions are informed by barrier analysis	M	M	M	M	M	M	M
6d. Interventions involve actions that target a mix of member, provider, community, system, and entity	M	M	M	M	M	M	M
6e. New or enhanced, starting after baseline year	M	PM	M	M	M	M	NM
6f. All interventions have corresponding intervention tracking measures (generally monthly or quarterly), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in First Remeasurement Period and Second Remeasurement Period/Final PIP Reports)	M	M	M	M	PM	M	M

MY: measurement year; QIP: quality improvement project; ACNM: Alabama Care Network Mid-State; ACNS; Alabama Care Network Southeast; GCTC: Gulf Coast Total Care; MCA-C: My Care Alabama Central; MCA-E: My Care Alabama East; MCA-NW: My Care Alabama Northwest; NACC: North Alabama Community Care; PIP: performance improvement project; N/A: not applicable; M: met; PM: partially met; NM: not met; CM: care management.

Table 23: Substance Use Disorder QIP - MY 2023 Validation Results

Validation Elements	ACNM	ACNS	GCTC	MCA-C	MCA-E	MCA-NW	NACC
Topic/Rationale							
1a. Attestation signed and project identifiers completed	M	M	M	M	M	M	M
1b. Supported with entity-level data (e.g., historical data related to disease prevalence or screening rates)	M	M	M	M	M	M	M
Aim							
2a. Aims described for all performance indicators and include corresponding goals	M	M	M	M	PM	M	M
2b. Goal sets a target improvement rate that is bold, feasible, and based upon baseline data and strength of interventions, with rationale (e.g., benchmark)	M	M	M	M	PM	M	M
2c. Vision statement aligns with aim, goals, and interventions	M	M	PM	M	M	M	M
Methodology							
3a. Performance indicators are clearly defined and measurable (specifying numerator and denominator criteria with clearly defined timeframe)	M	M	M	M	M	M	M
3b. Performance indicators measure changes in health status, functional status, satisfaction, or processes of care with strong associations with improved outcomes	M	M	M	M	M	M	M

Validation Elements	ACNM	ACNS	GCTC	MCA-C	MCA-E	MCA-NW	NACC
3c. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly and consistently defined	M	M	M	PM	M	M	M
3d. Procedures indicate data source, hybrid vs. administrative, reliability (e.g., Inter-Rater Reliability [IRR])	M	M	M	M	M	M	M
3e. If sampling was used, the entity identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.	N/A	N/A	N/A	N/A	N/A	N/A	N/A
3f. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	M	M	M	M	M	M	M
3g. Study design specifies data analysis procedures with a corresponding timeline	M	M	M	N/A	M	M	M
Population analysis and stratification of performance indicator(s)							
4a. Entity provides a description of their population and its characteristics	M	M	M	PM	M	M	M
4b. Stratifies results for at least one performance indicator across subgroups	M	M	M	M	NM	PM	M
Barrier analysis							
5a. Barriers listed represent obstacles to achieving improved rates on performance indicators	M	M	M	M	M	M	M
5b. Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or entity. Entity uses two or more of the methodologies in parentheses, at least one of which is directly from providers or members (e.g. member complaint data, member or provider survey, member advisory committee, member input at focus groups and/or Quality Meetings, from CM outreach, member complaint data, member surveys, and/or member advisory committee, provider input at focus groups, Quality Meetings, provider survey, literature review). IPRO strongly suggests combining qualitative and quantitative data for barrier analysis to understand why there are patterns in the data that you see.	M	M	PM	M	M	PM	M
5c. There is at least one barrier corresponding to each performance indicator	M	M	M	M	M	M	M

Validation Elements	ACNM	ACNS	GCTC	MCA-C	MCA-E	MCA-NW	NACC
5d. Barrier analysis reflects additional knowledge gained throughout course of PIP (interim and final reports)	N/A	N/A	M	N/A	N/A	N/A	N/A
Robust interventions							
6a. All performance indicators addressed by at least one intervention	M	M	M	M	M	M	M
6b. Interventions are active and clearly defined	M	M	PM	M	M	M	M
6c. Interventions are informed by barrier analysis	M	M	M	M	M	M	M
6d. Interventions involve actions that target a mix of member, provider, community, system, and entity	M	M	M	M	M	M	M
6e. New or enhanced, starting after baseline year	M	M	M	M	M	M	M
6f. All interventions have corresponding intervention tracking measures (generally monthly or quarterly), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in First Remeasurement Period and Second Remeasurement Period/Final PIP Reports)	M	M	M	M	M	M	M

MY: measurement year; QIP: quality improvement project; ACNM: Alabama Care Network Mid-State; ACNS; Alabama Care Network Southeast; GCTC: Gulf Coast Total Care; MCA-C: My Care Alabama Central; MCA-E: My Care Alabama East; MCA-NW: My Care Alabama Northwest; NACC: North Alabama Community Care; PIP: performance improvement project; N/A: not applicable; M: met; PM: partially met; NM: not met; CM: care management.

IV. Validation of Performance Measures

Objectives

AMA selects ACHN PMs to assess access to care, effectiveness of care, and use of services. PM validation for reporting year 2023 covered MY 2022 (January 1, 2022−December 31, 2022). One of the mandatory activities for EQR is validation of PMs, the objective of which is to assess the accuracy and reliability of the PMs reported and to determine the extent to which they follow established measure technical specifications and are in accordance with the specifications in *Title 42 CFR 438.358(b)(2)*.

Technical Methods of Data Collection and Analysis

IPRO prepares the validation methodology, including the documentation/data request with instructions and data file layouts for submitting EI-level data and validation tools that are compliant with CMS's *EQR Protocol 2. Validation of Performance Measures*. The instructions include a list of state-required PMs and a request that the state return a list of numerators and denominators, a list of enrollees included as PM numerator positives, a list of documents to be reviewed, and information systems (IS) background information.

IPRO conducts a source code review to assess compliance with PM technical specifications. The state submits the source code used to generate eligible populations, denominator requirements, and numerator compliant hits for each PM along with related flowcharts, software documentation, input and output file record layouts and field descriptions, input and output record counts, and job logs. IPRO reviews the source code for each PM to assess compliance with specifications for all calculations (eligible population, denominator, numerator, and algorithms). The state also submits EI-level data files, in a format specified by IPRO, via a secure file transfer protocol (FTP) site (https://send.ipro.org).

Concurrent with source code validation, IPRO validates the accompanying EI-level data files by conducting several checks on each file. The EI-level data files include all EIs in the PM denominator with indicators of PM numerator compliance. The IPRO-generated validation programs and software programs used for each PM are based on the precise measure specifications.

IPRO uses a standardized validation tool to provide review comments on both the source code and EI-level data files and communicates any issues to state staff for response, clarification, revision, and/or resubmission. The tool documents IPRO's validation findings, the state's responses to IPRO's questions, and other review activities. Throughout the source code review process, the validation team maintains regular contact with designated state staff via telephone and email, provides technical assistance on programming issues, and answers any questions the state may have regarding PM technical specifications, submission requirements, and/or the validation process itself. The state is given the opportunity to revise and resubmit both the source code and data until its submissions are fully compliant with PM specifications.

Description of Data Obtained

IPRO requested and received the following documentation related to PM calculation from AMA:

- AMA source code for the measures,
- EI-level detail files,
- preliminary rates,
- response to IPRO findings to preliminary rates, and
- final rates.

In addition, IPRO received an Information Systems Capabilities Assessment (ISCA) worksheet completed by AMA, which was organized into the following five sections:

- Data Integration and Systems Architecture,
- Enrollment System(s) and Processes,
- Claim/Encounter System(s) and Processes,
- Provider Data System(s) and Processes, and
- Oversight of Contracted Vendor(s).

IPRO employs several techniques to assess whether the state's PM rates are valid, unbiased, and reportable. This assessment includes calculating rates using EI-level data files and comparing the rates against available national benchmarks.

Conclusions and Comparative Findings

In 2021, AMA contracted with IPRO to conduct the ISCA in accordance with Appendix A of the *CMS External Quality Review (EQR) Protocols* report. No issues were found that impacted the reporting of the measures.

To make an overall assessment about the quality, timeliness, and access to care provided by each ACHN entity and to track performance over CY 2022 IPRO assigned measures to one or more of the three domains depicted in **Table 24**.

Table 24: ACHN Performance Measure Domains

Measure	Quality	Timeliness	Access
Adult BMI Assessment	–	–	X
Antidepressant Medication Management	X	–	–
Asthma Medication Ratio (adult)	X	–	–
Asthma Medication Ratio (child)	X	–	–
Cervical Cancer Screening	–	–	X
Children and Adolescents' Access to Primary Care Practitioners (CAP-CH)	–	–	X
Initiation and Engagement of Treatment for AOD (Continuation)	X	X	–
Initiation and Engagement of Treatment for AOD (Initiation)	X	X	–
Live Births Less Than 2,500 Grams	X	–	–
Timeliness of Prenatal Care	–	X	–
Weight Assessment and Counseling for Children/Adolescents – BMI Assessment	–	–	X
Well-Child Visits in the First 15 Months of Life	–	X	X

ACHN: Alabama Coordinated Health Network; BMI: body mass index; AOD: alcohol and other drugs.

Table 25 displays the performance measure rates for MY 2022 for all entities, the statewide average, and the statewide average percentile achieved for the NCQA 2022 benchmark. Green shading indicates the ACHN performed at or above the statewide 2022 performance. Red shading indicates the ACHN performed below the statewide 2022 performance. Gray shading indicates that these rates were retired and therefore no NCQA benchmarks are reported.

Table 25: ACHN Quality Measure Rates for August 2023 – Incentive Report

Measure Description[1]	ACNM	ACNS	GCTC	MCA-C	MCA-E	MCA-NW	NACC	2022 Statewide Average	Statewide Average Percentile
Adult BMI Assessment[2]	89.9%	88.8%	91.7%	92.3%	92.1%	91.2%	89.4%	*	-
Antidepressant Medication Management (Continuation Phase)	30.7%	27.7%	25.6%	24.9%	28.0%	28.7%	26.6%	26.3%	< 5th
Asthma Medication Ratio: Aged 19–64 Years (19−50)	69.3%	80.2%	72.1%	73.7%	73.8%	72.5%	76.0%	73.6%	> 95th
Asthma Medication Ratio: Aged 5–18 Years (5−11)	81.2%	84.9%	81.5%	85.8%	89.2%	85.4%	89.7%	85.6%	90th
CAP-CH (HEDIS®) Aged 12–24 Months	86.0%	89.0%	86.5%	87.8%	90.5%	89.4%	88.5%	*	-
CAP-CH (HEDIS) Aged 25 Months–6 Years	80.3%	84.2%	77.3%	82.2%	86.3%	82.1%	81.3%	*	-
CAP-CH (HEDIS) Aged 7–11 Years	86.2%	88.5%	81.3%	85.9%	91.1%	86.9%	86.8%	*	-
CAP-CH (HEDIS) Aged 12–19 Years	83.5%	86.9%	80.3%	82.8%	88.0%	84.7%	84.0%	*	-
Cervical Cancer Screening	48.0%	47.2%	47.3%	44.7%	43.3%	46.0%	43.7%	47.0%	10th
Initiation and Engagement of Treatment for AOD (Initiation)	35.7%	35.3%	36.9%	32.7%	30.7%	37.8%	35.1%	34.7%	5th
Initiation and Engagement of Treatment for AOD (Engagement)	6.6%	9.1%	7.9%	5.3%	7.2%	11.7%	9.3%	6.8%	10th
Live Births Weighing Less Than 2,500 Grams	13.1%	10.8%	12.3%	13.6%	8.9%	10.9%	9.8%	*	-
Timeliness of Prenatal Care	78.1%	81.7%	78.9%	73.0%	68.6%	73.3%	64.2%	71.1%	5th
Well-Child Visits in the First 15 Months of Life	53.5%	65.8%	50.2%	51.9%	61.0%	50.4%	56.4%	54.6%	33.33rd
Weight Assessment and Counseling for Children/Adolescents – BMI Assessment	97.2%	98.5%	97.4%	97.7%	98.0%	97.9%	98.2%	95.1%	> 95th

[1]Green shading indicates the ACHN qualified for the incentive based on the annual performance rates. Red shading indicates the ACHN did not qualify for the incentive based on the annual performance rates. Gray shading indicates that these rates were retired and therefore no NCQA benchmarks are reported.
[2]The 2019 rate reported to CMS represents the 18−64 years of age group. The ACHN rate is for those aged 18−75 years.
*Rates were retired by CMS therefore no rates were reported.
ACHN: Alabama Coordinated Health Network; ACNM: Alabama Care Network Mid-State; ACNS: Alabama Care Network Southeast; GCTC: Gulf Coast Total Care; MCA-C: My Care Alabama Central; MCA-E: My Care Alabama East; MCA-NW: My Care Alabama Northwest; NACC: North Alabama Community Care; HEDIS: Healthcare Effectiveness Data and Information Set; BMI: body mass index; AOD: alcohol and other drug; CAP-CH: Children and Adolescents' Access to Primary Care Practitioners.

The following presents a summary of the findings indicated in **Table 25**:

- In the domain of **quality**, the statewide average was above the National 2022 Medicaid 95th percentile for Asthma Medication Ratio (aged 19–64 years). The statewide average was below the National 2022 Medicaid 5th percentile for Antidepressant Medication Management (continuation phase).
- In the domain of **timeliness**, the statewide average was at the National 2022 Medicaid 5th percentile for Initiation and Engagement of Treatment for AOD (initiation) and Timeliness of Prenatal Care.
- In the domain of **access**, the statewide average was above the National 2022 Medicaid 95th percentile for Weight Assessment and Counseling for Children/Adolescents: BMI Assessment. The statewide average was at the National 2022 Medicaid 10th percentile for Cervical Cancer Screening.
- All seven entities exceeded the statewide average for Weight Assessment and Counseling for Children/Adolescents: BMI Assessment. Five entities exceeded the statewide average for the following measures: Antidepressant Medication Management (continuation phase), Initiation and Engagement of Treatment for AOD (initiation and engagement), and Timeliness of Prenatal Care.

V. Review of Compliance with Medicaid and CHIP Managed Care Regulations

Objectives

Per *Title 42 CFR § 438.358*, a review of a managed care entity's compliance with the standards set forth in *42 Code of Federal Regulations Part 438 Managed Care Subpart D MCO, PIHP and PAHP Standards,* the disenrollment requirements and limitations described in *42 Code of Federal Regulations 438.56,* the enrollee rights requirements described in *42 Code of Federal Regulations 438.100,* the emergency and post-stabilization services requirements described in *42 Code of Federal Regulations 438.114,* and the quality assessment and performance improvement requirements described in *42 Code of Federal Regulations 438.330* is a mandatory external quality activity. Further, the state, its agent, or the external quality review organization must conduct this review within the previous 3-year period.

The Alabama Medicaid Agency conducts a variety of oversight activities to ensure ACHN adherence to standards related to member rights and protections, access to services, structure and operations, measurement and improvement, and grievance system standards, as well as all applicable elements of the ACHN contract.

Title 42 CFR § 438.358 Activities related to external quality review (a)(1) mandates that the state or an external quality review organization must perform the review to determine managed care compliance with federal Medicaid standards. To meet this federal regulation, the Alabama Medicaid Agency contracted with IPRO to conduct the 2023 systems performance reviews (SPR).

The period under review was October 1, 2022, through September 30, 2023.

Technical Methods of Data Collection and Analysis

IPRO's assessment was conducted in alignment with the CMS's *EQR Protocol 3. Review of Compliance with Medicaid and CHIP Managed Care Regulations* and included reviews of ACHN entity-documented policies and procedures, individual EI case files, and interviews with key members of the entity's staff.

The SPR included a comprehensive evaluation of entity policies, procedures, enrollee case files, and other materials corresponding to the review areas in **Table 26**. For the areas that included file review, 15 files were requested for each area. In some instances, there were fewer than 15 files available for review.

Table 26: SPR Areas and Corresponding Materials Reviewed

Area	Document Review	File Review
Care Coordination and Continuity of Care	✓	✓
Confidentiality	✓	N/A
Disenrollment	✓	N/A
Enrollee Rights	✓	N/A
Grievance and Appeal Systems	✓	✓
Health Information Systems	✓	N/A
Information Requirements and EI Materials	✓	N/A
Provider Selection and Provider Participation	✓	N/A
Quality Assurance and Performance Improvement	✓	N/A
Subcontractual Relationships and Delegation	✓	N/A

SPR: systems performance review; EI: eligible individual; N/A: not available.

For this review, determinations of "met," "partial," and "non met" were used for each element under review. Definitions of these review determinations are presented in **Table 27**.

Table 27: SPR Determination Definitions

Review Determination	Definition
Met	The entity has met or exceeded the requirement.
Partial	The entity had partially met the requirement.
Not Met	The entity has not met the requirement.

SPR: systems performance review.

The initial documentation review consisted of policies and procedures, EI-facing materials, provider-facing materials, EI case files, and other documents as needed to demonstrate compliance with specific contractual or regulatory requirements. A team of eight experienced IPRO compliance officers, clinical and nonclinical, convened to review the ACHN entities' policies, procedures, and materials and assess their concordance with the state's contract requirements. This review was documented using audit tools IPRO developed to capture the review elements and record the findings. These review tools, with IPRO's initial findings, were used to guide the interview portion of the review.

The interview component of the review was composed of a one-day video conference call with each entity, which included a review of elements in each of the review tools that received less than full compliance based upon initial documentation review. Staff interviews were used to further explore the written documentation and for the entity to provide additional documentation, if available. File review, as indicated, was conducted to assess the entity's implementation of policies and in accordance with state standards.

Description of Data Obtained

For the SFY 2023 SPR, IPRO performed a comprehensive review of all evaluation areas, drawing on information from ACHN entities' policies and procedures, IS demonstrations and documentation, meeting minutes and notes, reports, subcontracts with delegates, grievance files, and care coordination files.

Conclusions and Comparative Findings

Each of the ACHN entities achieved an overall review determination of partial, indicating that one or more of the requirements reviewed during the 2023 SPR did not demonstrate full compliance. **Tables 28 and 29** display the ACHN entities' compliance determinations.

Table 28: CFR Standards to State Compliance Tool Crosswalk and Document Review Findings

CFR Standard Name	CFR Citation	2023 SPR Tool	Document Review Findings						
			ACNM	ACNS	GCTC	MCA-C	MCA-E	MCA-NW	NACC
Overall compliance score			**Partial**	**Partial**	**Partial**	**Partial**	**Partial**	**Partial**	**Partial**
Information Requirements	**438.10**	Information Requirements and EI Materials	Met	Met	Met	Partial	Partial	Partial	Partial
Enrollee Rights	**438.100**	Enrollee Rights and Responsibilities, and Enrollment	Met	Met	Met	Met	Met	Met	Partial
Emergency and Post Stabilization Service	**438.114**								
Coordination and Continuity of Care	**438.208**	Care Coordination	Met	Met	Partial	Partial	Met	Partial	Partial
Practice Guidelines	**438.236**								
Provider Selection	**438.214**	Provider Selection and Participation	Met	Met	Met	Met	Met	Met	Met
Confidentiality	**438.224**	Confidentiality	Met	Met	Met	Met	Met	Met	Partial
Grievance and Appeal Systems	**438.228**	Grievances	Met	Met	Met	Met	Met	Met	Partial
Subcontractual Relationships and Delegation/Prohibited Affiliations	**438.230** **438.610**	Subcontracts/Prohibited Affiliations	Met	Met	Met	Met	Met	Met	Met
Health Information Systems	**438.242**	Health Information Management Systems	Met	Met	Met	Met	Met	Met	Met
QAPI	**438.330**	QAPI/Quality Management	Partial	Partial	Partial	Partial	Partial	Partial	Partial
Disenrollment	**438.56**	Disenrollment and Reenrollment	Met	Met	Met	Met	Met	Met	Met
Availability of Services	**438.206**	Does not apply to PCCM-Es[1]	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Assurances of Adequate Capacity and Services	**438.207**								
Coverage and Authorization of Services	**438.210**								

[1] CFR requirement does not apply to PCCM-Es. PCCM-E specific contracted services are reviewed in the Enrollee Rights and Information Requirements and EI Materials tool.
CFR: Code of Federal Regulations; SPR: systems performance review; ACNM: Alabama Care Network Mid-State; ACNS: Alabama Care Network Southeast; GCTC: Gulf Coast Total Care; MCA-C: My Care Alabama Central; MCA-E: My Care Alabama East; MCA-NW: My Care Alabama Northwest; NACC: North Alabama Community Care; EI: eligible individual; N/A: not applicable; QAPI: Quality Assurance and Performance Improvement.

Table 29: File Review Findings

CFR Standard Name	ACNM	ACNS	GCTC	MCA-C	MCA-E	MCA-NW	NACC
438.208 Coordination and Continuity of Care							
Family Planning	Met	Met	Partial	Partial	Partial	Partial	Partial
General Care Coordination	Met	Met	Partial	Partial	Partial	Partial	Partial
Maternity Care Coordination	Partial	Partial	Partial	Partial	Partial	Partial	Partial
Sickle Cell Disease	Partial	Partial	Partial	Partial	Partial	Partial	Partial
438.228 Grievance and Appeal System							
EI Grievances	Met	Met	Met	Met	Met	Met	Met

CFR: Code of Federal Regulations; ACNM: Alabama Care Network Mid-State; ACNS: Alabama Care Network Southeast; GCTC: Gulf Coast Total Care; MCA-C: My Care Alabama Central; MCA-E: My Care Alabama East; MCA-NW: My Care Alabama Northwest; NACC: North Alabama Community Care; EI: eligible individual; PCCM-E: primary care case management entity.

ACN Mid-State

The following presents a summary of ACN Mid-State's performance in the 2023 SPR.

Information Requirements

- All requirements were addressed in ACN Mid-State's policies and procedures.

Disenrollment Requirements

- All requirements were addressed in ACN Mid-State's policies and procedures.

Enrollee Rights and Protection

- All requirements were addressed in ACN Mid-State's policies and procedures.

Care Coordination

- All requirements were addressed in ACN Mid-State's policies and procedures.
- Family Planning CC file review: 15 of 15 files reviewed met the requirements.
- General CC file review: 15 of 15 files reviewed met the requirements.
- Maternity CC file review: 14 of 15 cases reviewed met the requirements.
  - Case #6: The second encounter occurred at 31 weeks, which is the 3rd trimester. Could not locate evidence of postpartum encounter. Case was closed on 12/12/22. During the virtual interviews, the ACHN acknowledged this finding and stated there was a change in the requirements that may have accounted for this error.
- Sickle Cell CC file review: 10 of 15 cases reviewed met the requirements.
  - Five of 15 cases reviewed did not have evidence of follow-up encounter.

Provider Selection and Participation

- All requirements were addressed in ACN Mid-State's policies and procedures.

Confidentiality

- All requirements were addressed in ACN Mid-State's policies and procedures.

Grievance and Appeals

- All requirements were addressed in ACN Mid-State's policies and procedures.
- Grievance file review: 7 of 7 cases reviewed met the requirements.

Subcontractual Relationships and Delegation

- All requirements were addressed in ACN Mid-State's policies and procedures.

HIMS

- All requirements were addressed in ACN Mid-State's policies and procedures.

Quality Management and Performance Improvement (QAPI)

- Of the 63 requirements reviewed for ACN Mid-State, 60 were full and 3 were partial. The partial determinations reflected requirements related to measurement of performance using objective quality indicators, and planning and initiation of activities for increasing or sustaining improvement.

ACN Southeast

The following presents a summary of ACN Southeast's performance in the 2023 SPR.

Information Requirements

- All requirements were addressed in ACN Southeast's policies and procedures.

Disenrollment Requirements

- All requirements were addressed in ACN Southeast's policies and procedures.

Enrollee Rights and Protection

- All requirements were addressed in ACN Southeast's policies and procedures.

Care Coordination

- All requirements were addressed in ACN Southeast's policies and procedures.
- Family Planning CC file review: 15 of 15 files reviewed met the requirements.
- General CC file review: 15 of 15 files reviewed met the requirements.
- Maternity CC file review: 14 of 15 cases reviewed met the requirements.
  - Case #9: The initial visit was 1/19/22. Could not locate additional attempts to contact noted until 8/10/22 (unsuccessful phone attempt).
- Sickle Cell CC file review: 12 of 15 cases reviewed met the requirements.
  - Cases #12, #13, and #14 did not have evidence of face-to-face encounters during months 4–6.

Provider Selection and Participation

- All requirements were addressed in ACN Southeast's policies and procedures.

Confidentiality

- All requirements were addressed in ACN Southeast's policies and procedures.

Grievance and Appeals

- All requirements were addressed in ACN Southeast's policies and procedures.
- Grievance file review: 3 of 3 cases reviewed met the requirements.

Subcontractual Relationships and Delegation

- All requirements were addressed in ACN Southeast's policies and procedures.

HIMS

- All requirements were addressed in ACN Southeast's policies and procedures.

Quality Management and Performance Improvement (QAPI)

- Of the 63 requirements reviewed for ACN Southeast, 60 were full and 3 were partial. The partial determinations reflected requirements related to measurement of performance using objective quality indicators, and planning and initiation of activities for increasing or sustaining improvement.

GCTC

The following presents a summary of GCTC's performance in the 2023 SPR.

Information Requirements

- All requirements were addressed in GCTC's policies and procedures.

Disenrollment Requirements

- All requirements were addressed in GCTC's policies and procedures.

Enrollee Rights and Protection

- All requirements were addressed in GCTC's policies and procedures.

Care Coordination

- Three requirements were partially addressed, and one was not addressed in GCTC's policies and procedures. The partial determinations reflected requirements related to care coordinator caseloads,

while the not determination was related to allowance requests for care coordinator caseload requirements (which had previously been an issue for the entity). The entity was encouraged to add this requirement to an existing policy or create a new one.

- Family Planning CC file review: 10 of 15 files reviewed met the requirements.
  - Case #3: 11/11/21 was the last successful encounter/evaluation; the next attempt to contact the EI did not occur until 11/3/22 and 2/7/23, with closure note on 4/12/23.
  - Case #7: Could not locate reason case was closed. No follow-up was conducted after the initial encounter.
  - Case #11: Could not locate evidence that priority 1 topics of discussion for STD prevention and breast self-exam were conducted.
  - The case was closed 6 months after the second encounter on 7/1/22 – could not locate contact attempts to the EI and there were still open goals.
  - Case #13: The case was closed 6 months after the second encounter on 4/7/22 – could not locate contact attempts to the EI (a high school sophomore) and there were still open goals.
  - Case #14: Could not locate evidence that the EI's anxiety and issues with vaping were addressed.
- General CC file review: 11 of 15 files reviewed met the requirements.
  - Case #8: Could not locate contact between 9/28/22 and 1/6/23.
  - Case #9: Could not locate evidence of contact between March–June and in December.
  - Case #11: There was a face-to-face (F2F) on 3/10/23, a call attempt on 7/31, and a successful call on 8/1, which exceeds the 90-day maximum between encounters.
  - Case #14: 7/26/22 was the last telephonic contact before the 10/6/22 closing telephonic encounter.
- Maternity CC file review: 12 of 15 cases reviewed met the requirements.
  - Case #4: Could not locate evidence of encounter with EI during the 2nd and 3rd trimesters.
  - Case #10: Could not locate evidence of follow-up within the 2nd trimester/13–28 weeks age of gestation (AOG).
  - Case #16: Could not locate evidence of follow-up during the 2nd trimester (13–28 weeks AOG).
- Sickle Cell CC file review: 7 of 15 files reviewed met the requirements.
  - Case #1: The risk changed multiple times. Could not locate 4–6 encounters.
  - Case #3: Smoking was not addressed in care plan or task notes.
  - Case #4: The EI was stratified as medium risk on the screening, which neglected to identify sickle cell disease as stated in the notes.
  - Case #6: The EI was stratified as medium risk on the screening.
  - Case #11: The EI was stratified as medium risk on the screening.
  - Case #14: The EI was stratified as medium risk on the screening.
  - Case #16: At 6/23/23 encounter, the risk was downgraded to medium, less than the 6-month minimum requirement.
  - Case #17: There were no encounters during month 2 (August).

Provider Selection and Participation

- All requirements were addressed in GCTC's policies and procedures.

Confidentiality

- All requirements were addressed in GCTC's policies and procedures.

Grievance and Appeals

- All requirements were addressed in GCTC's policies and procedures.
- Grievance file review: 15 of 15 cases reviewed met the requirements.

Subcontractual Relationships and Delegation

- All requirements were addressed in GCTC's policies and procedures.

HIMS

- All requirements were addressed in GCTC's policies and procedures.

Quality Management and Performance Improvement (QAPI)

- Of the 63 requirements reviewed for GCTC, 59 were full and 4 were partial. One of the partial determinations reflected a requirement related to measurement of performance using objective quality indicators, another reflected evaluation of the effectiveness of the interventions based on the performance measures, and two others were related to planning and initiation of activities for increasing or sustaining improvement.

MCA-C

The following presents a summary of MCA-C's performance in the 2023 SPR.

Information Requirements

- Two requirements were partially addressed in MCA-C's policies and procedures. The partial determinations reflected requirements related to informing the EI that information is available in paper form from the entity without charge upon request and provided within 5 business days.

Disenrollment Requirements

- All requirements were addressed in MCA-C's policies and procedures.

Enrollee Rights and Protection

- All requirements were addressed in MCA-C's policies and procedures.

Care Coordination

- All requirements were addressed in MCA-C's policies and procedures.
- Family Planning C file review C: 12 of 15 files reviewed met the requirements.
  - Case #4: Could not locate evidence that the diagnosis of diabetes was addressed in the care plan.
  - Case #6: Could not locate the evaluation. Could not locate evidence of contact to EI after enrollment.
  - Case #12: Could not locate evidence that diagnosis (heart failure) was addressed in the care plan.
- General CC file review: 13 of 15 files reviewed met the requirements.
  - Case #5: Could not locate evidence of PHQ-A and CRAFFT screening.
  - Case #15: No evidence of visit between 01/03/23 and 04/13/23.
- Maternity CC file review: 12 of 15 cases reviewed met the requirements.
  - Case #4: No evidence of in-home postpartum encounter.
  - Case #8: Delivery date 8/24/23, but no evidence of inpatient delivery encounter.
  - Case #10: Delivery date 07/04/23, but no evidence of in-home postpartum encounter.
- Sickle Cell CC file review: 9 of 15 files reviewed met the requirements.
  - Case #4: Could not locate the evaluation. Could not locate evidence of MCT within 60 calendar days of the initial/first visit. Could not locate encounter or follow up between 04/10/23 and 08/29/23.
  - Case #5: Initial outreach was not done within required timeframe.
  - Case #9: Could not locate encounters between 5/6 and 8/8.
  - Case #13: The first MCT was not completed in time. First encounter date 04/10/23, MCT date 06/21/23.
  - Case #14: Referral date 03/31/23, first documented contact date 06/12/23. Could not locate evidence of MCT. Could not locate evidence of encounter after 6/30/23.
  - Case #15: First documented contact was on 4/13/23, which is untimely.

Provider Selection and Participation

- All requirements were addressed in MCA-C's policies and procedures.

Confidentiality
- All requirements were addressed in MCA-C's policies and procedures.

Grievance and Appeals
- All requirements were addressed in MCA-C's policies and procedures.
- Grievance file review: 15 of 15 cases reviewed met the requirements.

Subcontractual Relationships and Delegation
- All requirements were addressed in MCA-C's policies and procedures.

HIMS
- All requirements were addressed in MCA-C's policies and procedures.

Quality Management and Performance Improvement (QAPI)
- Of the 63 requirements reviewed for MCA-C, 61 were full and 2 were partial. The partial determinations reflected requirements related to measurement of performance using objective quality indicators.

MCA-E
The following presents a summary of MCA-E's performance in the 2023 SPR.

Information Requirements
- Two requirements were partially addressed in MCA-E's policies and procedures. The partial determinations reflected requirements related to informing the EI that information is available in paper form from the entity without charge upon request and provided within 5 business days.

Disenrollment Requirements
- All requirements were addressed in MCA-E's policies and procedures.

Enrollee Rights and Protection
- All requirements were addressed in MCA-E's policies and procedures.

Care Coordination
- All requirements were addressed in MCA-E's policies and procedures.
- Family Planning CC file review: 12 of 15 files reviewed met the requirements.
  - Case #2: Could not locate evidence of contact with EI after enrollment (11/09/22) except on 05/19/23.
  - Case #4: Could not locate the evaluation. Could not locate evidence of follow-up with EI after enrollment on 06/09/23.
  - Case #9: Could not locate the evaluation.
- General CC file review: 14 of 15 files reviewed met the requirements.
  - Case #8: Could not locate evidence of contact for the months of July and August.
- Maternity CC file review: 9 of 15 cases reviewed met the requirements.
  - Case #6: No evidence of contact with EI between 05/26/23 and 09/22/23.
  - Case #7: No evidence of contact/follow-up with EI between 01/17/23 and 03/30/23; 03/30/23 and 05/15/23.
  - Case #8: No evidence of member contact or contact attempt between 02/17/23 and 08/14/23. No evidence of evaluation. No evidence of care plan update.
  - Case #9: No evidence of follow-up with EI after enrollment date of 06/13/23. No evidence of evaluation. No evidence of care plan update.
  - Case #15: No evidence of follow-up with EI after enrollment on 12/30/22. No evidence of evaluation. No evidence of care plan update.
  - Case #16: Could not locate evidence of 2nd follow-up or visit within the 3rd trimester.

- Sickle Cell CC file review: 7 of 11 files reviewed met the requirements.
  - Case #3: Referral date 02/28/23, first documented contact with EI was 03/10/23 – 8 business days from receipt of referral.
  - Case #4: Could not locate evidence of encounter during the month of May.
  - Case #6: Referral receipt date 03/17/23, first documented outreach date 04/04/23 – 7 business days from receipt of the referral. Could not locate evidence of encounter within the same calendar month after 04/04/23.
  - Case #9: Could not locate evidence of substance abuse screening – UNCOPE.

Provider Selection and Participation

- All requirements were addressed in MCA-E's policies and procedures.

Confidentiality

- All requirements were addressed in MCA-E's policies and procedures.

Grievance and Appeals

- All requirements were addressed in MCA-E's policies and procedures.
- Grievance file review: 4 of 4 cases reviewed met the requirements.

Subcontractual Relationships and Delegation

- All requirements were addressed in MCA-E's policies and procedures.

HIMS

- All requirements were addressed in MCA-E's policies and procedures.

Quality Management and Performance Improvement (QAPI)

- One of the 63 requirements reviewed for MCA-E was partial. The partial determination reflected a requirement related to the composition of the Regional Management Committee.

MCA-NW

The following presents a summary of MCA-NW's performance in the 2023 SPR.

Information Requirements

- Two requirements were partially addressed in MCA-NW's policies and procedures. The partial determinations reflected requirements related to provision of materials that describe the services provided by the ACHN Program and providing care coordination contact information online.

Disenrollment Requirements

- All requirements were addressed in MCA-NW's policies and procedures.

Enrollee Rights and Protection

- All requirements were addressed in MCA-NW's policies and procedures.

Care Coordination

- Four requirements were partially addressed in MCA-NW's policies and procedures. Two of the partial determinations were related to care coordinator caseloads, another was related to staffing requirements, and one related to behavioral health services trainings for participating providers.
- Family Planning CC file review: 11 of 15 files reviewed met the requirements.
  - Case #3: EI's diagnosis of postpartum pre-eclampsia could not be located in the care plan or in the notes. File met the criteria for high risk, but the determination was set for low risk.
  - Case #6: Could not locate the reason the case was closed. Could not locate follow-up encounter documented.

- Case #11: EI uses tobacco/alcohol or has a history of tobacco/alcohol abuse but could not locate this being addressed in the care plan or the notes. During the interview, MCA-NW reported that this issue was addressed in the maternity care coordination program and submitted documentation. Upon review, the EI's maternity case was closed after the postpartum information form (PPI) was collected on 8/7 with the smoking goal and intervention still open. There was no evidence that tobacco cessation counseling was offered and that a referral was made to the Alabama Department of Public Health (ADPH) Quitline for this EI.
- Case #15: EI has controlled asthma and needs education regarding her medical condition (as identified in the assessment) but this was not addressed in the care plan or the notes.

- General CC file review: 13 of 15 files reviewed met the requirements.
  - Case #3: No evidence of evaluation found. Care plan goals were due 3 months after 01/13/23. Case closed on 06/20/23 due to EI being unable to be reached since 05/12/23.
  - Case #12: Could not locate the evaluation. Could not locate an encounter noted after enrollment date on 11/01/22.
- Maternity CC file review: 11 of 15 cases reviewed met the requirements.
  - Case #4: Could not locate evidence of follow-up during the 2nd trimester.
  - Case #8: Could not locate evidence of encounter during the 3rd trimester. Delivery date 07/17/23, missed delivery encounter date 09/27/23. Could not locate evidence of in-home postpartum encounter.
  - Case #12: EI first called entity on 02/01/23 to schedule enrollment for maternity services. EI called again on 02/27/23 stating she was supposed to receive a call back to get enrolled but never got a call.
  - Case #15: Could not locate evidence of contact, contact attempts, or encounter between 04/25/23 and 08/24/23.
- Sickle Cell CC file review: 6 of 15 files reviewed met the requirements.
  - Case #2: Could not locate evidence of MCT within 60 calendar days of the initial visit. Could not locate evidence of encounter between 02/06/23 and 04/06/23.
  - Case #3: Could not locate evidence of outreach to EI's mother between 03/03/23 and 03/23/23. Could not locate evidence of subsequent outreach. Screening date 02/28/23, health risk, and psychosocial assessment completed on 03/28/23. Could not locate evidence of MCT completed within 60 calendar days.
  - Case #5: Could not locate evidence of MCT within 60 days of the initial encounter. Initial contact was 02/15/23, could not locate evidence of follow-up within the same month. Could not locate contact attempts/encounter noted for the months of July, August, or September.
  - Case #6: Referral receipt date 02/07/23, documented contact with EI's mother 02/17/23, which is not within the required timeframe. Could not locate evidence of contact/encounter from May until September 2023.
  - Case #7: Could not locate evidence of MCT. Could not locate evidence of contacts after 05/11/23.
  - Case #10: Could not locate evidence of contact or contact attempt for the month of July.
  - Case #12: Could not locate evidence of MCT within 60 calendar days of the initial encounter. Could not locate evidence of encounter during the month of May, June, or August.
  - Case #13: Could not locate evidence of MCT completed within 60 calendar days of the initial encounter. Initial encounter date 03/01/23, could not locate evidence of encounter within the same calendar month. Could not locate evidence of encounter during the month of April.
  - Case #16: Could not locate evidence of MCT within 60 calendar days of the initial encounter. Initial encounter date 02/09/23, could not locate evidence of encounter within the same calendar month. Could not locate evidence of encounter or contact for the months of March, May, or July.

Provider Selection and Participation

- All requirements were addressed in MCA-NW's policies and procedures.

Confidentiality
- All requirements were addressed in MCA-NW's policies and procedures.

Grievance and Appeals
- All requirements were addressed in MCA-NW's policies and procedures.
- Grievance file review: 15 of 15 cases reviewed met the requirements.

Subcontractual Relationships and Delegation
- All requirements were addressed in MCA-NW's policies and procedures.

HIMS
- All requirements were addressed in MCA-NW's policies and procedures.

Quality Management and Performance Improvement (QAPI)
- Two of the 63 requirements reviewed for MCA-NW were partial. The partial determinations reflected requirements related to measurement of performance using objective quality indicators.

NACC
The following presents a summary of NACC's performance in the 2023 SPR.

Information Requirements
- One of the requirements was partially addressed in NACC's policies and procedures. The partial determination reflected a requirement related to specifying enrollee rights in member materials, on or before the first visit for CC services.

Disenrollment Requirements
- All requirements were addressed in NACC's policies and procedures.

Enrollee Rights and Protection
- One of the requirements was partially addressed in NACC's policies and procedures. The partial determination reflected a requirement related to specifying enrollee rights in member materials.

Care Coordination
- Seven requirements were partially addressed in NACC's policies and procedures, and two were not met. One of the partial determinations was related to implementation of a program to integrate behavioral health and medical care, another was related to screening and assessment for appropriateness of CC services, another was related to education of EIs regarding services provided by the PCCM-E, another was related to linkage of EIs to appropriate services to integrate behavioral health and medical care, another to consultation to the MCT regarding behavioral health issues or topics and resources in the area, another one to transitional care for enrollees requiring CC services who transition from a psychiatric facility to the community, and one to integration of behavioral and medical care issues. The unmet determinations involved requirements related to requests for allowances other than the approved ranges in caseload requirements, and to outreach activities in prevention of substance abuse issues.
- Family Planning CC: 9 of 15 files reviewed met the requirements.
    - Case #2: Missing items from the care plan (unsupportive parents and education up to 9th grade).
    - Case #3: Could not locate evaluation completed at 1/25 encounter, which exceeds the minimal evaluation requirement of being completed every 90 days.
    - Case #7: The assessments identified that the EI planned to apply for WIC – could not locate this item in the care plan. After the virtual interview, NACC submitted the maternity care coordination notes for this EI to demonstrate that WIC had been addressed, but the maternity care coordination file was from before the EI's family planning care coordination case began. The family planning care coordinator

should have added WIC to track the EI's status to ensure completion of WIC referral and education started from the EI's maternity care coordination case.
    - Case #8: The HR&PA identified that EI planned to apply for WIC – could not locate this item in the care plan. After the virtual interview, NACC submitted the maternity care coordination notes for this EI to demonstrate that WIC item had been addressed, but the maternity care coordination file was from before the EI's family planning care coordination case began. Additionally, there was only screening and assessment that took place for the maternity case – the maternity care coordinator was to review WIC education with the EI at the 2nd & 3rd trimester follow up; there were no other encounters, and the maternity case was closed a year later. The family planning care coordinator should have added WIC to track the EI's status to ensure completion of WIC referral and education started from the EI's maternity care coordination case.
    - Case #10: EI had multiple physical and mental health issues detailed in the assessment, but these medical conditions were not addressed in the care plan or task notes. After the virtual review, NACC submitted the EI's maternity care coordination file, which showed that these conditions were addressed (mental health referral declined); however, the maternity case was closed 7/24/23. For continuity of care, these items should have been included in the task notes of the open family planning care coordination case.
    - Case #13: EI has depression and anxiety identified on her assessment, but these medical conditions were not addressed in the care plan or the task notes. Could not locate evidence of follow-up with the EI regarding IUD, as indicated in the notes from 5/4. After the virtual review, NACC submitted the EI's maternity care coordination file, which showed that these conditions were being addressed; however, the maternity case was closed 8/16/23 after delivery visit on 1/19/23. For continuity of care, these items should have been included in the task notes of the family planning care coordination case, which was closed prematurely without proper contact attempts.
- General CC: 8 of 15 files reviewed met the requirements.
    - Case #3: There was no crisis plan for this EI, who had been identified for CC services from her hospitalization for suicidal ideation. After the virtual interview, NACC submitted the mental health checklist used by CCs in discussion with EIs; however, this checklist does not have any items pertaining to a crisis plan.
    - Case #6: Care management notes state that the transition of care nurse did not complete depression and substance screening on this EI due to not being age appropriate, but this EI was aged 12 years at the time of this note/visit.
    - Case #8: There was no crisis plan for this EI, who had been identified for CC services from her hospitalization for suicidal ideation. After the virtual interview, NACC submitted the mental health checklist used by CCs in discussion with EIs; however, this checklist does not have any items pertaining to a crisis plan.
    - Case #11: EI was screened on 1/9/23. First attempt to contact was untimely (1/17/23).
    - Case #12: EI had a score of 9 for her PHQ-A and could not locate evidence of referrals or the EI declining mental health services. Additionally, the care plan did not reflect the positive result from the screening.
    - Case #14: There was no crisis plan for this EI, who had been identified for CC services from her hospitalization for suicidal ideation. After the virtual interview, NACC submitted the mental health checklist used by CCs in discussion with EIs; however, this checklist does not have any items pertaining to a crisis plan.
    - Case #15: EI was screened on 8/31/23. First attempt to contact was untimely (9/11/23).
- Maternity CC: 11 of 15 cases reviewed met the requirements.
    - Case #3: EI had open goal and intervention still in motion but could not locate an encounter or update since the delivery encounter – case appears to still be open.

- Case #6: First follow-up encounter was untimely. It occurred 2/20/23 when EI is in her 3rd trimester (30 weeks). For the initial face-to-face encounter, the CC reported: "EI requested to complete this encounter telephonically. CC using clinical judgement, agreed a telephonic encounter is an appropriate method to complete the encounter."
- Case #8: The estimated date of confinement (EDC) was 7/27/23 but could not locate notes or encounters after the 6/8/23 encounter – case appears to still be open.
- Case #14: Education intervention was evaluated as complete with goal of EI demonstrating improved knowledge, but there had been no follow-up encounter for this evaluation to take place. At 3/10/23 delivery encounter, CC had reminded EI of postpartum home visit to be conducted 4–8 weeks. There was only one call attempt on 6/30 by a community health worker (CHW) about Medicaid terminating, and then CC completed PPI form and closed EI's case 8/11. This EI had no prenatal care. Could not locate completed screenings.

- Sickle Cell CC: 8 of 15 files reviewed met the requirements.
  - Case #2: HR&PA identified EI as having autism but could not locate this being addressed in the care plan or the task notes. Evaluation of the care plan was conducted at every encounter and detailed in task notes, but the care plan itself was not updated, at least every 90 days: care plan only had initial and final inputs.
  - Case #7: Evaluation of the care plan was conducted at every encounter and detailed in task notes, but the care plan itself was not updated, at least every 90 days: care plan only had initial 2/3 input and 4/7 update. There was only one contact attempt on 8/29/23 for month 7.
  - Case #8: Evaluation was only documented in task notes for the initiation of the care plan and for goal #3 on 5/10/23. The task notes reported the care plan being "evaluated and updated as required" but could not locate evidence of this in the care plan. When interventions were completed, there was a date in the care plan to mark completion; however, intervention progression was not documented.
  - Case #9: Evaluation of the care plan was conducted at every encounter and detailed in task notes, but the care plan itself was not updated, at least every 90 days: care plan only had initial and final inputs.
  - Case #12: The task notes stated at every encounter that "the EI's care plan was evaluated and updated as required" but could not locate documentation of this occurring between 4/14/23 and 8/21/23 in the care plan. Could only locate one contact attempt on 6/29/23 for month 3.
  - Case #13: Could not locate within the care plan that all goals were addressed. Could not locate encounters during month 2 of the case (April).
  - Case #15: Medication reconciliation was tasked to CHW in 3/10/23 task note; however, could not locate evidence this was completed. Evaluation of the care plan was conducted at every encounter and detailed in task notes, but the care plan itself was not updated, at least every 90 days: care plan only had initial and final inputs.

Provider Selection and Participation

- All requirements were addressed in NACC's policies and procedures.

Confidentiality

- One of the requirements was not addressed in NACC's policies and procedures. The unmet requirement was related to safeguards restricting the use or disclosure of information concerning individuals.

Grievance and Appeals

- One of the requirements was not addressed in NACC's policies and procedures. The unmet requirement was related to appropriate parties initiating action within 24 hours if an EI's health and safety are at risk.
- Grievance file review: 10 of 10 cases reviewed met the requirements.

Subcontractual Relationships and Delegation

- All requirements were addressed in NACC's policies and procedures.

HIMS

- All requirements were addressed in NACC's policies and procedures.

Quality Management and Performance Improvement (QAPI)

- Three of the 63 requirements reviewed for NACC were partial. One of the partial determinations reflected requirements related to measurement of performance using objective quality indicators and two were related to planning and initiation of activities for increasing or sustaining improvement.

VI. MCE Responses to the Previous EQR Recommendations

Title 42 CFR § 438.364 External quality review results(a)(6) require each ATR include "an assessment of the degree to which each MCO, PIHP, PAHP, or PCCM entity has effectively addressed the recommendations for QI[6] made by the EQRO during the previous year's EQR." **Tables 30–36** display the ACHN entities' responses to the recommendations for QI made by IPRO during the previous EQR, as well as IPRO's assessment of these responses.

ACN Mid-State Response to Previous EQR Recommendations

Table 30 displays ACN Mid-State's responses related to the *RY 2023 Annual External Quality Review Technical Report,* as well as IPRO's assessment of ACN Mid-State's response.

Table 30: ACN Mid-State Response to Previous EQR Recommendations

Recommendation for ACN Mid-State	ACN Mid-State Response/Actions Taken	IPRO Assessment of Entity Response[1]
Quality improvement projects		
Adverse Birth Outcomes QIP: To demonstrate an improvement, the target rate should be adjusted so that it is lower than the baseline (a lower rate is desirable).	What has the ACHN done or planned to do to address the recommendation? • The target rate on this QIP template has been adjusted so that it is lower than the baseline rate for reporting years 2023 and 2024. When and how will this be accomplished? • This has been completed. What are the expected outcomes or goals of the actions to be taken? • We hope to have a more accurate measurement of babies born weighing less than 2500 grams for the 2024-2025 reporting cycle. What is the ACHN's process for monitoring the actions to determine their effectiveness? • We will continue to use reporting data provided by The Agency as well as internal reports from our HIMS to evaluate the effectiveness of our interventions.	Addressed
Childhood Obesity QIP: The numerator and denominator values associated with the measures for the baseline	What has the ACHN done or planned to do to address the recommendation? • The numerator and denominator values for the baseline period have been added to the template for reporting years 2023 and 2024. When and how will this be accomplished?	Addressed

[6] quality improvement.

Recommendation for ACN Mid-State	ACN Mid-State Response/Actions Taken	IPRO Assessment of Entity Response[1]
period are missing. The descriptions should be replaced with values.	• This has been accomplished. What are the expected outcomes or goals of the actions to be taken? • Data on the reporting years 2023 and 2024 QIP templates for Childhood Obesity QIP template will be accurate. What is the ACHN's process for monitoring the actions to determine their effectiveness? • We will continue to use reporting data provided by The Agency as well as internal reports from our HIMS to evaluate the effectiveness of our interventions.	
Substance Use Disorder QIP: Review Barrier 1 (lack of support for management of comorbid medical conditions prevent SUD treatment adherence) and indicate how this was identified. Factors associated with success/failure should be tied to specific interventions and outcomes.	What has the ACHN done or planned to do to address the recommendation? • Barriers are identified through outreach and enrollment of EI's that qualify for these interventions. • As barriers are identified relating to management of comorbid medical conditions, personalized care plans specific to comorbid conditions will be created through the care coordination process. If EI is agreeable to the care plan addressing their comorbid condition. When and how will this be accomplished? • This is being accomplished currently through outreaching specific SUD population in an effort to improve treatment adherence and address comorbid conditions through care coordination services. What are the expected outcomes or goals of the actions to be taken? • Measurement of these outcomes will be obtained by looking at the successful number of enrollments as a result of SUD outreach over the total outreach population. What is the ACHN's process for monitoring the actions to determine their effectiveness? • We will continue to use reporting data provided by The Agency as well as internal reports from our HIMS to evaluate the effectiveness of our interventions	Addressed

Recommendation for ACN Mid-State	ACN Mid-State Response/Actions Taken	IPRO Assessment of Entity Response[1]
Compliance review		
ACN Mid-State should include in staff training the requirement regarding documentation to support the need for a change in the risk level not captured on the Risk Assessment form shall be documented in the task notes or progress notes in HIMS, with new goals and interventions.	What has the ACHN done or planned to do to address the recommendation? • Mid-State plans to train staff on the importance of documenting in HIMS system to support the need for a change in the risk level not captured on the risk assessment form. When and how will this be accomplished? • This will be accomplished at our next departmental staff meeting on 2/14/24. • This will be accomplished by providing refresher training for staff on the use of utilizing task notes, or progress notes in HIMS with a corresponding goal and intervention when necessary. What are the expected outcomes or goals of the actions to be taken? • We expect that by providing refresher training and reinforcing the contents of that training through monthly audits we will improve as an entity with respect to documentation supporting the need for a change in risk level. What is the ACHN's process for monitoring the actions to determine their effectiveness? • Mid-State performs monthly chart audits on all staff members and will utilize audits as a tool to measure the success of this training or the need for additional training.	Addressed
There continue to be opportunities for ACN Mid-State to analyze their activities to date and see how they could better target/impact their indicators for all three QIP topics.	What has the ACHN done or planned to do to address the recommendation? • ACNM continually reviews QIP interventions and makes modifications in processes in an effort to improve our ability to target/impact the indicators for each topic. When and how will this be accomplished? • This is an ongoing process. (Monthly meetings between quality teams, and ED and QM to ensure progress and updates are made accordingly) What are the expected outcomes or goals of the actions to be taken? • We expect to improve our ability to target/impact indicators for each topic as the reporting cycle progresses. Given that these recommendations were made prior to a new cycle, we are hopeful this will be the case.	Partially addressed

Recommendation for ACN Mid-State	ACN Mid-State Response/Actions Taken	IPRO Assessment of Entity Response[1]
	What is the ACHN's process for monitoring the actions to determine their effectiveness? • We will continue to use reporting data provided by The Agency as well as internal reports from our HIMS to evaluate the effectiveness of our interventions.	
Performance measures		
ACN Mid-State should consider reviewing and trend performance for Antidepressant Medication Management, Initiation and Engagement of Treatment for AOD, Well-Child Visits in the First 15 Months of Life, and Child Access to Care, to specifically target performance for these measures. Further, determine if a particular demographic subgroup is disproportionately impacted.	What has the ACHN done or planned to do to address the recommendation? • ACNM has created a quality measures dashboard that all staff use to identify any quality measures that a recipient qualifies for. When a recipient qualifies for a quality measure, a person-centered care plan is created and implemented to assist the recipient in meeting that measure, if the EI agrees to the care plan. • In the future, ACNM is considering using the disproportionate index to further break down these various measures into subgroups who might be disproportionately impacted. When and how will this be accomplished? • ACNM is currently working toward accomplishing this in RY 2023 and going forward by training staff on how to identify those recipients who qualify for each measure and working to meet the measure(s) through person-centered care planning and care coordination services. What are the expected outcomes or goals of the actions to be taken? • ACNM is hopeful that by making a concerted effort to address the quality measures we can impact overall population health and recipient health outcomes as well as improve our performance on these measures. What is the ACHN's process for monitoring the actions to determine their effectiveness? • We will continue to use reporting data provided by The Agency as well as internal reports from our HIMS to evaluate the effectiveness of our interventions	Partially addressed

[1]IPRO assessments are as follows: addressed: entity's quality improvement (QI) response resulted in demonstrated improvement; partially addressed: entity's QI response was appropriate, but improvement was not yet observed; remains an opportunity for improvement: entity's QI response did not address the recommendation, improvement was not observed, or performance declined.

ACN: Alabama Care Network; EQR: external quality review; QIP: quality improvement project; EI: eligible individual; ACHN: Alabama Coordinated Health Network; HIMS: Health Information Management System; ACNM: Alabama Care Network Mid-State; SUD: substance use disorder; AOD: alcohol and other drug; RY: review year; ED: emergency department; QM: quality management.

ACN Southeast Response to Previous EQR Recommendations

Table 31 displays ACN Southeast's responses related to the *RY 2023 Annual External Quality Review Technical Report,* as well as IPRO's assessment of ACN Southeast's response.

Table 31: ACN Southeast Response to Previous EQR Recommendations

Recommendation for ACN Southeast	ACN Southeast Response/Actions Taken	IPRO Assessment of Entity Response[1]
Quality Improvement projects		
Adverse Birth Outcomes QIP: The entity should continue to focus on improving the rate of well-child visits for infants.	ACNS has implemented multiple interventions to improve EPSDT/Well Child visit rates. ACNS started a Newborn Contact Program in early 2022 where Care Coordinators attempt to enroll all newborns and follow them for 6 months. We continued this project into 2023. This project has led to noticeable improvement in well child visits within the first 15 months of life. For the last two years ACNS has met its Well Child 15 Month Quality Measure goals and should meet them again for 2023. ACNS is continuing its program with our largest pediatric provider to have Community Health Workers contact recipients to ensure they schedule and attend EPSDT/Well Child visits.	Addressed
Childhood Obesity QIP: The entity should ensure all interventions have accurate dates stated in the report. Further, the entity should ensure all data are contemporaneous and accurate.	ACNS has expanded the use of its Quality Committee to ensure multiple people revise QIP forms and ensure all reports have accurate dating. ACNS will continue to use the most up to date data it has access to when reporting on interventions.	Addressed
Substance Use Disorder QIP: The entity should ensure appropriate version control of the spreadsheet, if not already doing so.	ACNS has expanded the use of its Quality Committee to ensure multiple people revise QIP forms and ensure all reports and spreadsheets are the appropriate versions.	Addressed

Recommendation for ACN Southeast	ACN Southeast Response/Actions Taken	IPRO Assessment of Entity Response[1]
Compliance review		
In the area of Quality Management, there continue to be opportunities for ACN Southeast to analyze their activities to date and see how they could better improve interventions across QIPs.	ACNS will continue to analyze past successes and failures to determine necessary adjustments to our QIPs for CY 2023-2024. For ABO, for example, ACNS initially gave out diapers to pregnant recipients who attended 80% of prenatal and postpartum visits. After experiencing shipping issues and receiving feedback from recipients, ACNS shifted to providing gift cards for the same amount, which were noticeably cheaper and easier to handle. For interventions that prove to be unsuccessful, such as our attempt to partner with KidOne to transport recipients to WIC appointments, both we and our contracting partners revised efforts multiple times to encourage recipient buy-in. However, following multiple quarters or no recipient interest we met with KidOne and mutually agreed to terminate the intervention and shift our efforts and resources elsewhere.	Addressed
Performance measures		
ACN Southeast should consider reviewing and trend performance for Well-Child Visits in the First 15 Months of Life, Antidepressant Medication Management, Initiation and Engagement of Treatment for AOD, Live Births Less Than 2,500 Grams, and Child Access to Care; and develop or modify interventions to specifically target performance for these measures. Further, determine if a particular demographic subgroup is disproportionately impacted.	ACNS has reviewed these performance measures to identify trends and opportunities for improvement. ACNS has performed overrepresentation analyses as well as other data examinations and determined that in some cases particular demographic subgroups are disproportionately impacted. • For Well-Child Visits in the First 15 Months of Life ACNS will continue to enact our newborn program as it has returned demonstrable improvement across demographic subgroups and improved our overall quality score. • For antidepressant medication management we continue to have the ACNS pharmacists reach out to eligible recipients. • For Initiation and Engagement of Treatment for AOD ACNS has determined men 50 years and older being much more likely to have an AOD SUD diagnosis. ACNS will continue to work with our partner SpectraCare to attempt to influence these populations. ACNS is also expanding its preventive. • For Live Births Less Than 2,500 Grams ACNS has determined there are several population groups at greater risk than others are. In particular, ACNS has noted that black maternity recipients have LBW at a nearly double rate to white and Hispanic recipients. ACNS has started a pilot program in one of our more rural and high-risk counties, Bullock, which	Partially addressed

Recommendation for ACN Southeast	ACN Southeast Response/Actions Taken	IPRO Assessment of Entity Response[1]
	follows all maternity recipients intensely. If it proves effective, ACNS will try to expand the service to other regions of particularly high risk. • Child Access to Care numbers are reviewed monthly during the ACNS Quality Committee meetings. The Quality Manager regularly visits provider offices with lists of recipients that have not been seen in a set time period to encourage them to engage with the recipients and get them into visits	

[1]IPRO assessments are as follows: addressed: entity's quality improvement (QI) response resulted in demonstrated improvement; partially addressed: entity's QI response was appropriate, but improvement was not yet observed; remains an opportunity for improvement: entity's QI response did not address the recommendation, improvement was not observed, or performance declined.

ACN: Alabama Care Network; ACNS: Alabama Care Network Southeast; EQR: external quality review; LBW: low birth weight; EPSDT: Early and Periodic Screening, Diagnostic and Treatment; QIP: quality improvement project; AOD: alcohol and other drug; SUD: substance use disorder; QI: quality improvement; CY: calendar year; ABO: adverse birth outcomes; WIC: Special Supplemental Nutrition Program for Women, Infants, and Children.

Gulf Coast Total Care Response to Previous EQR Recommendations

Table 32 displays GCTC's responses related to the *RY 2023 Annual External Quality Review Technical Report*, as well as IPRO's assessment of GCTC's response.

Table 32: GCTC Response to Previous EQR Recommendations

Recommendation for GCTC	GCTC Response/Actions Taken	IPRO Assessment of Entity Response[1]
Quality improvement projects		
Adverse Birth Outcomes QIP: For Indicator 3, the corresponding target rate of 50% was based off of brainstorming and should be modified according to the data that have been collected to date. The first and second interim measurements have both exceeded the target rate, so it is recommended that the entity establish a new target for these indicators.	For indicator 3, target rate was increased from 50% to 70% for 2023, and this rate was exceeded. For 2024, GCTC will establish new target rate for indicator 3.	Addressed
Childhood Obesity QIP: The ACHN entity is encouraged to sustain and expand current interventions, as well as follow up on outcomes among EIs touched by one or more interventions. The entity should ensure that relevant data (i.e., ITM data, as well as outcome measure data) are collected and evaluated in order to determine if the success of the project can be attributed to their efforts.	For the fourth quarter of 2023, GCTC added intervention to perform outreach to EIs age 7 to 11 with Z68.53 diagnosis code (overweight) in order to offer referral to UAB dietician. There is a reporting process in place to allow for follow up tracking. GCTC will work to sustain and expand current interventions for 2024. GCTC will collect and evaluate ITM and outcome measure data to assess for success and determine if attributed to interventions.	Addressed

Recommendation for GCTC	GCTC Response/Actions Taken	IPRO Assessment of Entity Response[1]
Substance Use Disorder QIP: The entity should provide baseline measures for each intervention. Also, the entity is encouraged to sustain and expand current interventions, as well as follow up on outcomes among EIs touched by one or more interventions. The entity should ensure that relevant data (i.e., ITM data, as well as outcome measure data) are collected and evaluated in order to determine if the success of the project can be attributed to their efforts.	GCTC will provide baseline measures for each intervention. GCTC will work to sustain and expand current interventions and will implement process in order to follow up on outcomes for EIs touched by one or more interventions. GCTC will collect and evaluate ITM and outcome measure data to assess for success and determine if attributed to interventions.	Addressed
Compliance review		
In maternity care coordination, the entity should adhere to the encounter schedule to ensure completion of all care coordination activities.	GCTC has provided staff training regarding encounter schedule for maternity care coordination and will monitor through monthly audits. Training will continue to be provided as often as needed based on identified audit discrepancies.	Partially Addressed
Care coordinators should follow the protocol for when an EI is unable to be reached to prevent premature case closure.	GCTC has provided staff training regarding protocol for EIs unable to be contacted. Training will continue to be provided as often as needed based on identified audit discrepancies.	Addressed
Performance measures		
GCTC should consider reviewing and trend performance for Antidepressant Medication Management, Well-Child Visits in the First 15 Months of Life, and Child Access to Care and develop or modify interventions to specifically target performance for these measures. Further, determine if a particular demographic subgroup is disproportionately impacted.	Planned Interventions related to Antidepressant Medication Management, Well-Child Visits in the First 15 Months of Life, and Child Access to Care are as follows: • Antidepressant Medication Management – GCTC will perform provider outreach in order to educate providers regarding measure and promote care coordination referrals for EIs diagnosed with major depressive disorder and prescribed antidepressant. GCTC has also provided staff training on incorporating quality measures into EI's care plan as applicable. This is monitored via monthly internal audits. • Well-Child Visits in First 15 Months of Life – GCTC has implemented newborn care coordination enrollment initiative in order to promote and	Partially Addressed

Recommendation for GCTC	GCTC Response/Actions Taken	IPRO Assessment of Entity Response[1]
	support child visits in first 15 months of life. GCTC has provided staff training on incorporating quality measures into EI's care plan as applicable. This is monitored via monthly internal audits. • Child Access to Care – GCTC will continue to perform outreach in order to promote annual visits with PCP as part of Childhood Obesity QIP as well as the Well-Child Visit initiative. GCTC has provided staff training on incorporating quality measures into EI's care plan as applicable. This is monitored via monthly internal audits. GCTC will review performance measure data for Antidepressant Medication Management, Well-Child Visits in First 15 Months of Life, and Child Access to Care and will stratify based on age, race, gender, zip code, county, PCP visit completed in previous 12 months. GCTC will determine if particular demographic subgroup is disproportionately impacted. Interventions will be modified as appropriate based on data review.	

[1]IPRO assessments are as follows: addressed: entity's quality improvement (QI) response resulted in demonstrated improvement; partially addressed: entity's QI response was appropriate, but improvement was not yet observed; remains an opportunity for improvement: entity's QI response did not address the recommendation, improvement was not observed, or performance declined.

GCTC: Gulf Coast Total Care; EQR: external quality review; QIP: quality improvement project; EI: eligible individual; ACHN: Alabama Coordinated Health Network; ITM: intervention tracking measure; ZIP: Zone Improvement Plan; PCP: primary care provider; QI: quality improvement; UAB: University of Alabama Birmingham.

My Care Alabama Central Response to Previous EQR Recommendations

Table 33 displays MCA-C's responses related to the *RY 2023 Annual External Quality Review Technical Report*, as well as IPRO's assessment of MCA-C's response.

Table 33: MCA-C Response to Previous EQR Recommendations

Recommendation for MCA-C	MCA-C Response/Actions Taken	IPRO Assessment of Entity Response[1]
Quality improvement projects		
Adverse Birth Outcomes QIP: The entity should consider adding additional interventions, since two of the interventions have been stopped due to the entity's lost contact with Baptist Family Medicine, which impacted two of their barriers.	What has the ACHN done or planned to do to address the recommendation? • MCA-Central is expanding current efforts within ABO. A secondary Care Coordinator (CC) has been trained to assist in facilitating Making Proud Choices (MPC), as well as scheduling expansion to include summer months. When and how will this be accomplished? • MCA-Central has identified a supporting intervention within MPC cohorts to increase referrals to Family Planning Services, reducing adverse birth outcomes in the Medicaid Population. • Implementation of this intervention will begin Q1 2024. • EIs participating in MPC cohorts will be the target population. EIs will be presented contact information to MCA-Central Care Coordinators (CC) and Community Health Workers. EI's interested in Family Planning (FP) services will be screened and assigned FP Care Coordination. What are the expected outcomes or goals of the actions to be taken? • This intervention seeks to increase rates of contraceptive accessibility among EIs aged 12-19 years and increase impact on ABO Quality Measures. What is the ACHN's process for monitoring the actions to determine their effectiveness? • MCA-Central will monitor rates of referrals received from the MPC Care Coordinator on a quarterly basis, and track FP referral rates from the MPC Cohort. • MCA-Central has developed and implemented an internal tracker that will be completed by the MPC CC and monitored by the Quality Care Manager (QCM). • The QCM and MPC CC will meet and review MPC FP referral rates following completion of each MPC cohort (approx.. Every 6-8 weeks).	Addressed

Recommendation for MCA-C	MCA-C Response/Actions Taken	IPRO Assessment of Entity Response[1]
Childhood Obesity QIP: The entity is encouraged to think about the barrier (why women are not continuing to breastfeed at 2 months of age) and then develop actions to target this accordingly. Once an intervention has been established, then they can create an ITM to track progress of that intervention.	What has the ACHN done or planned to do to address the recommendation? • MCA-Central has identified that return to work and lack of access to free/affordable breast pumps is a barrier to continued breastfeeding rates within the identified population. MCA-Central is actively seeking electric breast pump vendors and partners to secure free breast pumps for patients enrolled in MCA-Central's Strong Momma Program (SM). When and how will this be accomplished? • Breast pumps will be provided to Strong Momma EIs during their 3rd trimester. What are the expected outcomes or goals of the actions to be taken? • MCA-Central anticipates increased rates of breast feeding at 30 & 60 days postpartum. What is the ACHN's process for monitoring the actions to determine their effectiveness? • Breast pump incentives will be tracked through the current EI tracker utilized to capture. • The ACHN will monitor the trends through compliance comparisons of breast feeding efficacy at 30 & 60 days postpartum. • Trends will be monitored through the current SM tracking tool.	Addressed
Substance Use Disorder QIP: Ensure that ITM data are collected and reported quarterly to inform intervention progress. Also, continue thinking about how to sustain and expand interventions and efforts, targeting the maximum number of EIs as possible.	What has the ACHN done or planned to do to address the recommendation? • MCA-Central met with its contracted SUD Partner, R.O.S.S. Both entities' referral processes were reviewed. Opportunity for improvement was identified, plans to implement improvements were developed. Improvement efforts include staff trainings and ongoing reporting management efforts. • MCAC is also taking a preventative approach in drug avoidance education in schools called Operation Prevention.	Addressed

Recommendation for MCA-C	MCA-C Response/Actions Taken	IPRO Assessment of Entity Response[1]
	When and how will this be accomplished? • MCA-Central hosted internal Care Coordination SUD referral review. • This review deconstructed current SUD referral processes and resulted in R.O.S.S. identifying new regional peer support specialist. • Additional improvement meetings have been scheduled to review rates of SUD EI referrals. • Conducting the Operation Prevention program in local high schools What are the expected outcomes or goals of the actions to be taken? • This effort seeks to identify and resolve barriers to SUD services and improve partnership processes. • Better understanding of drug use effects and prevention of SUD. We also expect to expand in other schools. What is the ACHN's process for monitoring the actions to determine their effectiveness? • The ACHN will continue to monitor monthly timeliness of R.O.S.S.'s data reporting, trends of EI referrals, EI links to services, and overall number of EIs referred within the MCAC region. • Pre and post survey for Operation Prevention.	
Compliance review		
In the area of Care Coordination, the entity should ensure that care plans accurately document all encounters including evaluations and follow-ups. The ACHN entity should continue to ensure that care plans accurately document all encounters.	What has the ACHN done or planned to do to address the recommendation? • MCA-Central provides continued care plan trainings and chart audits. • We are also implementing a new compliance policy with our care plan. • As well as one-on-one coaching with our care coordinators. When and how will this be accomplished? • Also chart audits are performed ongoing monthly. What are the expected outcomes or goals of the actions to be taken? • MCA-Central anticipates improved documentation, accuracy, and timeliness, as well as compliance with the visit schedule as an expected outcome from these actions. What is the ACHN's process for monitoring the actions to determine their effectiveness?	Partially Addressed

Recommendation for MCA-C	MCA-C Response/Actions Taken	IPRO Assessment of Entity Response[1]
	• MCA-Central performs chart audits internally as well as the Alabama Medicaid Agency chart audits help us determine the effectiveness of our trainings.	
It is recommended that MCA-Central continue to work with providers to encourage participation in the medical management meetings.	MCA-Central will continue to engage providers and encourage Medical Management Meeting compliance. MCA-Central will outreach to providers on a monthly basis to identify provider barriers and educate on participation and the quality incentive program. MCA-Central seeks to increase contract provider participation in alignment with AMA requirement. We perform monthly trainings during team meetings and quarterly trainings on care plans. MCA-Central will continue to us the MMM Participation Report to monitor provider participation.	Partially Addressed
Performance measures		
MCA-Central should consider reviewing and trend performance for Antidepressant Medication Management, Initiation and Engagement of Treatment for AOD, Well-Child Visits in the First 15 Months of Life, and Timeliness of Prenatal Care; and develop or modify interventions to specifically target performance for these measures. Further, determine if a particular demographic subgroup is disproportionately impacted.	What has the ACHN done or planned to do to address the recommendation? • MCA-Central has extracted and implemented target lists stratified by QMs. • MCA-Central has performed cold calls to assist with scheduling Well-Child appointments. We work closely with the provider groups to close the gap with Well-Child Visits to ensure that this subgroup is attending the visits. • We also review analytics to capture patients who have gaps in care. • We have continuous discussion with our provider groups as well as embedding at our large pediatric offices and FQHCs. • We receive missed appointment roster from our provider groups. When and how will this be accomplished? • Target list continue to be disseminated on a monthly basis to CCs. • These actions are ongoing and performed as needed. What are the expected outcomes or goals of the actions to be taken? • Improvement action applies include; SUD QIP referral process improvements, Well Child Initiative, stratified monthly outreach target list based on QM trends, and efforts to increase community partnerships and resources. • MCA-Central hopes to close the gaps in quality of care.	Partially Addressed

Recommendation for MCA-C	MCA-C Response/Actions Taken	IPRO Assessment of Entity Response[1]
	• We have also implanted goals for our associates to meet to ensure improvement. What is the ACHN's process for monitoring the actions to determine their effectiveness? • We monitor the effectiveness of our plans via our analytics.	

[1]IPRO assessments are as follows: addressed: entity's quality improvement (QI) response resulted in demonstrated improvement; partially addressed: entity's QI response was appropriate, but improvement was not yet observed; remains an opportunity for improvement: entity's QI response did not address the recommendation, improvement was not observed, or performance declined.

MCA-C (or MCAC): My Care Alabama Central; EQR: external quality review; QIP: quality improvement project; ITM: intervention tracking measure; EI: eligible individual; ACHN: Alabama Coordinated Health Network; AOD: alcohol and other drug; MMM: medical management meeting; QI: quality improvement; ABO: adverse birth outcomes; Q: quarter; SUD: substance use disorder; ROSS: Recovery Organization of Support Specialists; QM: Quality Management.

My Care Alabama East Response to Previous EQR Recommendations

Table 34 displays MCA-E's responses related to the *RY 2023 Annual External Quality Review Technical Report*, as well as IPRO's assessment of MCA-E's response.

Table 34: MCA-E Response to Previous EQR Recommendations

Recommendation for MCA-E	MCA-E Response/Actions Taken	IPRO Assessment of Entity Response[1]
Quality improvement projects		
Adverse Birth Outcomes QIP: The entity identified various counties for which interventions would be piloted. To add context to their decision on the selection of these counties, the entity should cite their approach in their sampling technique/methods to ensure the counties being piloted are representative of their entire population.	What has the ACHN done or planned to do to address the recommendation? • MCA-East has expanded the adverse birth outcome project to cover all counties in MCA-East. When and how will this be accomplished? • We previously increased our birth outcome projects to include all 12 counties and have recently launched a new project that is covering only Calhoun during Q1 of 2024. This was launched starting in one county (Calhoun) because we have 13 DHCP groups in the region and seven are located in Calhoun County with 10 providers. Starting Q2 2024 we will expand to the remaining counties in the region. What are the expected outcomes or goals of the actions to be taken? • The expected goal is to make a positive impact on adverse birth outcomes and reduce low birth weights by addressing pregnancy induced hypertension and promoting consistent prenatal appointment attendance. What is the ACHN's process for monitoring the actions to determine their effectiveness? • MCA-East recipients are encouraged to continue to monitor their blood pressure throughout the postpartum period, MCA-East Quality nurse will continue to follow up with the recipients enrolled into change of heart to educate and monitor their blood pressure though the pregnancy and postpartum period. For the project of encouraging adequate prenatal care, we will monitor the effectiveness based on the rate of prenatal appointments that our recipients are receiving.	Addressed
Childhood Obesity QIP: The ACHN entity should consider updating their target rate for Indicator 1 (90.0%), given the 95.6% rate achieved.	What has the ACHN done or planned to do to address the recommendation? • We changed the goal because the rate decreased to 84% in 2021 during pandemic. We are attempting to build these visits back up. When and how will this be accomplished?	Addressed

Recommendation for MCA-E	MCA-E Response/Actions Taken	IPRO Assessment of Entity Response[1]
	• MCA-East has been utilizing a target list to reach out to children who have missed ESPDT appointments to help them schedule an appointment. What are the expected outcomes or goals of the actions to be taken? • Our goal is to build our well child visit rate back to 96% or higher eventually. What is the ACHN's process for monitoring the actions to determine their effectiveness? • We utilize claims data to determine how many well child visits are kept	
Substance Use Disorder QIP: The entity identified various counties for which interventions would be piloted. To add context to their decision on the selection of these counties, the entity should cite their approach in their sampling technique/methods to ensure the counties being piloted are representative of their entire population.	What has the ACHN done or planned to do to address the recommendation? • MCA-East partners with R.O.S.S. for SUD management. The program is in operation in all 12 MCAE counties. When and how will this be accomplished? • This project is current, and we accomplish regional operation by consistent communication with R.O.S.S. peer support specialists, as well as their director detailing our goals for impacting SUD in all MCA-East counties. What are the expected outcomes or goals of the actions to be taken? • Our goal is to provide consistent care coordination services and resources to the defined population as they seek treatment for substance use disorders. What is the ACHN's process for monitoring the actions to determine their effectiveness? • We monitor this by reviewing monthly reports provided by the R.O.S.S's executive director. MCA-East met with R.O.S.S. to review referral and reporting processes. R.O.S.S. plans to implement improvements to include staff trainings and reporting management efforts that include accuracy and timeliness.	Addressed
Compliance review		
In maternity care coordination, the ACHN entity should ensure that the care plan accurately documents all encounters including evaluations and follow-ups.	What has the ACHN done or planned to do to address the recommendation? • MCA-East has bi-monthly care plan trainings and we have also implemented a new key performance indicator policy reporting to better monitor these requirements. • We have also updated our chart audit tool to align with the Agency chart audit tool as well as performing caseload review.	Partially Addressed

Recommendation for MCA-E	MCA-E Response/Actions Taken	IPRO Assessment of Entity Response[1]
	When and how will this be accomplished? • MCA-East performs bi-monthly chart training at minimum. What are the expected outcomes or goals of the actions to be taken? • Taking these actions will ensure that the care plan accurately reflects all encounters and components of the care plan. What is the ACHN's process for monitoring the actions to determine their effectiveness? • We have updated our chart audits to reflect the agency chart audit tool as well as the caseload review	
It is recommended that MCA-East continue to work with providers to encourage participation in the medical management meetings.	What has the ACHN done or planned to do to address the recommendation? • MCA-East has sent out termination letters to provider groups. These letters have encouraged the providers to participate in the Medical Management Meetings. We also send out surveys, email reminders prior to the meeting, PowerPoint, and meeting minutes from the previous meeting. Additionally, we send out a WebEx information as additional reminder a few days before the Medical Management Meeting When and how will this be accomplished? • All material including reminders, meeting minutes, PowerPoints, and etc. are sent out prior to the actual Medical Management Meeting What are the expected outcomes or goals of the actions to be taken? • In performing these actions, we were able to improve participation in the Medical Management Meetings. We have also had 58 practices participate in the Medical Management Meeting last quarter. What is the ACHN's process for monitoring the actions to determine their effectiveness? • MCA-East monitors attendance and engagement with providers to determine the effectiveness of our outreach attempts.	Partially Addressed

Recommendation for MCA-E	MCA-E Response/Actions Taken	IPRO Assessment of Entity Response[1]
Performance measures		
MCA-East should consider reviewing current activities and adjusting interventions that can improve performance for Initiation and Engagement of Treatment for AOD, and Timeliness of Prenatal Care. Further, determine if a particular demographic subgroup is disproportionately impacted.	What has the ACHN done or planned to do to address the recommendation? • For the Timeliness of Prenatal Care MCA-East has CHWs working through analytics to identify maternity recipients for enrollment as well as using the SOBRA List on the newly assigned to ensure they are enrolled When and how will this be accomplished? • These are reviewed monthly. What are the expected outcomes or goals of the actions to be taken? • MCA-East utilizes this plan with the goal of capturing maternity recipients early in pregnancy. What is the ACHN's process for monitoring the actions to determine their effectiveness? • MCA-East sends out attempt to contact letters to recipient and if the letter is returned then we understand that the recipient is not receiving mail or a call	Partially Addressed

[1]IPRO assessments are as follows: addressed: entity's quality improvement (QI) response resulted in demonstrated improvement; partially addressed: entity's QI response was appropriate, but improvement was not yet observed; remains an opportunity for improvement: entity's QI response did not address the recommendation, improvement was not observed, or performance declined.

MCA-E (or MCAE): My Care Alabama East; EQR: external quality review; QIP: quality improvement project; ACHN: Alabama Coordinated Health Network; Q: quarter; DHCP: delivering health care provider; EPSDT: Early and Periodic Screening, Diagnostic and Treatment; ROSS: Recovery Organization of Support Specialists; AOD: alcohol and other drug; SUD: substance use disorder; QI: quality improvement; CHW: community health worker; EPSDT: Early Periodic Screening, Diagnosis, and Treatment; SOBRA: Sixth Omnibus Reconciliation Act.

My Care Alabama Northwest Response to Previous EQR Recommendations

Table 35 displays MCA-NW's responses related to the *RY 2023 Annual External Quality Review Technical Report*, as well as IPRO's assessment of MCA-NW's response.

Table 35: MCA-NW Response to Previous EQR Recommendations

Recommendation for MCA-NW	MCA-NW Response/Actions Taken	IPRO Assessment of Entity Response[1]
Quality improvement projects		
Adverse Birth Outcomes QIP: The entity should ensure all calculations and rounding are correct and consistent.	What has the ACHN done or planned to do to address the recommendation? • During the 2023 year MCA-NW reviewed the calculations and rounding to ensure that they were correct and updated. Will continue to monitor for accuracy. When and how will this be accomplished? • Each quarter before submission, the Quality Care Manager and Medical Director review the template for any error with the calculation in attempt to update before submission to IPRO for review. What are the expected outcomes or goals of the actions to be taken? • To ensure that the calculation and the data is correct. What is the ACHN's process for monitoring the actions to determine their effectiveness? • To monitor the calculation with the assistance of Medical Director and Executive Director. Evaluate options to add additional interventions to the QIP.	Addressed
Childhood Obesity QIP: The entity should discuss why interventions for Barrier 2 and Barrier 3 were discontinued. The entity should also develop further interventions for this QIP, following an examination of barriers associated with this topic. Finally, the entity should remain critical of project success and limitations moving forward, especially since all previous interventions have been discontinued and new	What has the ACHN done or planned to do to address the recommendation? • MCA-NW has updated CO QIP template, including the barrier to ensure that they are clearly defined. We have two (2) interventions that are ongoing and have not been discontinued. When and how will this be accomplished? • On the 2022 childhood obesity QIP template What are the expected outcomes or goals of the actions to be taken? • To ensure that the barriers are defined and clearly cited. What is the ACHN's process for monitoring the actions to determine their effectiveness? • Monitoring the ITM for effectiveness and making adjustments or additions as needed.	Partially Addressed

Recommendation for MCA-NW	MCA-NW Response/Actions Taken	IPRO Assessment of Entity Response[1]
interventions will be active for the next year of this QIP.		
Substance Use Disorder QIP: The entity should ensure all calculations and rounding are correct and consistent.	What has the ACHN done or planned to do to address the recommendation? • During the 2023 year MCA-NW reviewed the calculations and rounding to ensure that they were correct and updated. Will continue to monitor for accuracy. When and how will this be accomplished? • Each quarter before submission, the Quality Care Manager and Medical Director review the template for any error with the calculation in attempt to update before submission to IPRO for review. What are the expected outcomes or goals of the actions to be taken? • To ensure that the calculation and the data is correct. What is the ACHN's process for monitoring the actions to determine their effectiveness? • To review the QIP templates to ensure that the barrier/intervention/ITM tables are number correctly and the data is calculated correctly.	Addressed
Compliance review		
With regard to care coordination, the entity should: ▪ Adhere to the encounter schedule in order to conduct all necessary care coordination activities timely. ▪ Adhere to the MCT schedule and requirements to ensure all care coordination activities are being conducted. ▪ Ensure that all issues identified during the assessment are addressed in the care plan for proper follow-up. ▪ Ensure case closure procedures are being followed by care coordinators.	What has the ACHN done or planned to do to address the recommendation? • MCA-NW performs monthly audits with our Care Coordination Supervisor Team and Unit Managers who audit the care coordination chart audits. We also perform monthly trainings with the associates as well as perform Quality Chart Reviews When and how will this be accomplished? • We accomplish this by performing monthly trainings with our associates and provide performance incentive pay for reaching chart compliance goals. What are the expected outcomes or goals of the actions to be taken? • MCANW's goal is to ensure the overall QA audits are improved. What is the ACHN's process for monitoring the actions to determine their effectiveness? • We monitor these actions by performing audits, care coordination supervision, Quality Chart Reviews, and counseling	Partially addressed

Recommendation for MCA-NW	MCA-NW Response/Actions Taken	IPRO Assessment of Entity Response[1]
Performance measures		
MCA-NW should consider reviewing and trend performance for the Well-Child Visits in the First 15 Months of Life, Timeliness of Prenatal Care, and Asthma Medication Ratio measures; and develop or modify interventions to specifically target performance for these measures. Further, determine if a particular demographic subgroup is disproportionately impacted.	What has the ACHN done or planned to do to address the recommendation? • MCA-NW has performed cold calls to assist with scheduling Well-Child appointments. We work closely with the provider groups to close the gap with Well-Child Visits to ensure that this subgroup is attending the visits. • We also review analytics to capture patients who have gaps in care. • We have continuous discussion with our provider groups as well as embedding at our large pediatric offices and FQHCs. • We receive missed appointment roster from our provider groups. When and how will this be accomplished? • These actions are ongoing and performed as needed. What are the expected outcomes or goals of the actions to be taken? • MCA-NW hopes to close the gaps in quality of care. • We have also performance incentive goals for our associates to meet to ensure quality improvement. What is the ACHN's process for monitoring the actions to determine their effectiveness? • We monitor the effectiveness of our quality improvement plans	Partially addressed

[1]IPRO assessments are as follows: addressed: entity's quality improvement (QI) response resulted in demonstrated improvement; partially addressed: entity's QI response was appropriate, but improvement was not yet observed; remains an opportunity for improvement: entity's QI response did not address the recommendation, improvement was not observed, or performance declined.

MCA-NW (or MCANW): My Care Alabama Northwest; EQR: external quality review; ACHN: Alabama Coordinated Health Network; QIP: quality improvement project; CO: childhood obesity; ITM: intervention tracking measure; MCT: multidisciplinary care team; QA: quality assurance; FQHC: Federally Qualified Health Center.

North Alabama Community Care Response to Previous EQR Recommendations

Table 36 displays NACC's responses related to the *RY 2023 Annual External Quality Review Technical Report*, as well as IPRO's assessment of NACC's response.

Table 36: NACC Response to Previous EQR Recommendations

Recommendation for NACC	NACC Response/Actions Taken	IPRO Assessment of Entity's Response[1]
Quality improvement projects		
Adverse Birth Outcomes QIP: The entity is encouraged to sustain and expand current interventions, as well follow up on outcomes among EIs touched by one or more interventions. The entity should ensure that relevant data (i.e., ITM data, as well as outcome measure data) are collected and evaluated in order to determine if the success of the project can be attributed to their efforts.	What has the ACHN done or planned to do to address the recommendation? • NACC will continue ongoing research to identify possible interventions for inclusion and/or identify methods to sustain successful outcomes. Currently, significant efforts are being made to complete PPI collection in a timely manner so that outcomes can be correctly assessed. NACC will continue these efforts so that the success of any ABO projects can be assessed and attributed to efforts. When and how will this be accomplished? • Efforts regarding the development, implementation, and assessment of current and new interventions are ongoing and will continue throughout the program. What are the expected outcomes or goals of the actions to be taken? • NACC aims to add new interventions and/or fine-tune existing interventions to improve outcomes and/or positively affect more EIs. What is the ACHN's process for monitoring the actions to determine their effectiveness? • As with all interventions, ongoing monitoring is essential to identifying and addressing issues in a timely manner. Additionally, as done with previous projects, the use of root-cause analysis is necessary when worsening trends become apparent. NACC will continue to regularly monitor efforts and outcomes.	Addressed
Childhood Obesity QIP: New interventions (number of EIs that completed the food box program and number of food boxes that were delivered) are not necessarily interventions themselves but rather	What has the ACHN done or planned to do to address the recommendation? • The new interventions listed in the recommendation have been removed as interventions. The target rate for Indicator 1 will be reassessed before the next reporting period. When and how will this be accomplished?	Addressed

Recommendation for NACC	NACC Response/Actions Taken	IPRO Assessment of Entity's Response[1]
ITMs related to Intervention 7. The entity should remove those as interventions but leave them as ITMs. Also, the target rate for Indicator 1 should be adjusted since it is exceeded by the baseline and interim measurements.	• Efforts regarding the development, implementation, and assessment of current and new interventions are ongoing and will continue throughout the program. What are the expected outcomes or goals of the actions to be taken? • NACC aims to add new interventions and/or fine-tune existing interventions to improve outcomes and/or positively affect more EIs. What is the ACHN's process for monitoring the actions to determine their effectiveness? • As with all interventions, ongoing monitoring is essential to identifying and addressing issues in a timely manner. Additionally, as done with previous projects, the use of root-cause analysis is necessary when worsening trends become apparent. NACC will continue to regularly monitor efforts and outcomes.	
Substance Use Disorder QIP: While there is an appropriate rationale stated for the target, the baseline rate should be from CY 2019 (NACC states baseline is 2021 due to "delay in implementation and incomplete data"). Since there were interventions in place throughout 2020, the true baseline should be 2019. Also, Barrier 7 should be reviewed for clarity. Finally, the entity is encouraged to sustain and expand current interventions, as well follow up on outcomes among EIs touched by one or more interventions. The entity should ensure that relevant data are collected and evaluated in order to determine if the success of the project can be attributed to their efforts.	What has the ACHN done or planned to do to address the recommendation? • NACC has addressed the issue regarding the baseline in previous QIP reporting: • Issues regarding the inability to access the baseline rate was discussed at length with IPRO and the Alabama Medicaid Agency from the beginning of the measurement period. NACC was instructed to set baseline rate when sufficient data was obtained. Additionally, previous claims data is deleted by RMEDE upon receiving a new set of 36-month claims file. • NACC feels strongly that consideration regarding this recommendation should be made based on the organization's compliance with IPRO and the Alabama Medicaid Agency's previous instructions. • Barrier 7 will be reviewed for clarity. NACC will continue ongoing research to identify possible interventions for inclusion and/or identify methods to sustain successful outcomes. NACC will continue these efforts so that the success of any ABO projects can be assessed and attributed to efforts. When and how will this be accomplished? • Efforts regarding the development, implementation, and assessment of current and new interventions are ongoing and will continue throughout the program.	Addressed

Recommendation for NACC	NACC Response/Actions Taken	IPRO Assessment of Entity's Response[1]
	What are the expected outcomes or goals of the actions to be taken? • NACC aims to add new interventions and/or fine-tune existing interventions to improve outcomes and/or positively affect more EIs. What is the ACHN's process for monitoring the actions to determine their effectiveness? • As with all interventions, ongoing monitoring is essential to identifying and addressing issues in a timely manner. Additionally, as done with previous projects, the use of root-cause analysis is necessary when worsening trends become apparent. NACC will continue to regularly monitor efforts and outcomes.	
Compliance review		
The entity should continue tracking the progress of interventions, using the ITMs to determine which activities are progressing and leading to improvement. Rechart the QIP course if interventions are not leading to improvement. Also, it is recommended that the entity continue to work with providers to encourage participation in the medical management meetings.	What has the ACHN done or planned to do to address the recommendation? • ITM Progress and Medical Management Meetings (MMM): NACC has continued to track QIP progress and utilize ITM outcomes. NACC understands the importance of identifying and addressing interventions that do not lead to sustained improvement. NACC has significantly improved provider participation in MMMs using postcard reminders. Additionally, after each quarter, providers are notified of their participation status. Both approaches have been effective tools to increase participation. NACC will continue to use this approach as well as other methods of communication including, but not limited to email, fax, provider newsletters, memos, etc. When and how will this be accomplished? • ITM Progress and Medical Management Meetings: Both ITM progress and MMM participation are current activities that will continue throughout the program. For sustained outcomes to occur, continuous attention to these activities is required. What are the expected outcomes or goals of the actions to be taken? • ITM Progress and Medical Management Meetings: NACC aims to improve ITMs using effective interventions. NACC has developed many successful interventions throughout the Quality program timeline and aims to apply	Addressed

Recommendation for NACC	NACC Response/Actions Taken	IPRO Assessment of Entity's Response[1]
	the lessons learned to the other areas of Quality that need sustained improvement. What is the ACHN's process for monitoring the actions to determine their effectiveness? • ITM Progress and Medical Management Meetings: Both ITM progress and MMM participation are assessed quarterly at a minimum. If issues are identified, processes are assessed for possible improvement. NACC will continue to reach out to providers who have not met participation goals.	
General care coordination: The entity should consider providing further training of staff to utilize alternative sources of medication list if EI is unable to provide list.	What has the ACHN done or planned to do to address the recommendation? • NACC trains staff in reviewing medication claims both to identify the medications used but also to confirm the validity of medication lists provided by EIs. When and how will this be accomplished? • Clinical directors have been instructed to include this information in training and to ensure that all care coordinators are aware of and fully understand alternative options to identifying medication lists. What are the expected outcomes or goals of the actions to be taken? • NACC aims to accurately assess medication lists for all EIs enrolled with a care coordinator and to find alternative solutions when barriers regarding this information are presented. What is the ACHN's process for monitoring the actions to determine their effectiveness? • The process of identifying accurate medication lists is covered in training by clinical managers both in group training and one-on-one training. When any issue regarding care coordination is identified, these are addressed with care coordinators. This is especially true when identified during Alabama Medicaid Agency chart audits.	Addressed
Maternity care coordination: The entity should consider exploring ways to automate the tracking system to facilitate follow-up reminders for care coordinators.	What has the ACHN done or planned to do to address the recommendation? • Currently, NACC utilizes spreadsheets with automatic deadline calculations for care coordinators to use. NACC is working in collaboration with the EMR provider to identify a better system for setting reminders.	Partially addressed

Recommendation for NACC	NACC Response/Actions Taken	IPRO Assessment of Entity's Response[1]
	When and how will this be accomplished? • At this time, a deadline has not been established to integrate a new feature into the EMR. Given the nature of software development, NACC would be unable to identify a timeline for this implementation until a solution can be identified. However, these discussions have begun, and possible solutions are being explored. What are the expected outcomes or goals of the actions to be taken? • Currently, discussions regarding this development are in progress. However, NACC's aim is to create a system that improves tracking and reminders for effective care coordination. What is the ACHN's process for monitoring the actions to determine their effectiveness? • Reports regarding past due tasks can be developed and utilized to identify ongoing issues regarding the meeting of deadlines.	
Performance measures		
NACC should consider reviewing and trend performance for the Timeliness of Prenatal Care, Cervical Cancer Screening and Adult BMI Assessment measures; and develop or modify interventions to specifically target performance for these measures. Further, determine if a particular demographic subgroup is disproportionately impacted.	What has the ACHN done or planned to do to address the recommendation? • NACC is currently researching Timeliness of Prenatal Care, Cervical Cancer Screening and Adult BMI Assessment measures to have a more comprehensive understanding and assessment of the issues at hand. Without this baseline of understanding, NACC will be unable to develop and implement effective interventions that both address the measures and improve outcomes for disproportionately impacted subgroups. When and how will this be accomplished? • Research into these measures has already begun. NACC intends to follow established guidelines for developing interventions, unless otherwise directed by IPRO or Alabama Medicaid Agency. All developed interventions will be discussed at QIP reviews. What are the expected outcomes or goals of the actions to be taken? • NACC's first goal is to create a better understanding of the issues surrounding the Timeliness of Prenatal Care, Cervical Cancer Screening, and Adult BMI Assessment measures. As previously stated, without this understanding, NACC will be unable to effectively enact change.	Partially addressed

Recommendation for NACC	NACC Response/Actions Taken	IPRO Assessment of Entity's Response[1]
	What is the ACHN's process for monitoring the actions to determine their effectiveness? • The tracking of ITM and intervention outcomes are required to determine effectiveness. As with all interventions, NACC conducts ongoing research into the issues, assessment of outcomes, reviews of materials and process, etc. to ensure best efforts about being made. Additionally, the assessment of outcomes for disproportionately affected subgroups will be crucial to identifying the effectiveness of the efforts on these groups.	

[1]IPRO assessments are as follows: addressed: entity's quality improvement (QI) response resulted in demonstrated improvement; partially addressed: entity's QI response was appropriate, but improvement was not yet observed; remains an opportunity for improvement: entity's QI response did not address the recommendation, improvement was not observed, or performance declined.

NACC: North Alabama Community Care; EQR: external quality review; QIP: quality improvement project; EI: eligible individual; ITM: intervention tracking measure; MMM: medical management meeting; ACHN: Alabama Coordinated Health Network; ABO: adverse birth outcomes; BMI: body mass index; EMR: electronic medical record; PPI: Postpartum Information form.

VII. MCE Strengths, Opportunities for Improvement, and EQR Recommendations

Table 37 highlights each ACHN entity's performance strengths, opportunities for improvement, follow-up on prior EQRO recommendations, and this year's recommendations based on the aggregated results of SFY 2023 EQR activities as they relate to **quality**, **timeliness**, and **access**.

Table 37: Strengths, Opportunities for Improvement, and EQR Recommendations for All ACHN Entities

ACHN Entity	Strengths	Opportunities for Improvement	Recommendations	Standards
Quality improvement projects				
ACN Mid-State	**ABO**: None. **CO:** ACN Mid-State demonstrated improvement in all childhood obesity performance indicators from baseline (2019) to the final measurement period (2022). Two of the four performance indicators exceeded the target rate. **SUD:** ACN Mid-State demonstrated an improvement for the SUD performance indicator from baseline (2019) to the final measurement period (2022).	**ABO:** ACN Mid-State demonstrated a decline in performance for the adverse birth outcomes performance indicator percentage of live deliveries with low birth weight (defined as a weight of less than 2,500 grams) from baseline (2019) to the final measurement period (2022). The performance indicator also did not meet the target rate of 9.5%. **CO:** None. **SUD:** None.	**ABO:** ACN Mid-State should continue their performance improvement project interventions in an effort to reach their target indicator rates. It is recommended the entity consider targeting a larger population for the 2023–2024 QIP. **CO:** ACN Mid-State should continue their performance improvement project interventions as they have demonstrated sustained improvement. It is recommended the entity consider targeting a larger population for the 2023–2024 QIP. **SUD:** Although there was an improvement in rates from the baseline to final periods, there was a decline in performance during the interim periods and the target rate was not met. ACN Mid-State should consider adjusting interventions to improve the performance indicator rates. It is recommended the entity consider targeting a larger population for the 2023–2024 QIP.	Quality

ACHN Entity	Strengths	Opportunities for Improvement	Recommendations	Standards
ACN Southeast	**ABO:** ACN Southeast demonstrated an improvement in performance in two of three adverse birth outcomes performance indicators from baseline (2019) to the final measurement period (2022). Two of the three performance indicators exceeded the target rates. **CO:** ACN Southeast demonstrated an improvement in performance in one of two childhood obesity performance indicators from baseline (2019) to the final measurement period (2022). **SUD:** ACN Southeast demonstrated an improvement in performance for the SUD performance indicator from baseline (2019) to the final measurement period (2022).	**ABO:** ACN Southeast demonstrated a decline in performance in one of three adverse birth outcomes performance indicators from baseline (2019) to the final measurement period (2022). **CO:** ACN Southeast demonstrated a decline in performance in one of two childhood obesity performance indicators from baseline (2019) to the final measurement period (2022). **SUD:** None.	**ABO:** While improvement was observed in some indicators, success was not sustained throughout the project. ACN Southeast should continue their performance improvement project interventions and apply lessons learned to the 2023–2024 QIP. **CO:** While some performance indicators demonstrated an improvement between the second interim period (2021) and the final measurement period (2022), there was an overall decline in rates from baseline and no rates met the target rates. ACN Southeast should continue their performance improvement project interventions and apply lessons learned to the 2023–2024 QIP. **SUD:** ACN Southeast should continue their performance improvement project interventions in an effort to reach their target indicator rates. It is recommended to apply lessons learned to the 2023–2024 QIP.	Quality
GCTC	**ABO:** GCTC demonstrated an improvement in performance for one of three adverse birth outcomes performance indicators from baseline (2019) to the final measurement period (2022). One	**ABO:** GCTC demonstrated a decline in performance for two of three adverse birth outcomes performance indicators from baseline (2019) to the final measurement period (2022).	**ABO:** GCTC should continue their performance improvement project interventions in an effort to reach their target indicator rates. **CO:** GCTC should consider creating new interventions when previous	Quality

ACHN Entity	Strengths	Opportunities for Improvement	Recommendations	Standards
	of three performance indicators exceeded the target rate. **CO:** GCTC demonstrated an improvement in performance in one of three childhood obesity performance indicators from baseline (2019) to the final measurement period (2022). **SUD**: GCTC demonstrated an improvement in performance in two of three SUD performance indicators from interim period (2021) to the final measurement period (2022).	**CO:** GCTC demonstrated a decline in performance in two of three childhood obesity performance indicators from baseline (2019) to the final measurement period (2022). **SUD:** GCTC demonstrated a decline in performance in one of three SUD performance indicators from interim period (2021) to the final measurement period (2022).	interventions end, or performance declines. It is recommended to apply lessons learned to the 2023–2024 QIP. **SUD:** GCTC should enhance the barrier analysis process by considering the inclusion of multiple methods for identifying barriers. Additionally, it is recommended the entity consider targeting a larger population for the 2023–2024 QIP.	
MCA-C	**ABO:** None. **CO:** MCA-C demonstrated an improvement in performance for one of three childhood obesity performance indicators from baseline (2019) to the final measurement period (2022). **SUD:** MCA-C demonstrated an improvement in performance for two of three SUD performance indicators from baseline (2019) to the final measurement period (2022).	**ABO:** MCA-C demonstrated a decline in performance for one of three adverse birth outcomes performance indicators from interim period (2021) to the final measurement period (2022). **CO:** One of three performance indicators demonstrated a decline in performance from interim period (2020) to the final measurement period (2022). **SUD:** None.	**ABO:** MCA-C should consider avoiding adding new performance indicators towards the end of the QIP report cycle. Two of three performance indicators were added to the report during interim period (2021) but there were no rates reported therefore an assessment on performance could not be made. MCA-C should consider creating new interventions when previous interventions end, or performance declines. Additionally, it is recommended to apply lessons learned to the 2023–2024 QIP. **CO:** MCA-C should consider avoiding adding new performance indicators towards the end of the QIP report	Quality

ACHN Entity	Strengths	Opportunities for Improvement	Recommendations	Standards
			cycle. There was one performance indicator that was added to the report during interim period (2021) but there were no rates reported therefore an assessment on performance could not be made. Additionally, it is recommended to apply lessons learned to the 2023–2024 QIP. **SUD:** MCA-C should continue their performance improvement project interventions in an effort to reach their target indicator rates. MCA-C should consider avoiding adding new performance indicators towards the end of the QIP report cycle. One of three performance indicators was added to the report during the final measurement period (2022) and therefore an assessment on performance could not be made.	
MCA-E	**ABO:** MCA-E demonstrated an improvement in performance for one of three adverse birth outcomes performance indicators from baseline (2019) to the final measurement period (2022). **CO:** MCA-E demonstrated an improvement in performance for both childhood obesity performance indicators from baseline (2019) to the final measurement period (2022).	**ABO:** Two of three performance indicators declined in performance from baseline (2019) to the final measurement period (2022). **CO:** None. **SUD:** None.	**ABO:** MCA-E should continue their performance improvement project interventions in an effort to reach their target indicator rates. It is recommended to apply lessons learned to the 2023–2024 QIP. **CO:** MCA-E should continue their performance improvement project interventions in an effort to reach their target indicator rates.	Quality

ACHN Entity	Strengths	Opportunities for Improvement	Recommendations	Standards
	SUD: MCA-E demonstrated an improvement in performance for both SUD performance indicators from baseline (2019) to the final measurement period (2022).		**SUD:** MCA-E should continue their performance improvement project interventions in an effort to reach their target indicator rates.	
MCA-NW	**ABO:** MCA-NW demonstrated an improvement in performance for all three adverse birth outcomes performance indicators from baseline (2019) to the final measurement period (2022). **CO:** MCA-NW demonstrated an improvement in performance for the childhood obesity performance indicator from baseline (2019) to the final measurement period (2022). **SUD:** MCA-NW demonstrated an improvement in performance for one of two SUD performance indicators from baseline (2019) to the final measurement period (2022).	**ABO:** None. **CO:** None. **SUD:** MCA-NW demonstrated a decline in performance for one of two SUD performance indicators from baseline (2019) to the final measurement period (2022).	**ABO:** MCA-NW should continue their performance improvement project interventions in an effort to reach their target indicator rates. **CO:** MCA-NW should continue their performance improvement project interventions in an effort to reach their target indicator rates. **SUD:** MCA-NW should continue their performance improvement project interventions in an effort to reach their target indicator rates. It is recommended to apply lessons learned to the 2023–2024 QIP.	Quality
NACC	**ABO:** NACC demonstrated an improvement in performance for all three adverse birth outcomes performance indicators from baseline (2019) to the final measurement period (2022).	**ABO:** None. **CO:** None. **SUD:** An assessment of performance could not be completed for the SUD performance indicator due to data collection issues.	**ABO:** NACC should continue their performance improvement project interventions in an effort to reach their target indicator rates. **CO:** NACC should continue their performance improvement project	Quality

ACHN Entity	Strengths	Opportunities for Improvement	Recommendations	Standards
	CO: NACC demonstrated an improvement in performance for all three childhood obesity performance indicators from baseline (2019) to the final measurement period (2022). **SUD:** None.		interventions in an effort to reach their target indicator rates. **SUD:** NACC should continue their performance improvement project interventions in an effort to reach their target indicator rates. It is recommended to apply lessons learned to the 2023–2024 QIP.	
Compliance review				
ACN Mid-State	During the 2023 SPR, ACN Mid-State was in compliance with 9 of 10 document review domains. Below are the file reviews that met all review elements. • Care Coordination: 15 of 15 Family Planning CC files reviewed met the requirements. 15 of 15 General CC files reviewed met the requirements. 14 of 15 Maternity CC files reviewed met the requirements. 9 of 15 Sickle Cell CC files reviewed met the requirements. • Grievances: All files reviewed met the requirements.	During the 2023 SPR, ACN Mid-State was not in full compliance with 1 of 10 document review domains. Below are the file reviews that did not meet all review elements. • Care Coordination: 1 of 15 Maternity CC files reviewed did not meet the requirements. 6 of 15 Sickle Cell CC files reviewed did not meet the requirements. • Grievances: None.	ACN Mid-State should ensure its compliance with federal and state Medicaid standards by creating initiatives to address the 2023 SPR document review findings related to the QIP reports and medical management meetings. Additionally, ACN Mid-State should address care coordination file review findings by ensuring adherence to follow-up encounter requirements.	Quality Timeliness Access
ACN Southeast	During the 2023 SPR, ACN Southeast was in compliance with 9 of 10 document review domains. Below are the file reviews that met all review elements.	During the 2023 SPR, ACN Southeast was not in full compliance with 1 of 10 document review domains. Below are the file reviews that did not meet all review elements.	ACN Southeast should ensure its compliance with federal and state Medicaid standards by creating initiatives to address the 2023 SPR document review findings related to the QIP reports and medical	Quality Timeliness Access

ACHN Entity	Strengths	Opportunities for Improvement	Recommendations	Standards
	• Care Coordination: 15 of 15 Family Planning CC files reviewed met the requirements. 15 of 15 General CC files reviewed met the requirements. 14 of 15 Maternity CC files reviewed met the requirements. 12 of 15 Sickle Cell CC files reviewed met the requirements. • Grievances: All files reviewed met the requirements.	• Care Coordination: 1 of 15 Maternity CC files reviewed did not meet the requirements. 3 of 15 Sickle Cell CC files reviewed did not meet the requirements. • Grievances: None.	management meetings. Additionally, ACN Southeast should address care coordination file review findings by ensuring adherence to follow-up encounter requirements.	
GCTC	During the 2023 SPR, GCTC was in compliance with 8 of 10 document review domains. Below are the file reviews that met all review elements. • Care Coordination: 9 of 15 Family Planning CC files reviewed met the requirements. 11 of 15 General CC files reviewed met the requirements. 12 of 15 Maternity CC files reviewed met the requirements. 7 of 15 Sickle Cell CC files reviewed met the requirements. • Grievances: All files reviewed met the requirements.	During the 2023 SPR, GCTC was not in full compliance with 2 of 10 document review domains. Below are the file reviews that did not meet all review elements. • Care Coordination: 4 of 15 General CC files reviewed did not meet the requirements. 3 of 15 Maternity CC files reviewed did not meet the requirements. 6 of 15 Family Planning CC files reviewed did not meet the requirements. 8 of 15 Sickle Cell CC files reviewed did not meet the requirements. • Grievances: None.	GCTC should ensure its compliance with federal and state Medicaid standards by creating initiatives to address the 2023 SPR document review findings related to care coordination, QIP reports and medical management meetings. Additionally, GCTC should address care coordination file review findings by ensuring adherence to appropriate follow-up encounter requirements, addressing and documenting all identified needs in the care plan/task notes, and providing ongoing staff training on sickle cell disease risk stratification requirements.	Quality Timeliness Access
MCA-C	During the 2023 SPR, MCA-C was in compliance with 7 of 10 document review domains.	During the 2023 SPR, MCA-C was not in full compliance with 3 of 10 document review domains.	MCA-C should ensure its compliance with federal and state Medicaid standards by creating initiatives to address the 2023 SPR document	Quality Timeliness Access

ACHN Entity	Strengths	Opportunities for Improvement	Recommendations	Standards
	Below are the file reviews that met all review elements. • Care Coordination: 12 of 15 Family Planning CC files reviewed met the requirements. 13 of 15 General CC files reviewed met the requirements. 12 of 15 Maternity CC files reviewed met the requirements. 9 of 15 Sickle Cell CC files reviewed met the requirements. • Grievances: All files reviewed met the requirements.	Below are the file reviews that did not meet all review elements. • Care Coordination: 3 of 15 Family Planning CC files reviewed did not meet the requirements. 2 of 15 General CC files reviewed did not meet the requirements. 3 of 15 Maternity CC files reviewed did not meet the requirements. 6 of 15 Sickle Cell CC files reviewed did not meet the requirements. • Grievances: None.	review findings related to information requirements, enrollee rights, QIP reports, and medical management meetings. Additionally, MCA-C should address care coordination file review findings by ensuring timely and appropriate screenings and adherence to follow-up encounter requirements.	
MCA-E	During the 2023 SPR, MCA-E was in compliance with 8 of 10 document review domains. Below are the file reviews that met all review elements. • Care Coordination: 12 of 15 Family Planning CC files reviewed met the requirements. 14 of 15 General CC files reviewed met the requirements. 9 of 15 Maternity CC files reviewed met the requirements. 7 of 11 Sickle Cell CC files reviewed met the requirements. • Grievances: All files reviewed met the requirements.	During the 2023 SPR, MCA-E was not in full compliance with 2 of 10 document review domains. Below are the file reviews that did not meet all review elements. • Care Coordination: 3 of 15 Family Planning CC files reviewed did not meet the requirements. 1 of 15 General CC files reviewed did not meet the requirements. 6 of 15 Maternity CC files reviewed did not meet the requirements. 4 of 11 Sickle Cell CC files reviewed did not meet the requirements. • Grievances: None.	MCA-E should ensure its compliance with federal and state Medicaid standards by creating initiatives to address the 2023 SPR document review findings related to information requirements and medical management meetings. Additionally, MCA-E should address care coordination file review findings by ensuring timely and appropriate screenings, adherence to follow-up encounter requirements, and updating care plans in a timely manner.	Quality Timeliness Access

ACHN Entity	Strengths	Opportunities for Improvement	Recommendations	Standards
MCA-NW	During the 2023 SPR, MCA-NW was in compliance with 7 of 10 document review domains. Below are the file reviews that met all review elements. • Care Coordination: 11 of 15 Family Planning CC files reviewed met the requirements. 13 of 15 General CC files reviewed met the requirements. 11 of 15 Maternity CC files reviewed met the requirements. 6 of 15 Sickle Cell CC files reviewed met the requirements. • Grievances: All files reviewed met the requirements.	During the 2023 SPR, MCA-NW was not in full compliance with 3 of 10 document review domains. Below are the file reviews that did not meet all review elements. • Care Coordination: 4 of 15 Family Planning CC files reviewed did not meet the requirements. 2 of 15 General CC files reviewed did not meet the requirements. 4 of 15 Maternity CC files reviewed did not meet the requirements. 9 of 15 Sickle Cell CC files reviewed did not meet the requirements. • Grievances: None.	MCA-NW should ensure its compliance with federal and state Medicaid standards by creating initiatives to address the 2023 SPR document review findings related to the QIP reports, information requirements, care coordination, and medical management meetings. Additionally, MCA-NW should address care coordination file review findings by ensuring adherence to follow-up encounter requirements and updating care plans in a timely manner.	Quality Timeliness Access
NACC	During the 2023 SPR, NACC was in compliance with 6 of 10 document review domains. Below are the file reviews that met all review elements. • Care Coordination: 9 of 15 Family Planning CC files reviewed met the requirements. 8 of 15 General CC files reviewed met the requirements. 11 of 15 Maternity CC files reviewed met the requirements. 8 of 15 Sickle Cell CC files reviewed met the requirements. • Grievances:	During the 2023 SPR, NACC was not in full compliance with 4 of 10 document review domains. Below are the file reviews that did not meet all review elements. • Care Coordination: 6 of 15 Family Planning CC files reviewed did not meet the requirements. 7 of 15 General CC files reviewed did not meet the requirements. 4 of 15 Maternity CC files reviewed did not meet the requirements. 7 of 15 Sickle Cell CC files reviewed did not meet the requirements.	NACC should ensure its compliance with federal and state Medicaid standards by creating initiatives to address the 2023 SPR document review findings related to the QIP reports, information requirements, enrollee rights, grievances, confidentiality, and care coordination. Additionally, NACC should address care coordination file review findings by ensuring the implementation of crisis plans for EIs with behavioral health conditions, as applicable, addressing all identified needs, adhering to follow-up encounter	Quality Timeliness Access

ACHN Entity	Strengths	Opportunities for Improvement	Recommendations	Standards
	All files reviewed met the requirements.	• Grievances: None.	requirements, and updating care plans in a timely manner.	
Performance measures				
ACN Mid-State	ACN Mid-State's rates for the following measures exceeded the statewide average: Antidepressant Medication Management (Continuation Phase), Asthma Medication Ratio (Adult), Cervical Cancer Screening, Initiation and Engagement of Treatment for AOD (Initiation), Timeliness of Prenatal Care, and Weight Assessment and Counseling for Children/Adolescents – BMI Assessment.	ACN Mid-State's rates for the following measures were below the statewide average: Asthma Medication Ratio (Child), Initiation and Engagement of Treatment for AOD (Engagement), Live Births Weighing Less Than 2,500 Grams, and Well-Child Visits in the First 15 Months of Life.	ACN Mid-State should use the findings from the Entity Quality Measures Incentive report to inform the development of its annual quality improvement program. ACN Mid-State should concentrate on improving areas of care where its rates fall below the Alabama Medicaid benchmarks.	Quality Timeliness Access
ACN Southeast	ACN Southeast's rates for the following measures exceeded the statewide average: Antidepressant Medication Management (Continuation Phase), Asthma Medication Ratio (Adult and Child), Cervical Cancer Screening, Initiation and Engagement of Treatment for AOD (Initiation and Engagement), Timeliness of Prenatal Care, Well-Child Visits in the First 15 Months of Life, and Weight Assessment and Counseling for Children/Adolescents – BMI Assessment.	ACN Southeast's rate for Live Births Weighing Less Than 2,500 Grams measure was below the statewide average.	ACN Southeast should use the findings from the Entity Quality Measures Incentive report to inform the development of its annual quality improvement program. ACN Southeast should concentrate on improving areas of care where its rates fall below the Alabama Medicaid benchmarks.	Quality Timeliness Access
GCTC	GCTC's rates for the following measures exceeded the statewide	GCTC's rates for the following measures were below the statewide	GCTC should use the findings from the Entity Quality Measures Incentive	Quality Timeliness

ACHN Entity	Strengths	Opportunities for Improvement	Recommendations	Standards
	average: Cervical Cancer Screening, Initiation and Engagement of Treatment for AOD (Initiation and Engagement), Timeliness of Prenatal Care, and Weight Assessment and Counseling for Children/Adolescents: BMI Assessment.	average: Antidepressant Medication Management (Continuation Phase), Asthma Medication Ratio (Adult and Child), Live Births Weighing Less Than 2,500 Grams, and Well-Child Visits in the First 15 Months of Life.	report to inform the development of its annual quality improvement program. GCTC should concentrate on improving areas of care where its rates fall below the Alabama Medicaid benchmarks.	Access
MCA-C	MCA-C's rates for the following measures exceeded the statewide average: Asthma Medication Ratio (Adult and Child), Timeliness of Prenatal Care, and Weight Assessment and Counseling for Children/Adolescents: BMI Assessment.	MCA-C's rates for the following measures were below the statewide average: Antidepressant Medication Management (Continuation Phase), Cervical Cancer Screening, Initiation and Engagement of Treatment for AOD (Initiation and Engagement), Live Births Weighing Less Than 2,500 Grams, and Well-Child Visits in the First 15 Months of Life.	MCA-C should use the findings from the Entity Quality Measures Incentive report to inform the development of its annual quality improvement program. MCA-C should concentrate on improving areas of care where its rates fall below the Alabama Medicaid benchmarks.	Quality Timeliness Access
MCA-E	MCA-E's rates for the following measures exceeded the statewide average: Antidepressant Medication Management (Continuation Phase), Asthma Medication Ratio (Adult and Child), Initiation and Engagement of Treatment for AOD (Engagement), Well-Child Visits in the First 15 Months of Life, and Weight Assessment and Counseling for Children/Adolescents: BMI Assessment.	MCA-E's rates for the following measures were below the statewide average: Cervical Cancer Screening, Initiation and Engagement of Treatment for AOD (Initiation), Live Births Weighing Less Than 2,500 Grams, and Timeliness of Prenatal Care.	MCA-E should use the findings from the Entity Quality Measures Incentive report to inform the development of its annual quality improvement program. MCA-E should concentrate on improving areas of care where its rates fall below the Alabama Medicaid benchmarks.	Quality Timeliness Access

ACHN Entity	Strengths	Opportunities for Improvement	Recommendations	Standards
MCA-NW	MCA-NW's rates for the following measures exceeded the statewide average: Antidepressant Medication Management (Continuation Phase), Initiation and Engagement of Treatment for AOD (Initiation and Engagement), and Timeliness of Prenatal Care.	MCA-NW's rates for the following measures were below the statewide average: Asthma Medication Ratio (Adult and Child), Cervical Cancer Screening, Live Births Weighing Less Than 2,500 Grams, and Well-Child Visits in the First 15 Months of Life.	MCA-NW should use the findings from the Entity Quality Measures Incentive report to inform the development of its annual quality improvement program. MCA-NW should concentrate on improving areas of care where its rates fall below the Alabama Medicaid benchmarks.	Quality Timeliness Access
NACC	NACC's rates for the following measures exceeded the statewide average: Antidepressant Medication Management (Continuation Phase), Asthma Medication Ratio (Adult and Child), Initiation and Engagement of Treatment for AOD (Initiation and Engagement), Well-Child Visits in the First 15 Months of Life, and Weight Assessment and Counseling for Children/Adolescents: BMI Assessment.	NACC's rates for the following measures were below the statewide average: Cervical Cancer Screening, Live Births Weighing Less Than 2,500 Grams, and Timeliness of Prenatal Care.	NACC should use the findings from the Entity Quality Measures Incentive report to inform the development of its annual quality improvement program. NACC should concentrate on improving areas of care where its rates fall below the Alabama Medicaid benchmarks.	Quality Timeliness Access

EQR: external quality review; ACHN: Alabama Coordinated Health Network; ACN: Alabama Care Network; ABO: adverse birth outcomes; CO: childhood obesity; QIP: quality improvement project; BMI: body mass index; EI: eligible individual; SUD: substance use disorder; AOD: alcohol and other drugs; GCTC: Gulf Coast Total Care; MCA-C: My Care Alabama Central; MCA-E: My Care Alabama East; MCA-NW: My Care Alabama Northwest; NACC: North Alabama Community Care; SPR: systems performance review; CC: care coordination.