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External Quality Review Annual Technical Report

Reporting Year 2023

Review Period: January 1, 2021–December 31, 2022

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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 carry out 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) 2022 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 2022 (January 1, 2022–December 31, 2022), 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.

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 2021 and 2022 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 2021 and CY 2022 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

Six of the 7 entities demonstrated an improvement in at least one QIP performance indicator from baseline (CY 2019) to second year remeasurement (CY 2021). 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 nine performance indicators that demonstrated an improvement. In the domain of **timeliness**, there were eight performance indicators that demonstrated an improvement. In the domain of **access**, there were 10 performance indicators that 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.)*

[5] Children's Health Insurance Program.

Minimum Performance Standards

ACHN providers must meet a minimum of 50% of their quality metrics on a quarterly basis to be eligible for the quarterly quality bonus. The quality metrics used for bonus metric calculations in fiscal year (FY) 2023 were generated based on CY 2021 claims data. The quality bonus metrics are updated during October of each year utilizing the prior CY's claims data.

Performance Measures – Quality, Timeliness, and Access

In the domain of **quality**, the statewide average was above the 95th percentile for Asthma Medication Ratio (child and adult). In the domain of **access**, the statewide average was above the 95th percentile for Child BMI Assessment.

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) 2022 review period of October 1, 2021−September 30, 2022. All entities demonstrated full compliance in the areas of EI Materials, Rights, and Enrollment/Disenrollment; Grievances; Health Information Management Systems; and Provider Participation.

For detailed results of the 2022 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

Of the 52 indicators evaluated across QIP projects, 19 demonstrated a decline in performance from baseline (CY 2019) to the second interim remeasurement (CY 2021). Eight of these indicators were in **quality**, 4 were in **timeliness**, and 14 were in **access**. ACN Mid-State demonstrated a decline in performance in the following: the measure related to low birth weight (LBW), the percentage of children that had an annual well visit during the measurement year (MY), and the percentage of children with diagnosis of being overweight or obese. ACN Southeast demonstrated in decline in performance in the following: the percentage of infants with ≥ 6 well-child visits, the percentage of children aged 3–6 years with a body mass index (BMI) > 85th percentile, and the percentage of EIs with a substance use disorder (SUD) diagnosis who received treatment. GCTC demonstrated a decline in performance in the following: the measure related to LBW, the percentage of pregnant EIs receiving prenatal care in the first trimester, the percentage of EIs aged 3–17 years who have an annual BMI assessment completed, the percentage of EIs aged 7–11 with a diagnosis of being overweight, and the percentage of EIs aged 7–11 years with an annual primary care provider (PCP) visit. MCA-C showed a decline in performance in the percentage of students enrolled in a targeted high school that completed the Making Proud Choices curriculum. MCA-E showed a decline in performance in the following: the percentage of live births that had a postpartum visit between 21−56 days after delivery, the percentage of children aged 3−17 years with a diagnosis of being overweight or obese, and the percentage of EIs aged 18 years and over with a new episode of alcohol and other drug (AOD) abuse or dependence who initiated treatment within 14 days of the diagnosis. MCA-NW also showed a decline in the percentage of EIs aged 18 years and over with a new episode of AOD abuse or dependence who initiated treatment within 14 days of the diagnosis. NACC showed a decline in performance in the following: the percentage of pregnant EIs with a BMI greater than or equal to 30 receiving nutritional and healthy lifestyle counseling, the percentage of EIs aged 3–6 years with documentation of BMI in their medical record, and the percentage of EIs aged 3–6 years with a BMI between 85th and 94th percentiles. For detailed QIP results, refer to **Section III, Validation of Performance Improvement Projects**.

Performance Measures – Quality, Timeliness, and Access

*(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 below the 5th percentile for Antidepressant Medication Management.

In the domain of **timeliness**, the statewide average was below the 25th percentile for Well-Child Visits in the First 15 Months of Life, as well as for Timeliness of Prenatal Care.

In the domain of **access**, the statewide average was below the 25th 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 2022 SPR did not demonstrate full compliance. All the entities received a partial determination for Quality Management, ACN Mid-State received a partial determination for Care Coordination, and MCA-E and MCA-NW received partial determinations for Subcontracting. For detailed results of the 2022 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 adjust target rates where needed and continuously assess interventions to make improvements in the performance indicators.
- **ACN Southeast** entity should continue to focus on improving the rate of well-child visits for infants.
- **GCTC** should adjust target rates where needed and continuously assess interventions to make improvements in the performance indicators.
- **MCA-C** should consider adding additional interventions, since two of the interventions have been stopped.
- **MCA-E** should cite their approach in their sampling technique/methods to ensure the counties being piloted are representative of their entire population.
- **MCA-NW** should ensure all calculations and rounding are correct and consistent.
- **NACC** 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., intervention tracking measure 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.

Childhood Obesity

- **ACN Mid-State** should continuously assess barriers to EIs aged 3−11 years accessing annual well visits.
- **ACN Southeast** should ensure all interventions have accurate dates stated in the report. Further, the entity should ensure all data are contemporaneous and accurate.
- **GCTC** 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., intervention tracking measure 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.
- **MCA-C** is encouraged to think about why women are not continuing to breastfeed at 2 months of age and then develop actions to target this accordingly.

- **MCA-E and NACC** should consider updating their target rates for indicators where the target rate was achieved.
- **MCA-NW** should discuss why certain interventions were discontinued. The entity should also develop further Interventions for this QIP, following an examination of barriers associated with this topic.

Substance Use Disorder

- **ACN Mid-State** should review Barrier 1 (lack of support for management of comorbid medical conditions prevent SUD treatment adherence) and indicate how this was identified. Also, factors associated with success/failure should be tied to specific interventions and outcomes.
- **ACN Southeast** should ensure appropriate version control of their spreadsheet, if not already doing so.
- **GCTC** should provide baseline measures for each intervention. Also, 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., intervention tracking measure 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.
- **MCA-C** should ensure that intervention track measure data are collected and reported quarterly to inform intervention progress. They should also continue thinking about how to sustain and expand interventions and efforts, targeting the maximum number of EIs as possible.
- **MCA-E** should add context to their decision on the selection of counties for which interventions would be piloted. The entity should also cite their approach in their sampling technique/methods to ensure the counties being piloted are representative of their entire population.
- **MCA-NW** should ensure all calculations and rounding are correct and consistent.
- **NACC** should state an appropriate rationale for the target chosen. 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 (i.e., intervention tracking measure 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.

Systems Performance Review

Each ACHN entity should address the recommendations made in the SPR finding reports issued February 2023. Entity-specific care coordination file review finding recommendations are as follows:

ACN Mid-State

- General care coordination: ACN Mid-State should ensure that the evaluation process is implemented properly.
- Maternity care coordination: Care Coordinators should document in the task notes when letters are being mailed out to the EI.
- Family planning care coordination:
  - The entity should ensure that care coordinators follow the protocol for when an EI is unable to be reached to prevent premature case closure.
  - The entity should ensure that all needs identified in the assessment are addressed in the care plan.

ACN Southeast

- General care coordination:
  - The entity uses an “enrollment” date from their Magnolia system, which is the referral date that starts the clock for outreach to the EI. The entity advised that the assessment date is the enrollment and consent into care coordination. This needs to be clearly designated for future reviews.
  - Care coordinators should follow subsequent outreach protocols for scheduling the assessment with the EI.

- Maternity care coordination:
  - All identified needs on the assessment should be addressed in the care plan, with monitoring throughout the case for advancement towards goals.
  - The entity should adhere to the encounter schedule; biomonitoring visits cannot count as encounters.
- Family planning care coordination: All priority one discussion topics should be touched upon during all encounters to ensure the EI receives the education; planned discussions for future encounters are not ensured, as the care coordinator may lose contact with the EI. Care coordinators should follow case closure protocols.

GCTC

- General care coordination: GCTC should provide staff with ongoing education on appropriate follow-up procedures.
- Maternity care coordination: GCTC should explore ways to utilize the automated tracking system to facilitate follow-up reminders for care coordinators.
- Family planning care coordination: Staff should be retrained on follow-up requirements. (During the interview, it was noted that a system for automated follow-up reminders has recently been implemented.)

MCA-C

- General care coordination: MCA-C should continue to ensure that the care plan accurately documents all encounters.
- Maternity care coordination: MCA-C should ensure that the care plan accurately documents all encounters, including evaluations and follow-ups.
- Family planning care coordination: MCA-C should continue to ensure that the care plan accurately documents all encounters, including follow-ups.

MCA-E

- General care coordination: all files were fully compliant.
- Maternity care coordination: MCA-E should ensure that the care plan accurately documents all encounters, including evaluations and follow-ups.
- Family planning care coordination: all files were fully compliant.

MCA-NW

- General care coordination:
  - MCA-NW should adhere to the encounter schedule in order to conduct all necessary care coordination activities timely.
  - MCA-NW should adhere to the multidisciplinary care team (MCT) schedule and requirements to ensure all care coordination activities are being conducted.
  - MCA-NW should ensure that all issues identified during the assessment are addressed in the care plan for proper follow-up.
  - MCA-NW should ensure case closure procedures are being followed by care coordinators.
- Maternity care coordination: MCA-NW should adhere to the encounter schedule to ensure completion of all care coordination activities.
- Family planning care coordination: none indicated.

NACC

- General care coordination: NACC should consider providing further training of staff to utilize alternative sources of medication list if EI is unable to provide list.
- Maternity care coordination: NACC should consider exploring ways to automate the tracking system to facilitate follow-up reminders for care coordinators.
- Family planning care coordination: none indicated.

Performance Measures

- **Each entity** should review and trend their performance for the Antidepressant Medication Management measure and develop or modify interventions to specifically target performance for this measure. Further, each entity should determine if a particular demographic subgroup is under-represented or disproportionately impacted by lack of adequate antidepressant medication management.
- **Each entity** should review and trend their performance for the Initiation of Treatment for AOD measure and develop or modify interventions to specifically target performance for this measure. Further, each entity should determine if a particular demographic subgroup is under-represented or disproportionately impacted by the lack of initiation of treatment for AOD.
- **ACN Mid-State**, **GCTC**, **MCA-C**, **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. Further, each entity should determine if a particular demographic subgroup is under-represented or disproportionately impacted by lack of timely well-child visits.
- **MCA-C**, **MCA-E**, **MCA-NW**, 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. Further, each entity should determine if a particular demographic subgroup is under-represented or disproportionately impacted by untimely prenatal care.
- **Each entity** should review and trend their performance for children's access to care and develop or modify interventions to specifically target performance for these measures. Further, each entity should determine if a particular demographic subgroup is under-represented or disproportionately impacted by lack of adequate access to preventive care.

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 2002 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.

Table 1 displays Medicaid enrollment and assignment across the seven entities as of December 2022.

Table 1: Medicaid Enrollment and Assignment by ACHN Entity

ACHN Entity	Number of EIs Enrolled in ACHN (1/1/22–12/31/22)	Number of EIs Assigned to Region (12/1/22–12/31/22)
ACN Mid-State	16,242	159,054
ACN Southeast	15,133	142,574
Gulf Coast Total Care	13,449	173,794
My Care Alabama Central	18,178	136,276
My Care Alabama East	15,292	146,111
My Care Alabama Northwest	12,229	135,664
North Alabama Community Care	13,720	146,757

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 10 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.

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 are 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. These 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

QIP validation results for each ACHN entity are shown in **Tables 7–9.**

Table 7: Adverse Birth Outcomes QIP – MY 2021 Validation Results

Adverse Birth Outcomes QIP – Validation Elements	ACNM	ACNS	GCTC	MCA-C	MCA-E	MCA-NW	NACC
Project topic							
1. Attestation signed and project identifiers completed	Met	Met	Met	Met	Met	Met	Met
2. Project topic impacts the maximum proportion of EIs that is feasible	Met	Met	Met	Met	Met	Met	Met
3. Potential for meaningful impact on EI health, functional status, or satisfaction	Met	Met	Met	Met	Met	Met	Met
4. Topic reflects high-volume or high risk-conditions	Met	Met	Met	Met	Met	Met	Met
5. Topic supported by ACHN EI data (e.g., historical data related to disease prevalence)	Met	Met	Met	Met	Met	Met	Met
6. Aims, objectives, and interventions are in alignment	Met	Met	Met	Met	Met	Met	Met
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	Met	Met	Met	Met	Met	Met
Methodology							
8. Study uses objective, clearly defined, measurable, time-specific indicators to track performance and improvement outcomes	Met	Met	Met	Met	Met	Met	Met
9. Performance indicators are measured consistently over time	Met	Met	Met	Met	Met	Met	Met
10. Performance indicators measure changes in health status, functional status, satisfaction, or processes of care with strong associations with improved outcomes	Met	Met	Met	Met	Met	Met	Met
11. Eligible population (i.e., Medicaid enrollees to whom the QIP is relevant) is clearly defined	Met	Met	Met	Met	Met	Met	Met
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	Met	N/A	N/A	Met	Met	N/A
13. Data collection procedures to ensure that data are valid, reliable, and representative of the entire eligible population with a corresponding timeline	Met	Met	Met	Met	Met	Met	Met

Adverse Birth Outcomes QIP – Validation Elements	ACNM	ACNS	GCTC	MCA-C	MCA-E	MCA-NW	NACC
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 so that stagnating or worsening quarterly ITM trends will trigger barrier/root cause analysis	Met	Met	Met	Met	Met	Met	Met
15. Procedures indicate data source, hybrid vs. administrative, reliability (e.g., inter-rater reliability [IRR])	Met	Met	Met	Met	Met	Met	Met
16. Timeline specifies baseline, interim and final measurement time periods, start date for interventions, and QIP report due dates	Met	Met	Met	Met	Met	Met	Met
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)	Met	Met	Met	Met	Met	Met	Met
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	Met	Met	Met	Partially met	Met	Met	Met
19. Interventions are new or enhanced, starting after baseline period	Met	Met	Met	Met	Met	Met	Met
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)	Met	Met	Met	Met	Met	Met	Partially met
21. Interventions were modified and/or successes spread as informed by interpretation of ITMs	Met	Met	Met	Not met	N/A	Met	Met
Results							
22. In the Results Table, the numerators, denominators, and rates of the annual performance indicators are correctly reported	Met	Met	Partially met	Not met	Met	Partially met	Met
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.	Met	Met	Partially met	Met	Partially met	Met	Met
24. Improvement shown in annual performance indicators or quarterly ITMs?	Partially met	Met	Partially met	Partially met	Partially met	Partially met	Partially met

Adverse Birth Outcomes QIP – Validation Elements	ACNM	ACNS	GCTC	MCA-C	MCA-E	MCA-NW	NACC
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)	Met	Met	Met	Met	Met	Met	Met
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)	Partially met	Met	Met	Not met	Met	Met	Met
27. Identification of study limitations (i.e., factors that that threaten internal/external validity)	Met	Met	Met	Met	Met	Met	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 – MY 2021 Validation Results

Childhood Obesity – Validation Elements	ACNM	ACNS	GCTC	MCA-C	MCA-E	MCA-NW	NACC
Project topic							
1. Attestation signed and project identifiers completed	Met	Met	Met	Met	Met	Met	Met
2. Project topic impacts the maximum proportion of EIs that is feasible	Met	Met	Met	Met	Met	Met	Met
3. Potential for meaningful impact on EI health, functional status, or satisfaction	Met	Met	Met	Met	Met	Met	Met
4. Topic reflects high-volume or high risk-conditions	Met	Met	Met	Met	Met	Met	Met
5. Topic supported by ACHN EI data (e.g., historical data related to disease prevalence)	Met	Met	Met	Met	Met	Met	Met
6. Aims, objectives, and interventions are in alignment	Met	Met	Met	Met	Met	Met	Met
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.	Met	Met	Met	Met	Met	Met	Met
Methodology							
8. Study uses objective, clearly defined, measurable, time-specific indicators to track performance and improvement outcomes	Met	Met	Met	Met	Met	Met	Met
9. Performance indicators are measured consistently over time	Met	Met	Met	Met	Met	Met	Met

Childhood Obesity – Validation Elements	ACNM	ACNS	GCTC	MCA-C	MCA-E	MCA-NW	NACC
10. Performance indicators measure changes in health status, functional status, satisfaction, or processes of care with strong associations with improved outcomes	Met	Met	Met	Met	Met	Met	Met
11. Eligible population (i.e., Medicaid enrollees to whom the QIP is relevant) is clearly defined	Met	Met	Met	Met	Met	Met	Met
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	Met	N/A	N/A	Met	Met	N/A
13. Data collection procedures to ensure that data are valid, reliable, and representative of the entire eligible population with a corresponding timeline	Met	Met	Met	Met	Met	Met	Met
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 so that stagnating or worsening quarterly ITM trends will trigger barrier/root cause analysis	Met	Met	Met	Met	Met	Met	Met
15. Procedures indicate data source, hybrid vs. administrative, reliability (e.g., inter-rater reliability [IRR])	Met	Met	Met	Met	Met	Met	Met
16. Timeline specifies baseline, interim, and final measurement time periods, start date for interventions, and QIP report due dates	Met	Met	Met	Met	Met	Met	Met
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)	Met	Met	Met	Met	Met	Partially met	Met
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	Met	Met	Met	Met	Met	Met	Met
19. Interventions are new or enhanced, starting after baseline period	Met	Met	Met	Met	Met	Met	Met
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)	Met	Met	Met	Met	Met	Met	Met

Childhood Obesity – Validation Elements	ACNM	ACNS	GCTC	MCA-C	MCA-E	MCA-NW	NACC
21. Interventions were modified and/or successes spread as informed by interpretation of ITMs	Met	Met	Met	Met	Met	Partially met	Met
Results							
22. In the Results Table, the numerators, denominators, and rates of the annual performance indicators are correctly reported	Partially met	Met	Partially met	Met	Met	Met	Met
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.	Met	Met	Met	Met	Partially met	Partially met	Met
24. Improvement shown in annual performance indicators or quarterly ITMs?	Met	Partially met	Partially met	Partially met	Met	Met	Met
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)	Met	Met	Met	Met	Met	Met	Met
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)	Met	Met	Partially met	Met	Met	Met	Met
27. Identification of study limitations (i.e., factors that that threaten internal/external validity)	Met	Met	Met	Met	Met	Met	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; ACHN: Alabama Coordinated Health Network; EI: eligible individual; ITM: intervention tracking measure; N/A: not applicable.

Table 9: Substance Use Disorder QIP – MY 2021 Validation Results

Substance Use Disorder – Validation Elements	ACNM	ACNS	GCTC	MCA-C	MCA-E	MCA-NW	NACC
Project topic							
1. Attestation signed and project identifiers completed	Met	Met	Met	Met	Met	Met	Met
2. Project topic impacts the maximum proportion of EIs that is feasible	Met	Met	Met	Met	Met	Met	Met
3. Potential for meaningful impact on EI health, functional status, or satisfaction	Met	Met	Met	Met	Met	Met	Met
4. Topic reflects high-volume or high risk-conditions	Met	Met	Met	Met	Met	Met	Met
5. Topic supported by ACHN EI data (e.g., historical data related to disease prevalence)	Met	Met	Met	Met	Met	Met	Met
6. Aims, objectives, and interventions are in alignment	Met	Met	Partially met	Met	Met	Met	Met
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.	Met	Met	Partially met	Met	Met	Met	Partially met
Methodology							
8. Study uses objective, clearly defined, measurable, time-specific indicators to track performance and improvement outcomes	Met	Met	Met	Met	Met	Met	Met
9. Performance indicators are measured consistently over time	Met	Met	Met	Met	Met	Met	Met
10. Performance indicators measure changes in health status, functional status, satisfaction, or processes of care with strong associations with improved outcomes	Met	Met	Met	Met	Met	Met	Met
11. Eligible population (i.e., Medicaid enrollees to whom the QIP is relevant) is clearly defined	Met	Met	Met	Met	Met	Met	Met
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.	Met	N/A	N/A	N/A	Met	N/A	N/A
13. Data collection procedures to ensure that data are valid, reliable, and representative of the entire eligible population with a corresponding timeline	Met	Met	Met	Met	Met	Met	Met
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 so	Met	Met	Met	Met	Met	Met	Met

Substance Use Disorder – Validation Elements	ACNM	ACNS	GCTC	MCA-C	MCA-E	MCA-NW	NACC
that stagnating or worsening quarterly ITM trends will trigger barrier/root cause analysis							
15. Procedures indicate data source, hybrid vs. administrative, reliability (e.g., inter-rater reliability [IRR])	Met	Met	Met	Met	Met	Met	Met
16. Timeline specifies baseline, interim and final measurement time periods, start date for interventions, and QIP report due dates	Met	Met	Met	Met	Met	Met	Met
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)	Partially met	Met	Met	Met	Met	Met	Met
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	Met	Met	Met	Met	Met	Met	Met
19. Interventions are new or enhanced, starting after baseline period	Met	Met	Met	Met	Met	Met	Met
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)	Met	Met	Met	Met	Met	Partially met	Met
21. Interventions were modified and/or successes spread as informed by interpretation of ITMs	Met	Met	Met	Met	Met	Met	Met
Results							
22. In the Results Table, the numerators, denominators, and rates of the annual performance indicators are correctly reported	Met	Met	Partially met	Met	Met	Met	Met
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.	Met	Met	Met	Met	Met	Met	Met
24. Improvement shown in annual performance indicators or quarterly ITMs?	Partially met	Partially met	N/A	Met	Met	Met	Partially met
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)	Met	Met	Met	Met	Met	Met	Met

Substance Use Disorder – Validation Elements	ACNM	ACNS	GCTC	MCA-C	MCA-E	MCA-NW	NACC
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)	Partially met	Met	Partially met	Met	Met	Met	Met
27. Identification of study limitations (i.e., factors that that threaten internal/external validity)	Met	Met	Met	Met	Met	Met	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 Adverse Birth Outcomes QIP.

Table 10: Adverse Birth Outcomes QIP – MY 2021 Deficient Review Elements

Section	Review Element	Review Determination	Review Comments
Alabama Care Network Mid-State			
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	While the rationale of "AMA annual improvement target" is provided for Indicator 1, the target rate is higher (worse) than the baseline and thus should be adjusted so that it is lower than the baseline.
Results	24. Improvement shown in annual performance indicators or quarterly ITMs?	Partially met	While implementation of interventions (evidenced by ITM performance) seems to be progressing well, the annual performance indicator did not improve during interim period 1 and worsened during interim period 2.
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)	Partially met	The entity should discuss in more detail the progress of Indicator 1; specifically, why did the rate of LBW babies jump two points during interim periods 1 and 2? Additionally, timeframes should be cited under "Discussion of Results" (as opposed to simply indicating that the indicator improved by x%, for instance). Ideally, factors associated with success/failure should be tied to specific interventions and outcomes.
Gulf Coast Total Care			
Results	22. In the Results Table, the numerators, denominators, and rates of the annual performance indicators are correctly reported	Partially met	Numerators and denominators are not reported for interim period 1.

Section	Review Element	Review Determination	Review Comments
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	Target rates are reported within the Results Table; however, the target for Indicator 3 should be adjusted accordingly, given performance has exceeded this target in both 2020 and 2021.
Results	24. Improvement shown in annual performance indicators or quarterly ITMs?	Partially met	No improvements observed in Indicators 1 and 2; rather, there was a decline in performance from 2020 to 2021. There was, however, an improvement in Indicator 3.
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	My Care Alabama Central should consider adding additional interventions, considering two of the interventions have been stopped due to the ACHN entity's lost contact with Baptist Family Medicine (impacting two of their barriers).
Barrier analysis, interventions, and monitoring	21. Interventions were modified and/or successes spread as informed by interpretation of ITMs	Not met	No interventions were modified and/or success spread.
Results	22. In the Results Table, the numerators, denominators, and rates of the annual performance indicators are correctly reported	Not met	Indicator 4 is not reported for interim period 2.
Results	24. Improvement shown in annual performance indicators or quarterly ITMs?	Partially met	Improvement was shown in ITM 1a and 1b from Q2 to Q3 of CY 2021; however, there was no improvement seen in the overall indicators from CY 2020 to CY 2021.
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)	Not met	The ACHN entity claims to show improvement in Indicator 2; however, this appears to be canceled. The ACHN entity also claims to show improvement in Indicator 3; however, it states the start date was 1/11/22, and there are no data listed.
My Care Alabama East			
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	The ACHN entity will consider adjusting target rates for Indicator 2, as the target rates have been achieved for both interim periods 1 and 2.

Section	Review Element	Review Determination	Review Comments
Results	24. Improvement shown in annual performance indicators or quarterly ITMs?	Partially met	There was a slight decline in performance for Indicators 1 and 2 from 2020 to 2021; however, an improvement is still noted since baseline in 2019. Further, an improvement in performance from Indicator 3 was noted from 2020 to 2021; however, it remains a decline in performance when compared with 2019.
My Care Alabama Northwest			
Results	22. In the Results Table, the numerators, denominators, and rates of the annual performance indicators are correctly reported.	Partially met	My Care Alabama Northwest should ensure all calculations and rounding are correct and consistent.
Results	24. Improvement shown in annual performance indicators or quarterly ITMs?	Partially met	While some rates for ITMs improved, there were some that declined in performance. My Care Alabama Northwest should ensure all calculations and rounding are correct and consistent.
North Alabama Community Care			
Barrier analysis, interventions, and monitoring	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).	Partially met	ITM 1a is the same as Indicator 1. Entity should report on activities that measure progress of the interventions (e.g., how many EIs were contacted regarding nutritional counseling?).
Results	24. Improvement shown in annual performance indicators or quarterly ITMs?	Partially met	Improvement was observed in 2 of 3 indicators from interim period 1 to interim period 2.

QIP: quality improvement project; MY: measurement year; AMA: Alabama Medicaid Agency; ITM: interventions tracking measure; LBW: low birth weight; ACHN: Alabama Coordinated Health Network; Q: quarter; CY: calendar year; EI: eligible individual.

Childhood Obesity

Through the validation process, IPRO determined that the review elements shown in **Table 11** did not achieve full compliance in the Childhood Obesity QIP.

Table 11: Childhood Obesity QIP – MY 2021 Deficient Review Elements

Section	Review Element	Review Determination	Review Comments
Alabama Care Network Mid-State			
Results	22. In the Results Table, the numerators, denominators, and rates of the annual performance indicators are correctly reported	Partially met	The numerator and denominator values associated with the measures for the baseline period are missing. Replace descriptions with values.
Alabama Care Network Southeast			
Results	24. Improvement shown in annual performance indicators or quarterly ITMs?	Partially met	Indicator 1: Percentage of EIs aged 3−6 who had a well-child visit in the measurement year declined from 58.3% to 55.3%.
Gulf Coast Total Care			
Results	22. In the Results Table, the numerators, denominators, and rates of the annual performance indicators are correctly reported	Partially met	Show numerators and denominators for baseline and interim period 1. This helps assist in interpretation of the rates that are provided.
Results	24. Improvement shown in annual performance indicators or quarterly ITMs?	Partially met	Indicator 1: percentage of annual BMI assessments completed for EIs aged 3−17 years; outcome: target not met. Indicator 2: percentage of EIs aged 7−11 years with diagnosis code of Z68.53 or Z68.54; outcome: target not met. Indicator 3: percentage of EIs aged 7−11 years that had an annual PCP visit; outcome: target not met.
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)	Partially met	Discuss possible reasons for the steep decline in Q1 2022 in the denominator of ITM 1a (# of EIs aged 7−11 years in SW region with BMI assessed). Since there is only one other data point, it is impossible to tell if this can be attributed to random variation.
My Care Alabama Central			
Results	24. Improvement shown in annual performance indicators or quarterly ITMs?	Partially met	There is evidence of improvement in annual performance indicators but no evidence of improvement in quarterly ITMs.

Section	Review Element	Review Determination	Review Comments
My Care Alabama East			
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	The ACHN entity should consider updating their target rate for Indicator 1 (90.0%), given the 95.6% rate achieved.
My Care Alabama Northwest			
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)	Partially met	Claims data are still indicated as the method of barrier identification for Barriers 2 and 3; however, they are not likely to have led to the identification of these barriers (lack of provider training on coding BMI correctly and lack of education on healthy eating habits).
Barrier analysis, interventions, and monitoring	21. Interventions were modified and/or successes spread as informed by interpretation of ITMs.	Partially met	My Care Alabama Northwest should develop further interventions for the Childhood Obesity QIP, following an examination of barriers associated with this topic.
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	My Care Alabama Northwest should make appropriate adjustment to the target rate for incremental improvement.

QIP: quality improvement project; MY: measurement year; EI: eligible individual; BMI: body mass index; PCP: primary care provider; Q: quarter; SW: southwest; ACHN: Alabama Coordinated Health Network.

Substance Use Disorder

Through the validation process, IPRO determined that the review elements shown in **Table 12** did not achieve full compliance in the Substance Use Disorder QIP.

Table 12: Substance Use Disorder QIP – MY 2021 Deficient Review Elements

Section	Review Element	Review Determination	Review Comments
Alabama Care Network Mid-State			
Barrier analysis, interventions, and monitoring	17. Barriers to improvement are 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)	Partially met	The method of identification for Barrier 1 (care coordination strategies for patients can improve substance use disorder outcomes) is not a method, which requires analysis of data, review of literature, or input from providers/EIs, etc. Review the barrier (lack of support for management of comorbid medical conditions prevent SUD treatment adherence) and indicate how this was identified.
Results	24. Improvement shown in annual performance indicators or quarterly ITMs?	Partially met	Improvement was not observed in the performance indicator (percentage of EIs aged 18−64 years with a new episode of AOD abuse or dependence who engaged in treatment), although ITMs 2a and 2b are improving.
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)	Partially met	Factors associated with success/failure should be tied to specific interventions and outcomes.
Alabama Care Network Southeast			
Results	24. Improvement shown in annual performance indicators or quarterly ITMs?	Partially met	Although Alabama Care Network Southeast's performance indicator rate for the percentage of EIs with an SUD diagnosis who received treatment in the measurement year declined from 12.6% in 2020 to 7.89% in 2021, the entity sufficiently addressed this within the report. Through their partnership with SpectraCare, the entity stated they were able to identify that the increase of COVID-19 rates caused the emergency departments in the region to have been extremely busy and unable to keep substance use patients long enough for them to be seen by a peer specialist.
Gulf Coast Total Care			
Project topic	6. Aims, objectives, and interventions are in alignment	Partially met	It appears that the indicators under the Aims and Objectives section and in Table 6 were broken out into two time periods to display how 1a differs from 1 and how 2a differs from 2. The indicators outlined do not correspond with what is stated in the aim; instead, the aim cites a goal associated with initiation and continuation of AOD treatment.

Section	Review Element	Review Determination	Review Comments
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	Target rates are indicated, but there are no baseline rates.
Results	22. In the Results Table, the numerators, denominators, and rates of the annual performance indicators are correctly reported	Partially met	Neither baseline rates nor interim period 1 rates are reported for the new indicators (1a, 2a, and 3). Going forward, indicators should remain the same throughout the project and reflect the outcome (as opposed to process) the ACHN entity is interested in impacting.
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)	Partially met	While Gulf Coast Total Care indicates some of the challenges faced, there is no discussion of the results of ITMs and how those results inform success/failure of the project or processes associated with it. Add and include references to specific ITMs, timeframes, and data points.
My Care Alabama Northwest			
Barrier analysis, interventions, and monitoring	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)	Partially met	My Care Alabama Northwest should ensure all calculations and rounding are correct and consistent.
North Alabama Community Care			
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	While there is an appropriate rationale stated for the target, the baseline rate should be from CY 2019 (North Alabama Community Care 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.
Results	24. Improvement shown in annual performance indicators or quarterly ITMs?	Partially met	The percentage of EIs receiving brief interventions (ITM 5a) has demonstrated improvement throughout CY 2021. The other ITMs demonstrate little to no progress, with low percentages reported. Further, the indicator cannot be evaluated since data/rates prior to 2021 are not included in the report.

QIP: quality improvement project; MY: measurement year; EI: eligible individual; SUD: substance use disorder; ITM: intervention tracking measure; AOD: alcohol and other drug; COVID-19: 2019 novel coronavirus; ACHN: Alabama Coordinated Health Network; CY: calendar year.

QIP Summaries

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, 2021–2022

ACN Mid-State QIP Summaries
QIP 1: Adverse Birth Outcomes Validation Summary: N/A (the project was due to be completed on 12/31/2022 with the final report due on 6/1/2023).
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 2021–2022** • 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. • Outreached to EIs who deliver a low-weight baby (< 2,500 grams) to complete social determinants of health screening. • Referred postpartum EIs to family planning. • Implemented an education video series to promote healthy birth outcomes and decrease infant mortality. Topics included breastfeeding, counting the kicks, safe sleeping, and family planning. **Performance Improvement Summary** ACN Mid-State observed an increase in the percentage of live deliveries with low birth weight (defined as a weight of less than 2,500 grams) from baseline (2019) to the second interim remeasurement (2021). Of all EIs referred to in-house monitoring, 100% were successfully enrolled. Further, all care coordinators received education for basic nutrition for diabetes/hypertension management to better support and educate EIs. All EIs who completed a social determinants of health screening and who were identified as having a need were connected to a community resource. The percentage of postpartum EIs engaged in family planning increased from 9.2% to 27.8%.
QIP 2: Childhood Obesity Validation Summary: N/A (the project was due to be completed on 12/31/2022 with the final report due on 6/1/2023).
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. **Interventions in 2021–2022** • Provided MyPlate materials for nutrition education and provided jump ropes and Frisbees® to promote physical activity. • Provided MyPlate materials and other aids to promote physical activity to be distributed by providers to EIs aged 3–18 years with BMI > 85th percentile.

ACN Mid-State QIP Summaries
Performance Improvement Summary One of 4 indicators demonstrated improvement from baseline (2019) to the second interim remeasurement (2020). The percentage of annual BMI assessments completed for EIs aged 3–19 years of age improved significantly, while the percentage of EIs with an annual well visit and with a diagnosis of being overweight or obese saw a decline in performance.
QIP 3: Substance Use Disorder Validation Summary: N/A (the project was due to be completed on 12/31/2022 with the final report due on 6/1/2023).
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 2021–2022** • Used AMA data to outreach EIs with SUD for care coordination for primary/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. • Referred family members of EIs diagnosed with SUD to University of Alabama Family Wellness Program. **Performance Improvement Summary** After initial improvement during measurement period 1, there was a decline in performance in percentage of EIs with a new episode of AOD abuse or dependence who engaged in treatment during measurement period 2. There was progress made in the following interventions: percentage of EIs referred to peer support specialist and the percentage of EIs with a prescription for MAT who were enrolled in peer support.

ACN: Alabama Care Network; QIP: quality improvement project; N/A: not applicable; EI: eligible individual; BMI: body mass index; AMA: Alabama Medicaid Agency; SUD: substance use disorder; AOD: alcohol and other drug; ACHN: Alabama Coordinated Health Network; USDA: United State Department of Agriculture.

Table 14: ACN Southeast QIP Summaries, 2021–2022

ACN Southeast QIP Summaries
QIP 1: Adverse Birth Outcomes Validation Summary: N/A (the project was due to be completed on 12/31/2022 with the final report due on 6/1/2023).
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 2021–2022** • 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.

ACN Southeast QIP Summaries

- 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

An improvement in the percentage of pregnant EIs with a prenatal visit in the first trimester was observed from baseline (2019) to the second interim remeasurement (2021). The percentage of infants aged 0–15 months with 6 well-child visits demonstrated a decline in performance. The number of biomonitoring referrals and enrollment increased from 2020 to 2021. Those who completed the biomonitoring program demonstrated a longer gestational period (> 37 weeks), as well as greater birth weight (> 2,500 grams), than those who were lost to follow-up.

QIP 2: Childhood Obesity

Validation Summary: N/A (the project was due to be completed on 12/31/2022 with the final report due on 6/1/2023).

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 2021−2022

- Distributed MyPlate education and physical activity education to EIs 3–6 years of age with a BMI > 85th percentile.
- 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.
- Developed a process for referral of EIs 3–6 years of age who have a BMI > 85th percentile.
- Provided physical activity equipment (jump ropes) to elementary and middle schools in southeast region.

Performance Improvement Summary

Declines in performance were observed in the percentage of EIs 3–6 years of age with a well-child visit, as well as the percentage of EIs aged 3–6 years with a BMI > 85th percentile. The performance of the percentage of EIs aged 3– 6 years with a BMI between 5th and 85th percentile indicator was not able to be evaluated due to lack of a baseline measure.

QIP 3: Substance Use Disorder

Validation Summary: N/A (the project was due to be completed on 12/31/2022 with the final report due on 6/1/2023).

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 2021−2022

- Increased the number of substance use treatment programs that will prescribe substance use medication treatment within the region.
- QM and Pharmacy Director met with program directors/providers to discuss adding SUD medications to treatment options.

ACN Southeast QIP Summaries
• Assisted with transportation resources for SUD treatment when non-emergency transportation reimbursement is not available. • Developed process for ACN Southeast staff to assess EIs with a new SUD diagnosis who cannot be assessed by mental health within three days of diagnosis. • Developed referral process for providers to refer EIs with a new episode of SUD on the date of service. • 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 SU prevention educational materials. **Performance Improvement Summary** There was a decline in the percentage of EIs with an SUD diagnosis who received treatment from baseline (2019) to interim remeasurement 1 (2020) and a further decline to interim measurement period 2 (2021). The southeast region faced access issues, given the lack of facilities that provide SUD treatment services (only 4 out of the 13 counties in the southeast have residential treatment facilities). The ACHN entity again observed an increase in the number of EIs who were assessed by SpectraCare in emergency departments and is continuing to spread this pilot across several counties.

ACN: Alabama Care Network; QIP: quality improvement project; N/A: not applicable; BMI: body mass index; EI: eligible individual; DHCP: delivering healthcare professionals; SUD: substance use disorder; AOD: alcohol and other drug; QM: quality management; ACHN: Alabama Coordinated Health Network.

Table 15: GCTC QIP Summaries, 2021–2022

GCTC QIP Summaries
QIP 1: Adverse Birth Outcomes Validation Summary: N/A (the project was due to be completed on 12/31/2022 with the final report due on 6/1/2023).
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 2021–2022** • 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** While two indicators (percentage of live births weighing less than 2,500 grams and the percentage of EIs that received prenatal care in the first trimester) demonstrated a decline in performance, GCTC again exceeded their target of 50% for their third indicator (percentage of critical-risk EIs who completed 37 weeks of gestation). GCTC will continue to focus on their biomonitoring efforts going forward.

GCTC QIP Summaries
QIP 2: Childhood Obesity Validation Summary: N/A (the project was due to be completed on 12/31/2022 with the final report due on 6/1/2023).
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 2021–2022** • 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 Step Challenge. • Used AMA data to identify EIs in practice that have Z68.53 or Z68.54 diagnosis code and provided list to the practice. PCP selected EIs they believe will engage and benefit from initiatives. • Assisted PCPs in educating EIs (parent) on the importance of an annual PCP visit. **Performance Improvement Summary** There was a decline in performance in the percentage of annual BMI assessments completed for EIs 3–17 years of age, as well as the percentage of EIs 7–11 years of age that had an annual PCP visit and the percentage of EIs 7–11 years of age with a diagnosis of being overweight.
QIP 3: Substance Use Disorder Validation Summary: N/A (the project was due to be completed on 12/31/2022 with the final report due on 6/1/2023).
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 OUD and EIs with first MAT prescription fill. GCTC will make available a certified recovery support specialist (CRSS) through People Engaged in Recover (PEIR) that will engage and support EIs. **Interventions in 2021–2022** • CRSS performed outreach within 24 hours of receipt of referral to EIs with a new episode of AOD (specifically opioid-related, per ICD-10 F-11) abuse or dependence diagnosis or received first MAT prescription fill. CRSS assisted EIs in enrolling in care coordination and completing a placement assessment. CRSS also assisted EIs with accessing outpatient treatment through barrier assessment and support: scheduling the adult placement assessment, transporting, or providing transportation assistance, follow-up with EI to confirm assessment completion, periodic contact for guidance/encouragement, and connection to other community resources/referrals. • 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** The three active performance indicators in place in 2021 (the percentage of EIs 18 years and older with a new episode of an AOD who enrolled in care coordination, the percentage of EIs 18 years of age and older with an OUD and first MAT prescription filled that agreed to PEIR referral, and the percentage of eligible providers that participated/completed the OUD Educational Outreach and Survey that reports increased knowledge/understanding of OUD,

GCTC QIP Summaries
prescribing guidelines, treatment options and community resources) could not be assessed due to lack of baseline data. However, 2 of the 3 indicators exceeded their targets in interim measurement period 2.

QIP: quality improvement project; N/A: not applicable; GCTC: Gulf Coast Total Care; EI: eligible individual; AOD: alcohol and other drugs; AMA: Alabama Medicaid Agency; PCP: primary care provider; BMI: body mass index; OUD: opioid use disorder; ICD-10: International Classification of Diseases, 10th Revision; MAT: medication-assisted therapy.

Table 16: MCA-C QIP Summaries, 2021–2022

MCA-C QIP Summaries
QIP 1: Adverse Birth Outcomes Validation Summary: N/A (the project was due to be completed on 12/31/2022 with the final report due on 6/1/2023).
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 STIs and improving avoidance of teen pregnancy through the use of comprehensive sexual health curriculum for high school and an abstinence-based curriculum for the middle school. **Interventions in 2021–2022** • 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** There was a decline in performance from the baseline (2019) to the second interim remeasurement (2021) for the percentage of students enrolled in the targeted high school that completed the Making Proud Choices curriculum.
QIP 2: Childhood Obesity Validation Summary: N/A (the project was due to be completed on 12/31/2022 with the final report due on 6/1/2023).
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 2021–2022** • 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 # 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 # of Strong Mommas receiving electric breast pumps from WIC with support and education by the QIP nurses. **Performance Improvement Summary** There was an improvement in performance in the percentage of pregnant EIs enrolled in WIC during the prenatal period. The percentage of babies receiving breast milk at 2 months of age was unable to be evaluated due to lack of data.

MCA-C QIP Summaries
QIP 3: Substance Use Disorder Validation Summary: N/A (the project was due to be completed on 12/31/2022 with the final report due on 6/1/2023).
Aim MCA-C aims to provide SUD EIs with the increased opportunity to receive SUD treatment within a timely manner. **Interventions in 2021–2022** • 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 EIs who initiated treatment and had 2 or more AOD/MAT services within 30 days due to transportation support by PSS. **Performance Improvement Summary** Improvement was observed in Indicator 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) and Indicator 2 (number of EIs who initiated treatment and had two or more additional services within 30 days of initiation visit).

MCA-C: My Alabama Care Central; QIP: quality improvement project; N/A: not applicable; 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; PSS: Peer Support Specialist; AOD: alcohol and other drugs; MAT: medication-assisted treatment.

Table 17: MCA-E QIP Summaries, 2021–2022

MCA-E QIP Summaries
QIP 1: Adverse Birth Outcomes Validation Summary: N/A (the project was due to be completed on 12/31/2022 with the final report due on 6/1/2023).
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 2021–2022** • 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** There was an improvement in the percentage of women who smoke during pregnancy, as rates declined from baseline (2019) to the second remeasurement (2021). There was an improvement in performance for the low birth weight indicator (percentage of live births weighing less than 2,500 grams increased from baseline to remeasurement). Performance declined in the percentage of EIs that had a postpartum visit between 21–56 days following delivery.

MCA-E QIP Summaries
QIP 2: Childhood Obesity Validation Summary: N/A (the project was due to be completed on 12/31/2022 with the final report due on 6/1/2023).
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 2021−2022** • 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. **Performance Improvement Summary** There was a significant improvement in the percentage of children aged 3–17 years who had an outpatient visit with a PCP/ob/gyn practitioner and had evidence of BMI documentation during the MY.
QIP 3: Substance Use Disorder Validation Summary: N/A (the project was due to be completed on 12/31/2022 with the final report due on 6/1/2023).
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 2021−2022** • Implemented the use of PSSs to improve the percentage of initiation and engagement of treatment for AOD of 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** There was a decline in performance for the percentage of EIs that initiated AOD treatment from baseline (2019) to the second remeasurement (2021). The performance of Indicator 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) remained constant.

MCA-E: My Care Alabama East; QIP: quality improvement project; N/A: not applicable; EI: eligible individual; PCP: primary care provider; ob/gyn: obstetrician/gynecologist; BMI: body mass index; MY: measurement year; HEAL: Healthy Eating, Active Living; UAB: University of Alabama Birmingham; MAT: medication-assisted treatment. AOD: alcohol and other drugs.

Table 18: MCA-NW QIP Summaries, 2021–2022

MCA-NW QIP Summaries
QIP 1: Adverse Birth Outcomes Validation Summary: N/A (the project was due to be completed on 12/31/2022 with the final report due on 6/1/2023).
Aim MCA-NW aims to positively impact EI health outcomes and experiences of care by implementing the following interventions: increasing home visits to improve prenatal care, increasing early access to prenatal visits to improve birth outcomes, increasing staff knowledge to improve care coordination outcomes, and increasing enrollment in family planning to improve birth spacing. **Interventions in 2021–2022** • NFP provided education on prenatal care visits during the weekly visit in the first month of enrollment and during the biweekly visit after the first month of enrollment. • NFP increased EIs' knowledge about the postpartum care and visit with face-to-face discussion and/or handout to EIs. • NFP provided a face-to-face visit, phone discussion, and/or handout on healthy growth and development of the baby within the first week of delivery until the child is 2 years of age. • NFP provided a handout and/or face-to-face/phone discussions on the different types of contraceptive methods. **Performance Improvement Summary** Performance in the indicator (percentage of students who participated in women's health appointments at the BH Family Medicine Program and completed a screen) remained constant.
QIP 2: Childhood Obesity Validation Summary: N/A (the project was due to be completed on 12/31/2022 with the final report due on 6/1/2023).
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 2021–2022** • UMC provided nutritional and activity counseling to EIs (aged 3-17 years) whom had a sick visit without a well-child visit in the last 12 months and with a BMI of 95% or greater. • Developed a coding cheat sheet for providers to assist them in how to code BMI correctly. • Practices in Tuscaloosa and Bibb counties provided nutritional and activity counseling to EIs with a BMI of 95% or greater. **Performance Improvement Summary** The percentage of EIs 3–17 years of age who had an outpatient visit with a PCP or an ob/gyn and who had evidence of BMI documentation during the MY saw a significant improvement with rates in the second interim remeasurement exceeding the target. Two additional indicators were redesigned and initiated in 2021, resulting in a lack of baseline and interim measurement data.

MCA-NW QIP Summaries
QIP 3: Substance Use Disorder Validation Summary: N/A (the project was due to be completed on 12/31/2022 with the final report due on 6/1/2023).
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 2021–2022** • 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. • Social workers were trained on how to complete Adult Placement Assessment to assist ROSS with getting the assessment done in a timely manner. **Performance Improvement Summary** The percentage of EIs that initiated AOD treatment declined from baseline (2019) to the second interim remeasurement (2021); however, there was an improvement in the percentage of EIs that engaged (continued) in AOD treatment. The peer support specialists successfully provided orientation to various providers in Tuscaloosa County with the goal of continuing outreach until all providers in that county have been oriented to ROSS services, and then the focus will be Bibb County.

MCA-NW: My Care Alabama Northwest; QIP: quality improvement project; N/A: not applicable; EI: eligible individual; NFP: Nurse Family Partnership; UMC: University Medical Center; BMI: body mass index; MY: measurement year; BH: behavioral health; AOD: alcohol and other drugs; PCP: primary care provider; ob/gyn: obstetrician/gynecologist; DHCP: delivering health care provider; PSS: peer support specialist; ROSS: Recovery Organization of Support Specialists; SUD: substance use disorder.

Table 19: NACC QIP Summaries, 2021–2022

NACC QIP Summaries
QIP 1: Adverse Birth Outcomes Validation Summary: N/A (the project was due to be completed on 12/31/2022 with the final report due on 6/1/2023).
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 and increase the amount of EIs with maternal obesity and failed GTTs that receive nutritional and healthy lifestyle counseling during their pregnancy. **Interventions in 2021–2022** • 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.

NACC QIP Summaries

- 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

Indicator 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) showed a slight decrease in performance, while Indicator 2 (percentage of pregnant EIs that failed their GTT receiving nutritional and healthy lifestyle counseling) and Indicator 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) both showed substantial improvement over baseline.

QIP 2: Childhood Obesity

Validation Summary: N/A (the project was due to be completed on 12/31/2022 with the final report due on 6/1/2023).

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 the percentage of EIs aged 3−6 years with a BMI between 85%−94% receiving nutritional and healthy lifestyle counseling.

Interventions in 2021−2022

- Educated PCPs and pediatricians on the correct collection of BMI and reporting BMI on claims submissions.
- 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

There was a performance improvement in all indicators. The food box delivery intervention and the number of EIs returning the questionnaire associated with this program improved during the second interim remeasurement (2021).

NACC QIP Summaries
QIP 3: Substance Use Disorder Validation Summary: N/A (the project was due to be completed on 12/31/2022 with the final report due on 6/1/2023).
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 2021–2022** • Incentivized physicians to become MAT-certified by reimbursing physicians for the time spent completing certification. • Held Breakfast Club Peer Support meetings hosted by NACC staff, which included behavioral health nurses, ToC Nurses, and community health workers. Peer Support meetings attended by peer support professionals contracted with NACC through ROSS. • Coordinated after-hours support with ROSS to address the support needs of EIs with a substance use disorder diagnosis. • 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. **Performance Improvement Summary** Performance on the indicator (percentage of EIs aged 13 years and over with a new episode of SUD receiving SUD treatment) could not be evaluated due to the entity using 2021 data as the baseline data. The percentage of EIs receiving brief interventions (ITM 5a) remained steady in CY 2021 and first quarter 2022. Provider training on the referral process, as well as provider incentive for completing MAT certification, appeared to have a minimal impact on referrals to NACC and MAT certification, respectively, according to the ITMs. Further, an exceptionally low percentage of EIs identified with SUD contacted ROSS for support. Of EIs that providers had referred to NACC, an increasing percentage received brief intervention throughout 2021.

NACC: North Alabama Community Care; QIP: quality improvement project; N/A: not applicable; GTT: glucose tolerance test; EI: eligible individual; BMI: body mass index; PCP: primary care provider; ITM: intervention tracking measure; SUD: substance use disorder; MAT: medication-assisted treatment; ToC: transition of care; ROSS: Recovery Organization of Support Specialists; CY: calendar year.

Results of Second Year of QIPs

Table 20 displays a summary of IPRO's improvement assessment of indicator performance from baseline (2019) to the second interim remeasurement (2021) 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 Year 2 (2021)
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%; Target: 9.8%**	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%; Target: 73.5%**	Improvement
	2	Percentage of live births less than 2,500 grams **Baseline: 9.5%; Interim Y1: 9.7%; Interim Y2: 9.1%; Target: 8.9%**	Improvement
	3	Percentage of infants aged 0–15 months with ≥ 6 well-child visits **Baseline: 64.2%; Interim Y1: 60.2%; Interim Y2: 63.0%; Target: 65.0%**	Decline
Gulf Coast Total Care	1	Percentage of live births weighing less than 2,500 grams **Baseline: 10.4%; Interim Y1: 12.3%; Interim Y2: 13.9%; 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: 60.3%; Target: 74.2%**	Decline
	3	Percentage of EIs defined as critical risk who completed 37 weeks of gestation **Baseline: NA; Interim Y1: 52.8%; Interim Y2: 63.1%; Target: 50.0%**	Unable to evaluate performance at this time
My Care Alabama Central	1	Percentage of students enrolled in the targeted high school that completed the Making Proud Choices curriculum **Baseline: 88.0%; Interim Y1: 84.0%; Interim Y2: 78.0%; Target: 90.0%**	Decline
	3	Percentage of students enrolled in the targeted middle school that completed the curriculum **Baseline: NA; Interim Y1: NA; Interim Y2: 90.0%; Target: 90.0%**	Unable to evaluate performance at this time
	4	Percentage of teenage pregnancies in targeted school ZIP codes (from AMA claims) **Baseline: NA; Interim Y1: NA; Interim Y2: NA; Target: 5.9%**	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%; 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%; Target: 8.7%**	Improvement
	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%; Target: 74.8%**	Decline

ACHN Entity[1]	Indicator Number[2]	Indicator Description[3]	Assessment of Performance, Baseline (2019) to Year 2 (2021)
My Care Alabama Northwest	1	Percentage of students who participated in women's health appointments at the BH Family Medicine Program and completed a screen **Baseline: 62.1%; Interim Y1: 55.8%; Interim Y2: 62.1%; Target: 68.9%**	Performance remained constant
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: 90.6%; Interim Y2: 90.5%; Target: 93.0%**	Decline
	2	Percentage of pregnant EIs that failed their GTT receiving nutritional and healthy lifestyle counseling **Baseline: 80.4%; Interim Y1: 96.0%; Interim Y2: 93.5%; 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: 37.8%; Interim Y2: 23.8%; 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%; 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%; Target: 66.7%**	Decline
	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%; Target: 78.6%**	Decline
	4	Percentage of EIs aged 3–11 years with diagnosis of being overweight or obese during the MY **Baseline: 35.11%; Interim Y1: 41.8%; Interim Y2: 40.2%; Target: 34.11%**	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%; Target: 66.7%**	Decline
	2	Percentage of EIs aged 3–6 years with a BMI > 85th percentile **Baseline: 13.1%; Interim Y1: NA; Interim Y2: 32.2%; Target: 25.7%**	Decline
	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; Target: 64.0%**	Unable to evaluate performance at this time

ACHN Entity[1]	Indicator Number[2]	Indicator Description[3]	Assessment of Performance, Baseline (2019) to Year 2 (2021)
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: 61.6%; Target: 95.0%**	Decline
	2	Percentage of EIs aged 7–11 years with a diagnosis code of overweight (ICD-10 Z68.53) **Baseline: 42.8%; Interim Y1: NA; Interim Y2: 45.9%; Target: 41.8%**	Decline
	3	Percentage of EIs aged 7–11 years that had an annual PCP visit **Baseline: 89.1%; Interim Y1: 63.4%; Interim Y2: 64.9%; 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%; Target: 81.9%**	Unable to evaluate performance at this time
	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%; 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; 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/ob/gyn and had evidence of BMI documentation during the MY **Baseline: 15.30%; Interim Y1: 69.2%; Interim Y2: 95.6%; Target: 90.0%**	Improvement
	2	Percentage of children aged 3–17 years with a diagnosis of being overweight or obese in east region **Baseline: 31.77%; Interim Y1: 2.99%; Interim Y2: 45.80%; Target: 38.50%**	Decline
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%; Target: 65.0%**	Improvement
	2	Percentage of children aged 3–17 years who had nutritional counseling documentation during the MY **Baseline: NA; Interim Y1: NA; Interim Y2: NA; Target: NA**	Unable to evaluate performance at this time
	3	Percentage of children aged 3–17 years who had physical activity counseling documented during the MY **Baseline: NA; Interim Y1: NA; Interim Y2: NA; Target: NA**	Unable to evaluate performance at this time
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: 72.1%; Interim Y2: 72.13%; Target: 73.0%**	Improvement
	2	Percentage of EIs aged 3–6 years with a BMI between 85% and 94% **Baseline: 16.01%; Interim Y1: 14.7%; Interim Y2: 14.65%; Target: 14.0%**	Improvement
	3	Percentage of first-time pregnant EIs that were breastfeeding at postpartum visit **Baseline: 31.25%; Interim Y1: 45.6%; Interim Y2: 45.57%; Target: 46.0%**	Improvement

ACHN Entity[1]	Indicator Number[2]	Indicator Description[3]	Assessment of Performance, Baseline (2019) to Year 2 (2021)
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: 1.43%; Interim Y1: 12.5%; Interim Y2: 8.50%; 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: 7.89%; Target: 10.0%**	Decline
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) or first MAT prescription fill that enrolled and remained in active care coordination for at least 120 days **Baseline: NA; Interim Y1: NA; Interim Y2: 66.70%; Target: 50.0%**	Unable to evaluate performance at this time
	2	Percentage of EIs aged 18 years and older with a first MAT prescription filled that initiated counseling/behavioral therapies within 60 days of first fill **Baseline: NA; Interim Y1: NA; Interim Y2: 53.1%; Target: 20.0%**	Unable to evaluate performance at this time
	1a	Percentage of EIs aged 18 years and older with a new episode of opioid-related disorders (ICD-10 F-11) who enrolled in CC **Baseline: NA; Interim Y1: NA; Interim Y2: 23.6%; Target: 10.0%**	Unable to evaluate performance at this time
	2a	Percentage of EIs aged 18 years and older with an OUD and first MAT prescription filled and agreed to PEIR referral **Baseline: NA; Interim Y1: NA; Interim Y2: 15.5%; Target: 20.0%**	Unable to evaluate performance at this time
	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%; Target: 50.0%**	Unable to evaluate performance at this time
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%; 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%; Target: 5.2%**	Improvement

ACHN Entity[1]	Indicator Number[2]	Indicator Description[3]	Assessment of Performance, Baseline (2019) to Year 2 (2021)
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%; Target: 37.8%**	Decline
	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%; Target: 7.7%**	Performance remained constant
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: 41.1%; Interim Y2: 40.7%; 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: 20.6%; Interim Y2: 18.8%; 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 **Baseline: 4.61%; Interim Y1: 4.6%; Interim Y2: NA; Target: 4.77%**	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.
ACHN: Alabama Coordinated Health Network; QIP: quality improvement project; ACN: Alabama Care Network; Y1: year 1; year 2; EI: eligible individual; ZIP: Zone Improvement Plan; NA: not available; AMA: Alabama Medicaid Agency; MY: measurement year; BH: behavioral health; 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.

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 2022 covered MY 2021 (January 1, 2021−December 31, 2021). 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

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 21**.

Table 21: ACHN Performance Measure Domains

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

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

Table 22 displays the performance measures for MY 2021 for all entities, the statewide average, and the statewide average percentile achieved for the NCQA 2021 benchmark. Green shading indicates the ACHN performed at or above the statewide 2021 performance. Red shading indicates the ACHN performed below the statewide 2021 performance. Gray shading indicates that these rates were retired and therefore no NCQA benchmarks are reported.

Table 22: ACHN Quality Measures Rates for August 2022 – Incentive Report

Measure Description[1]	ACNM	ACNS	GCTC	MCA-C	MCA-E	MCA-NW	NACC	2021 SWA	SWA Percentile
Adult BMI Assessment[2]	88.2%	88.2%	90.6%	91.8%	92.3%	90.6%	89.4%	90.2%	–
Antidepressant Medication Management	27.4%	25.3%	24.5%	24.1%	26.0%	27.7%	26.6%	25.9%	< 5th
Asthma Medication Ratio: Aged 19–64 Years (19−50)	81.3%	85.7%	82.7%	86.2%	88.6%	85.0%	89.5%	85.6%	> 95th
Asthma Medication Ratio: Aged 5–18 Years (5−11)	64.8%	80.6%	72.3%	71.7%	75.7%	72.0%	73.9%	73.0%	> 95th
CAP-CH (HEDIS®) Aged 12–24 Months	77.6%	89.0%	86.0%	88.7%	89.7%	87.8%	86.9%	86.5%	–
CAP-CH (HEDIS) Aged 25 Months–6 Years	73.2%	85.8%	77.9%	83.6%	88.1%	82.8%	82.9%	82.0%	–
CAP-CH (HEDIS) Aged 7–11 Years	79.9%	89.1%	81.7%	85.3%	92.1%	86.7%	88.0%	86.1%	–
CAP-CH (HEDIS) Aged 12–19 Years	78.2%	87.5%	81.2%	82.2%	89.1%	84.9%	85.3%	84.1%	–
Cervical Cancer Screening	50.1%	48.5%	49.3%	47.0%	44.8%	47.2%	45.2%	47.4%	< 25th
Initiation and Engagement of Treatment for AOD (Initiation)	30.7%	38.0%	38.0%	33.0%	30.8%	39.4%	36.2%	35.2%	< 10th
Initiation and Engagement of Treatment for AOD (Engagement)	4.7%	9.3%	7.1%	4.4%	6.8%	9.0%	8.1%	7.1%	< 25th
Live Births Weighing Less Than 2,500 Grams	13.0%	9.5%	12.3%	13.3%	9.5%	11.7%	9.2%	11.2%	N/A
Timeliness of Prenatal Care	79.3%	83.8%	80.2%	72.3%	69.2%	74.6%	67.9%	75.3%	< 25th
Well-Child Visits in the First 15 Months of Life	52.3%	62.0%	47.3%	49.7%	59.3%	46.9%	52.9%	52.9%	< 25th
Weight Assessment and Counseling for Children/Adolescents – BMI Assessment	95.0%	97.1%	94.3%	96.0%	97.0%	95.8%	96.5%	96.0%	> 95th

[1] Green shading indicates the ACHN performed as well or better than the 2021 average statewide performance. Red shading indicates the ACHN performed below the statewide 2021 performance. 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.

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; NCQA: National Committee for Quality Assurance; HEDIS: Healthcare Effectiveness Data and Information Set; BMI: body mass index; AOD: alcohol and other drug; CMS: Centers for Medicare and Medicaid Services; CAP-CH: Children and Adolescents' Access to Primary Care Practitioners; SWA: statewide average.

The following presents a summary of the findings indicated in **Table 22**:

- In the domain of **quality**, the statewide average was above the 95th percentile for Asthma Medication Ratio (all age categories). The statewide average was below the 5th for Antidepressant Medication Management.
- In the domain of **timeliness**, the statewide average was below the 25th percentile for Well-Child Visits in the First 15 Months of Life, as well as for Timeliness of Prenatal Care.
- In the domain of **access**, the statewide average was above the 95th percentile for Child BMI Assessment. The statewide average was below the 25th percentile for Cervical Cancer Screening.
- Four entities exceeded the statewide average for Adult BMI Assessment. Four entities also exceeded the statewide average for all age categories of the CAP-CH measures, while two entities were below the SWA in all categories and one entity was below the SWA in two categories.

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

Objectives

Per *Title 42 CFR § 438.358*, a review must be conducted within the previous three-year period that determines an MCE's adherence to standards established by the state 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. AMA contracted with IPRO to conduct the SFY 2022 SPR.

Technical Methods of Data Collection and Analysis

The SPR was an assessment of ACHN entities' compliance with the ACHN RFP, the ACHN Operations Manual, and *Title 42 CFR § 43*8. Each ACHN entity was assessed for their compliance with contractual requirements related to the following SPR areas: Care Coordination; EI Materials, Rights, and Enrollment/Disenrollment; Grievances, Health Information Management System; Provider Participation; Quality Management; and Subcontracting.

Modifications were made to the review process to have activities take place virtually to mitigate the impact of the 2019 novel coronavirus (COVID-19) pandemic on participating stakeholders. Partial reviews were conducted for areas in which IPRO reviewed elements that were considered less than fully compliant during the 2020 SPR. Partial reviews were based on the "deeming" methodology. Deeming is an option that allows for information obtained from a previous review or related review to be used to demonstrate compliance. Requirements not reviewed during the 2022 SPR were reviewed in 2021 and deemed fully compliant. This does not indicate that these requirements were in compliance for 2022 but rather were not subject to review. New contract requirements were reviewed for all entities. Full reviews were conducted for all file review areas (i.e., Care Coordination and Grievances). Fifteen files were selected for Grievances, and 45 files were selected for Care Coordination (15 each for general, family planning, and maternity). Each set of 15 files had a five-file oversample.

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, files, and other materials corresponding to the areas in **Table 23**. For the areas that included file review, 20 files were requested for each area. In some instances, there were fewer than 20 files available for review.

Table 23: SPR Areas and Corresponding Materials Reviewed

Area	Document Review	File Review
Care Coordination	✓	✓
EI Materials, Rights, and Enrollment/Disenrollment	✓	N/A
Grievances	✓	✓
HIMS	✓	N/A
Provider Participation	✓	N/A
Subcontracting	✓	N/A
Quality Management	✓	N/A

SPR: systems performance review; EI: eligible individual; N/A: not applicable; HIMS: Health Information Management System.

For this review, determinations of "full," "partial," and "noncompliant" were used for each element under review. Definitions of these review determinations are presented in **Table 24**.

Table 24: SPR Determination Definitions

Review Determination	Definition
Full	The entity has met or exceeded the requirement.
Partial	The entity had partially met the requirement.
Noncompliant	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

To conduct the SFY 2022 SPR, IPRO utilized the SFY 2021 SPR findings to inform the deeming strategy. IPRO also utilized information contained within the 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 2022 SPR did not demonstrate full compliance. **Table 25** displays the ACHN entities' compliance determinations.

Table 25: CFR Standards to State Compliance Tool Crosswalk

CFR Standard Name	CFR Citation	SPR Tool Reference	ACNM	ACNS	GCTC	MCA-C	MCA-E	MCA-NW	NACC
Overall compliance score			**Partial**	**Partial**	**Partial**	**Partial**	**Partial**	**Partial**	**Partial**
Availability of Services	**438.206**	EI Materials, Rights, and Enrollment/Disenrollment	Full	Full	Full	Full	Full	Full	Full
Assurances of Adequate Capacity and Services	**438.207**								
Coverage and Authorization of Services	**438.210**								
Confidentiality	**438.224**								
Coordination and Continuity of Care	**438.208**	Care Coordination	Partial	Full	Full	Full	Full	Full	Full
Provider Selection	**438.214**	Provider Participation	Full	Full	Full	Full	Full	Full	Full
Practice Guidelines	**438.236**								
Grievance and Appeal Systems	**438.228**	Grievances	Full	Full	Full	Full	Full	Full	Full
Subcontractual Relationships and Delegation	**438.230**	Subcontracting	Full	Full	Full	Full	Partial	Partial	Full
Health Information Systems	**438.242**	Health Information Management Systems	Full	Full	Full	Full	Full	Full	Full
QAPI	**438.330**	Quality Management	Partial	Partial	Partial	Partial	Partial	Partial	Partial

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; QAPI: Quality Assurance and Performance Improvement.

ACN Mid-State

The following presents a summary of ACN Mid-State's performance in the 2022 SPR.

Care Coordination

- All requirements were addressed in ACN Mid-State's policies and procedures.
- One general file did not include an analysis and judgement of the effectiveness of a care plan to determine if goals were met and if outcomes were desirable.
- Two maternity files did not address all of the requirements for face-to-face interview during the inpatient delivery encounter.
- One family planning file was not based on the data collected in the Health Risk and Psychosocial Assessment.

EI Materials, Rights, and Enrollment/Disenrollment

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

Grievances

- All requirements were addressed in ACN Mid-State's policies and procedures.
- Fourteen of 15 files reviewed showed complaints related to PCPs, while 6 of 15 included evidence of denial of care coordination services.
- Seven files did not include a grievance form.
- Two files had no complaint resolution documented. (Post-interview documentation confirms resolution).

HIMS

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

Provider Participation

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

Quality Management

- Of the 20 requirements reviewed for ACN Mid-State, 18 were full and 2 were partial. The partial determinations reflected requirements related to evaluating the effectiveness of interventions and planning/initiation of activities for increasing or sustaining improvement.

Subcontracting

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

ACN Southeast

The following presents a summary of ACN Southeast's performance in the 2022 SPR.

Care Coordination

- All requirements were addressed in ACN Southeast's policies and procedures.
- One general file did not indicate at least one attempt (initial or subsequent outreach) to schedule a Health Risk and Psychosocial Assessment by written letter.
- One maternity file was not based on the data collected in the Health Risk and Psychosocial Assessment.
- One maternity file did not indicate a face-to-face or telephonic encounter, as clinically appropriate.
- Two family planning files did not indicate a face-to-face or telephonic encounter, as clinically appropriate.
- One family planning file indicated that an encounter did not address all requirements.

EI Materials, Rights, and Enrollment/Disenrollment

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

Grievances

- All requirements were addressed in ACN Southeast's policies and procedures.
- Each of the 10 files reviewed were complaints related to PCPs. While grievance forms were not provided in 9 of 10 cases, grievances were addressed in chart notes in all cases.

HIMS

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

Provider Participation

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

Quality Management

- Of the 20 requirements reviewed for ACN Southeast, 18 were full and 2 were partial. The partial determinations reflected requirements related to evaluating the effectiveness of interventions and planning/initiation of activities for increasing or sustaining improvement.

Subcontracting

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

GCTC

The following presents a summary of GCTC's performance in the 2022 SPR.

Care Coordination

- All requirements were addressed in GCTC's policies and procedures.
- One general file did not indicate that the PCCM-E made any outreach attempts to screen the EI within five business days from receipt of the referral.
- One general, one maternity, and three family planning files indicated that the care plan did not include all five required components.
- One general file indicated that the care plan was not updated based on the EI's needs within 90 days.
- One general and eight maternity files indicated that a visit/encounter did not address all requirements.
- One maternity file did not contain an evaluation that included an analysis and judgement of the effectiveness of a care plan to determine if goals were met.
- Two maternity files showed that care plans were not updated based on the EI's needs.
- One maternity file indicated that the visit/encounter was not completed face-to-face or telephonically.
- Four family planning files did not include an analysis and judgement of the effectiveness of a care plan to determine if goals were met.
- One family planning file did not demonstrate use of the PT+3[6] Teaching Methodology.
- One family planning file showed that the documented encounters did not address all requirements.

EI Materials, Rights, and Enrollment/Disenrollment

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

Grievances

- All requirements were addressed in GCTC's policies and procedures.
- Dissatisfaction with case manager or other PCCM-E staff was cited in two cases, while complaints related to PCPs were cited in four cases and denial of care in five cases.

[6] P = Personalize the PROBLEM, T = 'TAKLE' the problem, T = Set a Therapeutic Tone, A = Assess the knowledge level of the EI, K = Provide Knowledge, L = Listen for feedback, E = Elaborate or reeducate as needed. +3 = Summarize the teaching session into three essential points.

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

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

Quality Management
- Of the 21 requirements reviewed for GCTC, 3 were partial. Two of the partial determinations reflected requirements related to evaluating the effectiveness of interventions and planning/initiation of activities for increasing or sustaining improvement, and the other was related to the Regional Medical Management Committee composition requirements.

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

MCA-C
The following presents a summary of MCA-C's performance in the 2022 SPR.

Care Coordination
- All requirements were addressed in MCA-C's policies and procedures.
- Two general files did not contain appropriate screenings for the EI.
- One general file did not address all medical conditions identified in the EI's Health Risk and Psychosocial Assessment.
- Two maternity files did not contain all required components.
- One maternity file showed the in-home postpartum was not completed face-to-face.
- One maternity file showed the inpatient delivery encounter was not completed face-to-face.
- One family planning file did not have an individualized care plan.
- One family planning file did not show all requirements during the initial encounter.

EI Materials, Rights, and Enrollment/Disenrollment
- All requirements were addressed in MCA-C's policies and procedures.

Grievances
- All requirements were addressed in MCA-C's policies and procedures.
- In each of the 13 cases, documentation included evidence of complaints related to PCPs.

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

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

Quality Management
- Of the 21 requirements reviewed for MCA-C, 20 were full and 1 was partial. The partial determination was related to requirements regarding the composition of the Region Medical Management Committee.

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

MCA-E
The following presents a summary of MCA-E's performance in the 2022 SPR.

Care Coordination
- All requirements were addressed in MCA-E's policies and procedures.
- One family planning file encounter did not address all requirements.

EI Materials, Rights, and Enrollment/Disenrollment
- All requirements were addressed in MCA-E's policies and procedures.

Grievances
- All requirements were addressed in MCA-E's policies and procedures.
- In each of the 13 cases, documentation included evidence of complaints related to PCPs.

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

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

Quality Management
- Of the 19 requirements reviewed for MCA-E, 18 were full and 1 was partial. The partial determination was related to requirements regarding the composition of the Regional Medical Management Committee.

Subcontracting
- Of the 8 requirements reviewed for MCA-E, 4 were partial. The partial determinations reflected a subcontract that was missing requirement language. The entity indicated that this contract was expiring in March 2022, and thus no modifications took place.

MCA-NW
The following presents a summary of MCA-NW's performance in the 2022 SPR.

Care Coordination
- All requirements were addressed in MCA-NW's policies and procedures.
- One general file care plan was not based on the data collected in the Health Risk and Psychosocial Assessment.
- Two general file care plans were not updated based on the EI's needs every 90 days.
- Six general care files from the MCT were not completed within 60 calendar days of the initial/first visit or encounter.
- One general file did not have a visit/encounter during calendar months 0−1.
- One general file visit/encounter during calendar months 3−6 did not address all requirements.
- Two maternity files care plans were not updated based on the EI's needs during each encounter.
- Two maternity file encounters were not completed face-to-face or telephonic, as clinically appropriate.

EI Materials, Rights, and Enrollment/Disenrollment
- All requirements were addressed in MCA-NW's policies and procedures.

Grievances
- All requirements were addressed in MCA-NW's policies and procedures.
- Of the 15 cases reviewed, 14 indicated complaints related to PCPs, and 2 included evidence of denial of care coordination services.
- Five of the 15 files did not include a grievance form.

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

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

Quality Management
- Of the 22 requirements reviewed for MCA-NW, 19 were full and 3 were partial. The three partial determinations reflected the evaluation of the effectiveness of interventions, planning/initiating activities for increasing or sustaining improvement, and provider participation in medical management meetings.

Subcontracting
- Of the 8 requirements reviewed for MCA-E, 4 were partial. The partial determinations reflected a subcontract that was missing requirement language. The entity indicated that this contract was expiring in March 2022, and thus no modifications would take place.

NACC
The following presents a summary of NACC's performance in the 2022 SPR.

Care Coordination
- All requirements were addressed in NACC's policies and procedures.
- One general file showed that a medication reconciliation review was not conducted.
- Two maternity files care plans did not include all five required components.
- One maternity file did not include an analysis and judgement of the effectiveness of a care plan to determine if goals were met.
- One maternity care file was not updated based on the EI's needs during each encounter.
- Six maternity care file encounters were not completed face-to-face or telephonic, as clinically appropriate.

EI Materials, Rights, and Enrollment/Disenrollment
- All requirements were addressed in NACC's policies and procedures.

Grievances
- All requirements were addressed in NACC's policies and procedures.
- Of the 12 files reviewed, 10 included evidence of complaints related to PCPs, while 2 cases related to denial of care coordination services.
- NACC acknowledged three forms were not filled out completely.

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

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

Quality Management
- Of the 20 requirements reviewed for NACC, 17 were full and 3 were partial. The first partial determination was related to evaluation of the effectiveness of the interventions, the second was related to planning and initiation of activities for increasing or sustaining improvement, and the third was related to requirements regarding the composition of the Region Medical Management Committee

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

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[7] made by the EQRO during the previous year's EQR." **Tables 23–29** 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 26 displays ACN Mid-State's progress related to the *RY 2022 Annual External Quality Review Technical Report,* as well as IPRO's assessment of ACN Mid-State's response.

Table 26: 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		
Evaluate the LBW measure at the member level to understand factors that might be influencing this rate to increase over time. ACN Mid-State could perform a pareto analysis or stratify those who delivered a low birthweight baby by demographic factors to evaluate whether there are susceptible subpopulations that could benefit from being targeted with tailored interventions.	• What has the ACHN done or planned to do to address the recommendation? o For the 2023 Infant Mortality QIP Proposal, we completed a Disproportionate Index table for all women who gave birth in our region in 2021 and then filtered those who gave birth to a LWB in 2021. Of those that had LWB, a disproportionate number were Black. Additionally, we looked at smoking status for those women and found that smokers were at greater risk for LWB as were women who were stratified as high risk in Maternity Care Coordination. All of these variables are of interest to us for future interventions as we might target those specific populations and make a greater impact. We also plan to move forward with a diabetes intervention similar to our current HTN intervention in 2023. • When and how will this be accomplished? o We plan to include this in our outreach strategy during the next measurement cycle, 2023-2024. • What are the expected outcomes or goals of the actions to be taken? o We are hopeful that making more targeted outreach to women who are at highest risk for Adverse Birth Outcomes, will improve birth weights for those women who receive the interventions we provide. • What is the ACHN's process for monitoring the actions to determine their effectiveness? o 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

[7] quality improvement.

Recommendation for ACN Mid-State	ACN Mid-State Response/Actions Taken	IPRO Assessment of Entity Response[1]
Work with EIs and providers to help bolster access to well-child visits. By working with the EIs, the entities could both evaluate barriers and provide education regarding the importance of these visits, and that they are fully covered by Medicaid.	• What has the ACHN done or planned to do to address the recommendation? o ACNM currently provides outreach for well child visits based on Medicaid claims data. Since our return to the field in October 2022, we have staff members embedded in multiple large pediatric clinics as well who are able to educate families in person on the importance of attending well child visits and Medicaid coverage of these visits. • When and how will this be accomplished? o ACNM will continue to work to make targeted outreach to those who need well child visits for the 2023-2024 reporting cycle. • What are the expected outcomes or goals of the actions to be taken? o We hope to improve attendance of well child visits as well as provide education regarding the importance of these visits in maintaining health and early diagnosis and intervention when concerns arise. • What is the ACHN's process for monitoring the actions to determine their effectiveness? o 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
Continue to evaluate their interventions aimed at children with a BMI over the 85th percentile to determine if they are progressing at an acceptable rate to influence BMI, and/or if further barriers analysis/root cause analysis should be conducted to understand if current interventions remain most appropriate.	• What has the ACHN done or planned to do to address the recommendation? o With regard to participation in our Healthy Lifestyle Challenge we have had continuing success, however, many of those who agree to participate in the challenge do not complete it. This is an area we plan to further evaluate. In addition, we have added the Healthy Lifestyle questionnaire to our process and plan to use the data gathered from it to better measure outcomes with regard to healthy habits. • When and how will this be accomplished? o ACNM will continue to work toward these goals during the 2023-2024 reporting cycle. • What are the expected outcomes or goals of the actions to be taken? o Our overarching goal is to see improvement in overall BMI for region though this may not happen in the time allotted. We would also hope to see improvement in healthy lifestyle behaviors adopted by those who participate in the challenge as evidenced by questionnaire responses. • What is the ACHN's process for monitoring the actions to determine their effectiveness? o 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
Ensure the maximum proportion of EIs feasible are being targeted by interventions for Childhood Obesity QIP, following pilot testing (assuming pilot test demonstrated efficacy).	• What has the ACHN done or planned to do to address the recommendation? o At the initial launch of the Healthy Lifestyle Challenge, those staff who were members of the childhood obesity QIP team were the first to enroll EIs and follow the process. Since then, we have trained all ACNM staff on how to enroll and complete this challenge with our recipients. • When and how will this be accomplished? o ACNM will continue to work toward these goals during the 2023-2024 reporting cycle.	Addressed

Recommendation for ACN Mid-State	ACN Mid-State Response/Actions Taken	IPRO Assessment of Entity Response[1]
	• What are the expected outcomes or goals of the actions to be taken? o Now that all staff members have the ability to enroll in our Healthy Lifestyle Challenge, we anticipate improved participation and completion. • What is the ACHN's process for monitoring the actions to determine their effectiveness? o 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.	
Evaluate barriers to successfully contacting EIs with SUD diagnosis on a prescription, as well as barriers to EIs keeping their follow-up appointments.	• What has the ACHN done or planned to do to address the recommendation? o Staffing has been a barrier to our ability to make outreach to those with new MAT prescriptions in recent months. We have now increased our number of staff with experience in both mental health and substance use and hope to improve our numbers in that area. Additionally, we have discussed the use of the UAB Specialty Clinic appointment schedule to filter for those following up in Addiction Medicine. We have access to phone numbers through that schedule and are hopeful they are more current than those Medicaid may have on file for the recipient. • When and how will this be accomplished? o ACNM will continue to work toward these goals during the 2023-2024 reporting cycle. • What are the expected outcomes or goals of the actions to be taken? o We really hope to improve our outreach success with the SUD population during the next reporting cycle. While we have had several individual success stories that have been very encouraging, with time we would like to be able to reach more recipients to improve more outcomes. • What is the ACHN's process for monitoring the actions to determine their effectiveness? o 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		
Ensure that rationales for interventions are included within the care plan; that care plans have an evaluation of effectiveness; that all medical conditions in the Health Risk and Psychosocial Assessment be addressed in the care plan; that all EIs enrolled in family planning receive information/education about STD prevention; and that the Psychosocial Health Risk Assessment takes place within 5 business days from the date of the screening.	• What has the ACHN done or planned to do to address the recommendation? o January 12th, 2022- additional documentation training was provided which included the requirement that rationales for interventions are included within the care plan; that care plans have an evaluation of effectiveness, that all medical conditions in the Health Risk and Psychosocial Assessment be addressed in the care plan (or a note documented on assessment as to why a goal was not created) o March 9th, 2022- additional documentation training was provided which included the requirement that rationales for interventions are included within the care plan; that care plans have an evaluation of effectiveness, that all medical conditions in the Health Risk and Psychosocial Assessment be addressed in the care plan (or a note documented on assessment as to why a goal was not created) o May 25th, 2022- additional documentation training was provided which included the requirement that rationales for interventions are included within the care plan; that care plans have an evaluation of effectiveness, that all medical conditions in the Health Risk and Psychosocial Assessment be addressed in the care plan (or a note documented on assessment as to why a goal was not created), that all EIs enrolled in Family Planning care coordination receive education about STD prevention, and that the Psychosocial Health Risk Assessment takes place within 5 days from the date of the screening. o September 13th, 2022- additional documentation training was provided which included the requirement that rationales for interventions are included within the care plan; that care plans have an evaluation of effectiveness, that all medical conditions in the Health Risk and Psychosocial Assessment be addressed in the care plan (or a note documented on assessment as to why a goal was not created) o Individual education has also been provided as issues were identified from individual audit reviews o Additional documentation training will continue throughout 2023 as needed o Mid-State also hired a Quality Assurance trainer in 2022 to help with the auditing and training process • When and how will this be accomplished? o Additional documentation training will continue throughout 2023 as needed in both group and one on one settings • What are the expected outcomes or goals of the actions to be taken? o That documentation will continue to improve, and all care plan elements will be in compliance on Medicaid quarterly audits • What is the ACHN's process for monitoring the actions to determine their effectiveness? o Mid-State will continue to perform monthly audits for all licensed staff	Partially addressed

Recommendation for ACN Mid-State	ACN Mid-State Response/Actions Taken	IPRO Assessment of Entity Response[1]
Ensure contract language is included in all applicable policies and procedures.	• What has the ACHN done or planned to do to address the recommendation? o Updated Mid-State policies to include contract language in Spring and Fall 2022 • When and how will this be accomplished? o Applicable policies have been updated and approved, however, Mid-State will submit policy updates more timely in 2023. • What are the expected outcomes or goals of the actions to be taken? o Policies will be approved by Medicaid based on the addition of updated contract language • What is the ACHN's process for monitoring the actions to determine their effectiveness? o Mid-State will continue completing policy reviews yearly	Addressed
Performance measures		
Review and trend performance for Antidepressant Medication Management, Initiation and Engagement of Treatment for AOD, Well-Child Visits in the First 15 Months of Life, Cervical Cancer Screening, Adult BMI Assessment, 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.	• What has the ACHN done or planned to do to address the recommendation? ○ Mid-State developed a comprehensive quality measure spreadsheet in 2022. This spreadsheet was developed using Medicaid claims files received monthly. The spreadsheet was a big undertaking, but now that it is available, Mid-State plans to implement follow-up to high priority EIs during 2023. EIs will be considered high priority when they have multiple quality measures that are out of date. This list will be worked throughout the year and updated quarterly with claims data from the previous 3 months. • When and how will this be accomplished? ○ Outreach will occur throughout 2023 to address high priority patients • What are the expected outcomes or goals of the actions to be taken? ○ Expected outcome is that quality measure improvements will be made across the board in order to have a larger impact for the entire Medicaid population. • What is the ACHN's process for monitoring the actions to determine their effectiveness? ○ Mid-State will monitor the list quarterly to determine improvements in the number of EIs that have each quality measure addressed.	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; LBW: low birth weight; EI: eligible individual; ACHN: Alabama Coordinated Health Network; HTN: hypertension; HIMS: Health Information Management System; EI: eligible individual; ACNM: Alabama Care Network Mid-State; BMI: body mass index; SUD: substance use disorder; MAT: medication-assisted treatment; UAB: University of Alabama Birmingham; STD: sexually-transmitted disease; AOD: alcohol and other drug; QI: quality improvement.

ACN Southeast Response to Previous EQR Recommendations

Table 27 displays ACN Southeast's progress related to the *RY 2022 Annual External Quality Review Technical Report,* as well as IPRO's assessment of ACN Southeast's response.

Table 27: 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		
Evaluate the LBW measure at the member level to understand factors that might be influencing this rate to increase over time. ACN Southeast could perform a pareto analysis or stratify those who delivered a low birthweight baby by demographic factors to evaluate whether there are susceptible subpopulations that could benefit from being targeted with tailored interventions.	ACNS has used multiple data collection methods to determine which patient populations are at the greatest risk of LBW. We are aware of demographics that do show differences in our recipients with LBW (such as race, obesity, and place of residence) as well as those that have not shown strong correlations with LBW (such as preeclampsia and smoking). Our difficulties are more focused on how to reach and impact the populations that are most at risk for LBW. In Spring of 2023 ACNS will begin a pilot intervention where ACNS staff call every eligible enrolled maternity recipient in Bullock County monthly. This is the Southeast County with the highest levels of LBW and infant mortality. We are doing this to try to identify any possible barriers to care.	Addressed
Work with EIs and providers to help bolster access to well-child visits. By working with the EIs, the entities could both evaluate barriers and provide education regarding the importance of these visits, and that they are fully covered by Medicaid.	ACNS has implemented multiple interventions to improve EPSDT/Well Child visit rates. Starting in April of 2022, ACNS began a Newborn Contact Program where Care Coordinators attempt to enroll all newborns and follow them for 6 months. This project has led to noticeable improvement in well child visits within the first 15 months of life. In December of 2022, ACNS began a pilot program with our largest pediatric provider to have Community Health Workers contact recipients to ensure they schedule and attend EPSDT/Well Child visits.	Addressed
Continue to evaluate their interventions aimed at children with a BMI over the 85th percentile to determine if they are progressing at an acceptable rate to influence BMI, and/or if further barriers analysis/root cause analysis should be conducted to understand if current interventions remain most appropriate.	ACNS has modified and replaced multiple interventions for childhood obesity in our 2023 QIP proposals. ACNS still believes focusing on prevention and expanding healthy BMI is more effective than trying to reach only those above the 85th percentile for BMI.	Partially addressed
Ensure tables reflect rates that coincide with numerator and denominator components.	ACNS has made an effort to check and recheck rates on our QIP intervention tables.	Addressed

Recommendation for ACN Southeast	ACN Southeast Response/Actions Taken	IPRO Assessment of Entity Response[1]
Compliance review		
Ensure that rationales for interventions are included within the care plan; that all medical conditions identified in the Psychosocial Health Risk Assessment are addressed in the care plan; that all EIs enrolled in family planning receive information/education about STD prevention; that contact frequency requirements are met (based on EI risk level); and that a PHQ screening and substance use screening are completed.	ACNS has altered its HIMS system to add a mandatory field specifically for rationales and evaluations. ACNS agrees that medical conditions should be addressed in the care plan and if they are not then the reasons for refusal must be documented in the EHR. ACNS has modified our internal audit forms to ensure we are identifying all medical conditions. STD prevention is part of ACNS's updated assessment form for Family Planning and will be addressed at each encounter. ACNS's internal audits evaluate contact frequency requirements as well as PHQ and substance abuse screening. ACNS receives a monthly report on outstanding PHQ or substance use screenings.	Addressed
Ensure contract language is included in all applicable policies and procedures.	ACNS agrees that policies and procedures relevant to contracts should have appropriate contract language and has updated policies and procedures to do so.	Addressed
Performance measures		
Review and trend performance for Antidepressant Medication Management, Initiation and Engagement of Treatment for AOD, Cervical Cancer Screening, Adult BMI Assessment, 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. o For antidepressant medication management we continue to have the ACNS pharmacists reach out to eligible recipients every month. o For substance use ACNS has determined men 50 years and older being much more likely to have an AOD SUD diagnosis. o For all of our quality measures including Cervical Cancer Screening, Adult BMI Assessment, and Child Access to Care ACNS has added quality indicators on our internal audit tool to address compliance with quality measures. o o Child Access to Care numbers are reviewed monthly during the ACNS Quality Committee meetings.	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; ACNS: Alabama Care Network Southeast; EQR: external quality review; LBW: low birth weight; EI: eligible individual; EPSDT: Early and Periodic Screening, Diagnostic and Treatment; BMI: body mass index; QIP: quality improvement project; STD: sexually-transmitted disease; HIMS: Health Information Management System; PHQ: Patient Health Questionnaire; EHR: electronic health record; AOD: alcohol and other drug; SUD: substance use disorder; QI: quality improvement.

Gulf Coast Total Care Response to Previous EQR Recommendations

Table 28 displays GCTC's progress related to the *RY 2022 Annual External Quality Review Technical Report*, as well as IPRO's assessment of GCTC's response.

Table 28: GCTC Response to Previous EQR Recommendations

Recommendation for GCTC	GCTC Response/Actions Taken	IPRO Assessment of Entity Response[1]
Quality improvement projects		
Evaluate the LBW measure at the member level to understand factors that might be influencing this rate to increase over time. GCTC could perform a pareto analysis or stratify those who delivered a low birthweight baby by demographic factors to evaluate whether there are susceptible subpopulations that could benefit from being targeted with tailored interventions.	GCTC will analyze low birth weight data and stratify based on mother's age, zip code, county, gravida, race, birth spacing, morbidities (hypertension, obesity, diabetes, previous preterm delivery, smoking). GCTC will utilize this data to target susceptible subpopulations for tailored interventions.	Partially addressed
Work with EIs and providers to help bolster access to well child visits. By working with the EIs, the entities could both evaluate barriers and provide education regarding the importance of theses visits, and that they are fully covered by Medicaid.	GCTC will target newborns for care coordination services at the time of delivery with the goal of increasing access to well child visits (WC-15) through education of caregiver and assistance with addressing identified barriers. GCTC will work with providers to identify EIs in need of well child visit and offer assistance with contacting EIs regarding well child appointments. GCTC developed PSAs and saturated local radio market in order to promote well child visits. GCTC will monitor well child quality measure data to evaluate effectiveness of interventions.	Addressed
Explore how to effectively identify EIs early in pregnancy, and work with this population to overcome barriers associated with receipt of prenatal care in the first trimester.	GCTC has reached out to local community resources that provide early pregnancy testing in order to strengthen relationship and referral process. GCTC developed PSAs and saturated local radio market in order to promote contacting ACHN for enrollment and establishing early prenatal care.	Addressed
Ensure all barriers, interventions, and ITMs are in alignment and that the timeframes for interventions are stated and consistent with GCTC's activities.	GCTC will reevaluate to ensure that barriers, interventions, and ITMs are in alignment, and that timeframes for interventions are stated and consistent with GCTC's activities.	Addressed

Recommendation for GCTC	GCTC Response/Actions Taken	IPRO Assessment of Entity Response[1]
Compliance review		
Ensure that consent is obtained prior to provision of family planning care coordination activities; that all medical conditions identified in the Psychosocial Health Risk Assessment are addressed in the care plan; that all care plans include a rationale for each intervention; that all care plans have an evaluation of effectiveness; that all outreach attempts to EI are documented within the care plan; that all EIs enrolled in family planning receive information about STD prevention, and that male EIs receive information regarding testicular self-exams; that several outreach attempts take place to follow-up with EIs, and that all outreach is documented in the care plan/task notes; that the care plan is reviewed and evaluated with the EI during each encounter; that 3 attempts to conduct the Health Risk and Psychosocial Assessment are carried out (one of which must be a written letter); that all care plans are updated in response to a change in EI condition (health status, needs, caregiver status, health care event, etc.); and that the MCT meeting take place during calendar months 7-12 and every 6 months thereafter for high-risk EIs.	GCTC will provide staff training regarding compliance and will monitor through monthly audits. Training will be provided as often as needed based on identified audit discrepancies.	Addressed
Ensure CMC training takes place as required per the ACHN contract.	CMC training will be provided to staff during onboarding process and annually.	Addressed
Ensure contract language is included in all applicable policies and procedures.	GCTC will review policies and procedures annually to ensure compliance with contract.	Addressed

Recommendation for GCTC	GCTC Response/Actions Taken	IPRO Assessment of Entity Response[1]
Continue working with providers to bolster MMM attendance.	• GCTC will continue dialogue with providers in order to bolster MMM attendance and will initiate termination of ACHN contract for those who do not comply. Specifically, GCTC will: ○ Advertise MMM on GCTC's website at least one month in advance of the meeting to include date/time, topic, and registration information. ○ Send providers weekly emails announcing the MMM. ○ Remind providers of their contractual obligation to attend MMM. ○ Award one Continuing Medical Education (CME) unit for MMM attendance. ○ Notify providers that the recorded MMM is available on GCTC's website, following the completion of all MMM for that quarter. ○ Perform outreach to providers that fail to participate in MMM, to assess barriers to participation. ○ Facilitate additional MMM as needed, to accommodate providers that are unable to attend scheduled meetings. ○ Review the provider survey results, that AMA conducted regarding barriers to MMM attendance, and make appropriate changes if indicated.	Partially addressed
Performance measures		
Review and trend performance for Antidepressant Medication Management, Initiation and Engagement of Treatment for AOD, Well-Child Visits in the First 15 Months of Life, Timeliness of Prenatal Care, Cervical Cancer Screening, Adult BMI Assessment, 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.	GCTC will review 2022 performance measure data and will stratify based on age, race, gender, ZIP code, county, PCP visit completed in previous 12 months. The following measures are targeted through quality improvement projects: Initiation and Engagement of Treatment for AOD, Child Access to Care, Timeliness of Prenatal Care. GCTC will revise staff expectations and monthly internal quality audit tool to ensure that specific quality measures are included in care plan when applicable for EI.	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.

GCTC: Gulf Coast Total Care; EQR: external quality review; LBW: low birth weight; EI: eligible individual; PSA: public service announcement; ACHN: Alabama Coordinated Health Network; ITM: intervention tracking measure; STD: sexually-transmitted disease; AMA: Alabama Medicaid Agency; BMI: body mass index; ZIP: Zone Improvement Plan. PCP: primary care provider; MCT: multidisciplinary care team; MMM: medical management meeting; quality improvement; CMC: children with medical complexities.

My Care Alabama Central Response to Previous EQR Recommendations

Table 29 displays MCA-C's progress related to the *RY 2022 Annual External Quality Review Technical Report*, as well as IPRO's assessment of MCA-C's response.

Table 29: 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		

Target rates should be stated and reviewed across indicators, as adjustments may be warranted given that interim rates have exceeded these targets.	• What has the ACHN done or planned to do to address the recommendation?
	  ○ MCAC has reworked and updated the new QIP proposals with revised target rates for continuing projects for 2023. Target rates will continually be monitored and adjusted as appropriate.
	• When and how will this be accomplished?
	  ○ MCAC will regularly analyze data on no less than a quarterly basis and compare the target rates and ITMs. Templates will be updated and reported quarterly. Rates that were met and exceeded were not continued in the new project proposals. An emphasis will be put on ensuring the data is collected and reporting as the projects progress.
	• What are the expected outcomes or goals of the actions to be taken?
	  ○ The expected outcomes are to improve the rates toward the target rate, then to reevaluate the target rates and adjust accordingly.
	• What is the ACHN's process for monitoring the actions to determine their effectiveness?
	  ○ MCAC utilizes a lean Six Sigma approach for quality improvement. We will consistently analyze data for effectiveness and modify our approach as needed.
		Addressed

Ensure that ITM data are collected and reported quarterly, to inform intervention progress.	• What has the ACHN done or planned to do to address the recommendation?
	  ○ MCAC collects data for ITMs on an ongoing basis to ensure it is prepared for the quarterly reporting and for decision making in effectiveness.
	• When and how will this be accomplished?
	  ○ By utilizing claims data as well as QIP data which is tracked by the staff implementing these projects. Templates will be updated and reported quarterly. Rates that were met and exceeded were not continued in the new project proposals. An emphasis will be put on ensuring the data is collected and reporting as the projects progress.
	• What are the expected outcomes or goals of the actions to be taken?
	  ○ Accurate and timely reporting and adjustment to the interventions as needed based off of data informed decisions.
	• What is the ACHN's process for monitoring the actions to determine their effectiveness?
	  ○ MCAC utilizes a lean Six Sigma approach for quality improvement. We will consistently analyze data for effectiveness and modify our approach as needed.
		Partially addressed

Recommendation for MCA-C	MCA-C Response/Actions Taken	IPRO Assessment of Entity Response[1]

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?
	  ○ MCAC has been able to expand both the Childhood Obesity (CHO) and Adverse Birth Outcomes (ABO) QIPs. The CHO was expanded to more counties and the ABO was expanded to more schools.
	• When and how will this be accomplished?
	  ○ MCAC will continue to look at barrier analysis to see where these interventions are needed and expand accordingly. Expansion will depend on need as well as bandwidth.
	• What are the expected outcomes or goals of the actions to be taken?
	  ○ We will work towards the expansion related to portions of each project that touches and impacts more EIs. We will look at increasing or meeting our target rate as well.
	• What is the ACHN's process for monitoring the actions to determine their effectiveness?
	  ○ MCAC utilizes a lean Six Sigma approach for quality improvement. We will consistently analyze data for effectiveness and modify our approach as needed.
		Addressed

Compliance review		

Ensure that all care plans contain the 5 required components (assessment/identified needs, goals, interventions, rationales, and evaluation); that a standardized depression screening and substance use screening take place and are recorded in the EI's file; and that maternity EIs have follow-up encounters in the second and third trimesters and that these encounters/outreach efforts are documented in the EI's file.	• What has the ACHN done or planned to do to address the recommendation?
	  ○ MCAC has been and is currently working diligently on ensuring all the components of the care plan are documented completely and accurately. We have designated a nurse to focus on the quality of our charts by conducting ongoing chart audits and monitoring of these issues. Ongoing education is conducted at least monthly on all components of the care plan, including good and bad examples. MCAC recently had a HIMS system upgrade to allow better documentation of evaluations.
	• When and how will this be accomplished?
	  ○ In addition to the above, The Care Coordination Supervisors and our designated Nurse conducts monthly audits on all care coordinators looking for complete care plans as well as ensuring those follow up visits are conducted.
	• What are the expected outcomes or goals of the actions to be taken?
	  ○ MCAC expects more complete and accurate charts and all patients receiving all follow up as appropriate.
	• What is the ACHN's process for monitoring the actions to determine their effectiveness?
	  ○ Ongoing chart audits from the care coordinator, the supervisor, and our designated nurse with education on found items. Tracking common mistakes for training opportunities.
		Partially addressed

Recommendation for MCA-C	MCA-C Response/Actions Taken	IPRO Assessment of Entity Response[1]

Ensure contract language is included in all applicable policies and procedures.	• What has the ACHN done or planned to do to address the recommendation?
	  ○ MCAC and the Project Management Office continually reviews and policies and procedures for compliance with contract language. This process will continue.
	• When and how will this be accomplished?
	  ○ By comparing the current contract to our policies and procedures
	• What are the expected outcomes or goals of the actions to be taken?
	  ○ Updated the policies and procedures to ensure all are compliant with the contract language.
	• What is the ACHN's process for monitoring the actions to determine their effectiveness?
	  ○ MCAC and the Project Management Office continually reviews and policies and procedures for compliance with contract language.
		Addressed

Continue working with providers to bolster MMM attendance.	• What has the ACHN done or planned to do to address the recommendation?
	  ○ MCAC has improved the rates of provider participation by xx% since 2021 and we intend on continuing improvement.
	• When and how will this be accomplished?
	  ○ MCA-C will continue to work with providers to encourage participation in the Medical Management Meetings and understand barriers that prevent them from meeting the attendance requirements. Including one on one conversations with providers regarding participation and/or survey to access barriers. Once barriers are identified, we will work with the providers to address their barriers. MCA-C has implemented the MMM Recording process to allow a provider to make up a missed meeting. Lastly, MCAC will terminate contracts on those not compliant with the requirements. This process will be utilized to help improve the rates of participation.
	• What are the expected outcomes or goals of the actions to be taken?
	  ○ MCAC expects the percentage of provider participation to increase over the year.
	• What is the ACHN's process for monitoring the actions to determine their effectiveness?
	  ○ Continuous monitoring of Medical Management Meeting attendance as well as monitoring of referrals and MCT participation.
		Partially addressed

Recommendation for MCA-C	MCA-C Response/Actions Taken	IPRO Assessment of Entity Response[1]
Performance measures		

Review and trend performance for Antidepressant Medication Management, Initiation and Engagement of Treatment for AOD, Well-Child Visits in the First 15 Months of Life, Timeliness of Prenatal Care, Cervical Cancer Screening, Adult BMI Assessment, 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.	• What has the ACHN done or planned to do to address the recommendation?
	  ○ MCAC utilizes claims data to identity those EIs who are not meeting the quality measures. A barrier analysis is performed, and interventions are developed to try to help the EI obtain the service to meet the measure if applicable and obtainable. MCAC also work with providers and community partners with their patients who are not meeting the measures. MCAC staff reach out to these recipients to education them on the importance of obtaining these services. MCAC also is developing innovate interventions to help impact these rates.
	• When and how will this be accomplished?
	  ○ Target list and barrier analysis is conducted on an ongoing basis. Targeting recipients for closing gaps occurs daily. The use of targeted data from AMA claims to reach out to EIs that did not meet these required measures; using care coordinators in embedded offices to support the EIs that need to be seen by the provider using the provider quality measure summary list. The demographics of our members show 61% Black and 4% Hispanic/Latino that reflect our quality measures.
	• What are the expected outcomes or goals of the actions to be taken?
	  ○ MCAC expects improvement on all quality measures as well as an increase in appropriate utilization.
	• What is the ACHN's process for monitoring the actions to determine their effectiveness?
	  ○ Ongoing monitoring of the quality measure rates as well as analysis of MCAC's QIPs will be used to determine efficacy.
		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-C (or MCAC): My Care Alabama Central; EQR: external quality review; QIP: quality improvement project; ITM: intervention tracking measure; PCP: primary care provider; EI: eligible individual; ACHN: Alabama Coordinated Health Network; MCT: multidisciplinary care team; AOD: alcohol and other drug; BMI: body mass index; AMA: Alabama Medicaid Agency; MMM: medical management meeting; QI: quality improvement.

My Care Alabama East Response to Previous EQR Recommendations

Table 30 displays MCA-E's progress related to the *RY 2022 Annual External Quality Review Technical Report*, as well as IPRO's assessment of MCA-E's response.

Table 30: MCA-E Response to Previous EQR Recommendations

Recommendation for MCA-E	MCA-C Response/Actions Taken	IPRO Assessment of Entity Response[1]
Quality improvement projects		

Evaluate access among women seeking postpartum care to ensure there is an adequate volume of providers. Upon ruling out access issues, explore barriers faced by women in the postpartum period and work with this population to overcome these barriers to bolster visit attendance 21–56 days following delivery.	• What has the ACHN done or planned to do to address the recommendation?
	  ○ MCAE has identified a barrier for access to providers in the region. We have also identified other barriers outside of access issues that are out of our ability to improve are: lack of transportation resources, travel distance to provider, unable to take off work, and recipients who stay with family members out of the region/out of state after delivery. MCAE will continue to educate on the importance of attending the postpartum visit 21-56 days after delivery. MCAE will also continue to incentivize attendance to the postpartum visits.
	• When and how will this be accomplished?
	  ○ MCAE will continue to provide education on attending postpartum visits during their pregnancy, and at the delivery encounter. We will also have care coordinators attempting outreach before and during the 21-56-day time period to discuss their postpartum visit, and family planning needs. MCAE will continue to educate on available transportation resources, and incentivizing visits to postpartum appointments.
	• What are the expected outcomes or goals of the actions to be taken?
	  ○ MCAE expects to improve attendance of postpartum visits 21-56 days after delivery.
	• What is the ACHN's process for monitoring the actions to determine their effectiveness?
	  ○ Monitoring the rate of attendance of postpartum attendance
		Partially addressed

Continue targeting children with a diagnosis of overweight or obese and further explore barriers preventing them (and their caregivers) from accessing care, healthy foods, exercise equipment/space, etc.	• What has the ACHN done or planned to do to address the recommendation?
	  ○ MCAE will continue working on quality projects to put in place that will identify barriers and to target children who are overweight or obese. MCAE identifies potential socioeconomic barriers as: food deserts/swamps, school district, if their neighborhood/house has a safe location for outdoor activities, and the rising cost of healthy foods.
	• When and how will this be accomplished?
	  ○ MCAE will continue to target children with a diagnosis of overweight and obese children to further explore their barriers.
	• What are the expected outcomes or goals of the actions to be taken?
	  ○ MCAE will have success in removing barriers for children/families on access to care regarding dietary needs/education/resources.
	• What is the ACHN's process for monitoring the actions to determine their effectiveness?
		Partially addressed

Recommendation for MCA-E	MCA-C Response/Actions Taken	IPRO Assessment of Entity Response[1]
	○ MCAE will monitor the effectiveness by evaluating where the child/family is at the beginning of services and where they are when they finish services with MCAE.	
Compliance review		
Ensure that all EIs have a care plan on file; that all care plans contain the 5 required components (assessment/identified needs, goals, interventions, rationales, and evaluation); that a standardized depression screening takes place and is recorded in the EI's file; that follow-up telephone calls and encounters take place as required per the contact schedule and are documented in the EI's file; that EIs' physical and mental health concerns are addressed through formal interventions and/or referrals; and that MCT invitations are sent to high-risk EIs, and documented in the file.	• What has the ACHN done or planned to do to address the recommendation? ○ MCAE has provided multiple trainings and will continue to provide trainings to the care coordinators. We will continue to complete internal chart audits/caseload reviews to ensure that all required elements are being met, and that they are documented accurately. MCAE recently had a HIMS system upgrade to allow better documentation of the care plans. • When and how will this be accomplished? ○ This is an ongoing process that MCAE will continue to follow regarding trainings and chart audits. We provide re-fresher trainings as needed, and when there are updates from Alabama Medicaid Agency. Chart audits/care load reviews are completed monthly, and on an as needed basis. • What are the expected outcomes or goals of the actions to be taken? ○ MCAE expects to see continuous improvement on care plan documentation. • What is the ACHN's process for monitoring the actions to determine their effectiveness? ○ MCAE will monitor the effectiveness by the outcomes of our monthly audits, caseload reviews, and the Alabama Medicaid Agency audits.	Addressed
Ensure contract language is included in all applicable policies and procedures.	• What has the ACHN done or planned to do to address the recommendation? ○ MCAE and the Project Management office have and will continue to review policies and procedures for compliance with contract language. • When and how will this be accomplished? ○ MCAE and Project Management Office will continually review and update policies and procedures to include contract language. • What are the expected outcomes or goals of the actions to be taken? ○ MCAE policy and procedures to include contract language. • What is the ACHN's process for monitoring the actions to determine their effectiveness? ○ MCAE will monitor the effectiveness by correcting and updating findings.	Addressed
Continue working with providers to bolster MMM attendance.	• What has the ACHN done or planned to do to address the recommendation? ○ MCAE Executive director and Quality Care Manager provide meeting schedules, provide one (1) make up option with recording, and timely reminders. We will continue to educate on MMM in our outreach. We are also completing outreach to the providers to identify any barriers to attending the MMM's. • When and how will this be accomplished?	Partially addressed

Recommendation for MCA-E	MCA-C Response/Actions Taken	IPRO Assessment of Entity Response[1]
	○ MCAE is accomplishing this though frequent outreach via email, telephonic, and in-person outreach. • What are the expected outcomes or goals of the actions to be taken? ○ The expected outcome for MCAE is increased provider participation. • What is the ACHN's process for monitoring the actions to determine their effectiveness? ○ MCAE will monitor this by our provider rate of attendance in our medical management meetings, monitoring referrals, and MCT participation (when applicable).	
Performance measures		
Review and trend performance for Antidepressant Medication Management and Engagement in Treatment for AOD, Timeliness of Prenatal Care, Cervical Cancer Screening, and Adult BMI Assessment 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? ○ MCAE receives a target list from our pharmacy director to follow up with recipients who may have missed antidepressant refills. We are exploring opportunities to partner with new SUD resources in the community. We are incentivizing for timeliness of prenatal care and providing education to the recipients. Family Planning, maternity, and general care coordinators are educating on Cervical Cancer Screenings and assisting with scheduling. Medical Monitoring assists with identifying adult recipients who need a PCP and yearly physical, MIA assessment and refer them for care coordination. • When and how will this be accomplished? ○ MCAE's actions are ongoing, adjusting as needed. • What are the expected outcomes or goals of the actions to be taken? ○ MCAE expected outcome is to have increased compliance with preventative measures, medication compliance, increase access to resources to improve overall wellness, decreased adverse outcomes. • What is the ACHN's process for monitoring the actions to determine their effectiveness? ○ MCAE will complete Chart audits/case reviews by care coordination supervisors, continued medical monitoring by our care coordinator, monitoring trends in proportion of SUD sufferers who enter recovery sooner by quality care manager, tracking causes and occurrences of adverse outcomes and adjusting interventions to minimize causes.	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; MCE: managed care entity; EI: eligible individual; MMM: medical management meeting; PCP: primary care provider; ACHN: Alabama Coordinated Health Network: MCT: multidisciplinary care team; AOD: alcohol and other drug; BMI: body mass index; SUD: substance use disorder; QI: quality improvement.

My Care Alabama Northwest Response to Previous EQR Recommendations

Table 31 displays MCA-NW's progress related to the *RY 2022 Annual External Quality Review Technical Report*, as well as IPRO's assessment of MCA-NW's response.

Table 31: MCA-NW Response to Previous EQR Recommendations

Recommendation for MCA-NW	MCA-NW Response/Actions Taken	IPRO Assessment of Entity's Response[1]
Quality improvement projects		
Evaluate access among women seeking prenatal care, as well as barriers to receiving this care, in addition to best practices and barriers associated with early identification.	• What has the ACHN done or planned to do to address the recommendation? ○ During the 2022 year My Care Alabama Northwest (MCANW) completed bi-annual outreach to all the DHCPs in the region to assess access to care and appointment scheduling. MCANW provided education on referrals to the ACHN program, application assistance, and education on our care coordination services. ○ MCANW has developed a referral process with each of the DHCPs offices to ensure an EI referral is sent to the ACHN, if the EI is not already enrolled into care coordination services prior to the new obstetrician visit. MCANW competes meetings with each DHCP to discuss barriers to services and possible ways to eliminate those barriers. ○ Refer at risk and high risk EIs to Regional Nurse Family Partnership programs. ○ Partner with Quit Genius to decrease nicotine use during pregnancy, incentivize EIs for participation. ○ Partner with She Recovers for MAT services in Walker County, incentivize EIs for participation. ○ Barriers to care include late entry into OB care, extended waiting periods for new OB appointments, difficulties with applying to Medicaid, lack of DHCP providers in rural areas, the prevalence of substance use in the population, and travel into urban areas to receive care. • When and how will this be accomplished? ○ MCANW hosted bi-annual meetings with the DHCPs for continuous education and updates. ○ Care Coordinators are embedded into DHCP offices since Oct 1, 2023, to enroll EIs timely in services. ○ MCANW Marketing materials are distributed routinely to all Providers, Health Departments, Free Clinics and Pregnancy Testing Centers • What are the expected outcomes or goals of the actions to be taken? ○ The expected outcome is to increase early access to prenatal care and provide care coordination services on or before the first OB appointment. ○ Decrease poor birth outcomes. ○ Improve prenatal and postpartum rates. ○ Improve utilization of substance use disorder treatment	Partially addressed

Recommendation for MCA-NW	MCA-NW Response/Actions Taken	IPRO Assessment of Entity's Response[1]
	• What is the ACHN's process for monitoring the actions to determine their effectiveness? ○ Monitoring of prenatal and postpartum rates ○ Ongoing discussions with DHCPs	
Ensure the method of barrier identification corresponds with the barrier that is cited.	• What has the ACHN done or planned to do to address the recommendation? ○ MCANW defines methods to identify Regional barriers and will report appropriately. • When and how will this be accomplished? ○ Analysis is ongoing and reported quarterly in each QIP template. • What are the expected outcomes or goals of the actions to be taken? ○ To ensure that the barriers are clearly defined and cited. • What is the ACHN's process for monitoring the actions to determine their effectiveness? ○ Ongoing monitoring to ensure identification methods to the barrier is corresponding.	Partially addressed
Ensure comprehensive ITM data are collected and reported quarterly to inform intervention progress.	• What has the ACHN done or planned to do to address the recommendation? ○ MCANW receives data from partnerships and tracks the progress of the interventions to determine what activities are progressing and leading to improvements. • When and how will this be accomplished? ○ Using Six Sigma approach to quality improvement ○ Quarterly, updated on each QIP template. ○ MCANW will ensure the data is collected and reporting as the projects progress. • What are the expected outcomes or goals of the actions to be taken? ○ Accurate tracking and reporting of ITM data and making adjustments as needed. • What is the ACHN's process for monitoring the actions to determine their effectiveness? ○ Monitoring the ITMs for effectiveness and modify accordingly.	Addressed
Consistently number all barriers, interventions, and ITMs and ensure ITMs are calculated appropriately.	• What has the ACHN done or planned to do to address the recommendation? ○ MCANW will continue to update each QIP template to include the barriers, interventions, and ITM tables to ensure that they are numbered correctly and appropriately calculated. • When and how will this be accomplished? ○ Updated quarterly on each QIP template. • What are the expected outcomes or goals of the actions to be taken? ○ Accurate reporting of barriers, interventions, and ITM calculations • What is the ACHN's process for monitoring the actions to determine their effectiveness? ○ To review the QIP templates to ensure that the barriers, interventions, and ITM tables are numbered and calculated correctly.	Addressed

Recommendation for MCA-NW	MCA-NW Response/Actions Taken	IPRO Assessment of Entity's Response[1]
Compliance review		
Ensure that all EIs have a care plan on file; that all care plans contain the 5 required components (assessment/identified needs, goals, interventions, rationales, and evaluation); that follow-up telephone calls and encounters take place as required per the contact schedule and are documented in the EI's file; that medication reconciliation take place as required; that care plans are updated based on a change in the EI's needs at least once every 90 days; and that MCT meetings are conducted in the required 60-day time period for high-risk EIs.	• What has the ACHN done or planned to do to address the recommendation? ○ MCANW has curated a plan to ensure that care plan components can be identified in all care plans. With the latest HIMS upgrade, follow up task notes now include an evaluation portion to ensure evaluations are completed with every follow up. Interventions also have a dedicated space for rationales, to ensure rationales are discussed for every goal/intervention. MCANW will also conduct monthly audits and provide continuing staff education on the care plan components, MCTs, and timelines. • When and how will this be accomplished? ○ MCNW Quality Nurse conducts weekly spot checks to ensure components of the care plan are addressed. High Risk charts are monitored for MCT completion within 60 days of enrollment. The Pharmacy Director ensures the Medication Reconciliation process is in compliance. Supervisors complete formal monthly audits to ensure Agency elements are being met. • What are the expected outcomes or goals of the actions to be taken? ○ After the Quality Nurse/CC Supervisor complete audits the care coordinator is notified of any compliance gaps. Feedback includes recommendations, corrections needed, and any other quality concerns. The goal of the audit is to ensure that all charts remain in compliance, contain all required components, thus ensuring care coordinators are completing encounters per contract requirements. MCTs are completed and the Medication Reconciliation process is fulfilled. • What is the ACHN's process for monitoring the actions to determine their effectiveness? ○ After feedback is provided to the care coordinator via email the care coordinator will then have 72 hours to make any corrections needed and identify any areas of the care plan that have noted gaps. If no response is provided from the care coordinator, the supervisor will follow up with the care coordinator to ensure the email has been read and addressed. If ongoing concerns are noted, the supervisor will provide education and supervision to ensure charts will remain in compliance.	Partially addressed

Recommendation for MCA-NW	MCA-NW Response/Actions Taken	IPRO Assessment of Entity's Response[1]

Ensure contract language is included in all applicable policies and procedures.	• What has the ACHN done or planned to do to address the recommendation?
	  ○ MCANW and the AlaHealth Project Management Office (PMO) review Policy and Procedures to align with contract requirements.
	• When and how will this be accomplished?
	  ○ MCANW and the PMO office will continually review and update policies and procedures to include contract language.
	• What are the expected outcomes or goals of the actions to be taken?
	  ○ MCANW policy and procedures to include contract language.
	• What is the ACHN's process for monitoring the actions to determine their effectiveness?
	  ○ MCANW will monitor the effectiveness by any findings independently, and feedback received from systems performance reviews.
		Addressed

Continue working with providers to bolster MMM attendance.	• What has the ACHN done or planned to do to address the recommendation?
	  ○ MMMs are hosted twice per quarter and a recording for a one time catch-up are offered to Providers.
	• When and how will this be accomplished?
	  ○ MMM outreach is conducted quarterly to promote attendance.
	• What are the expected outcomes or goals of the actions to be taken?
	  ○ Provider attendance to the MMMs will meet the required terms in their ACHN agreement.
	• What is the ACHN's process for monitoring the actions to determine their effectiveness?
	  ○ MMM participation is monitored after each meeting and a one-time recording is offered via email invite to those that missed the meeting.
		Partially addressed

Performance measures		

Review and trend performance for Antidepressant Medication Management, Engagement in Treatment for AOD, Well-Child Visits in the First 15 Months of Life, Timeliness of Prenatal Care, Cervical Cancer Screening, Adult BMI Assessment, 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.	• What has the ACHN done or planned to do to address the recommendation?
	  ○ MCANW will use data from AMA claims to target EIs that are not meeting measures. We also perform yearly analysis to project the number of EIs needed to meet certain measurements. The Quality Manager, Quality Nurse, and Community Health Workers will screen and assign cases to care coordinators based on the EIs County of residence and/or their attributed Provider. They will attempt enrollment and manage the EI to address measures. MCANW develops interventions to help impact these rates.
	• When and how will this be accomplished?
	  ○ Utilize the care coordinators embedded in offices and the field to the target specific EIs not meeting measurements. We screen EIs on a continuous cycle and assign based on the care coordinators case load capacity.
	  ○ We also receive Provider referrals to address gaps in care and needed resources.
	  ○ We solicit feedback from Providers that attend our MMMs.
	• What are the expected outcomes or goals of the actions to be taken?
		Partially addressed

Recommendation for MCA-NW	MCA-NW Response/Actions Taken	IPRO Assessment of Entity's Response[1]
	○ Goal is to ensure that the EIs are educated on their conditions. ○ Increase compliance and utilization with provider services to improve quality of care. ○ MCANW expects improvement on all quality measures. ○ EIs are linked to community services. • What is the ACHN's process for monitoring the actions to determine their effectiveness? ○ Consistent monitoring of the quality rates and make changes to previous interventions, as needed.	

[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; EI: eligible individual; DHCP: delivering healthcare provider; ACHN: Alabama Coordinated Health Network; QIP: quality improvement project; ITM: intervention tracking measure; MCT: multidisciplinary care team; HIMS: Health Information Management System; CC: care coordination; MMM: medical management meeting ; AOD: alcohol and other drug; BMI: body mass index; QI: quality improvement.

North Alabama Community Care Response to Previous EQR Recommendations

Table 32 displays NACC's progress related to the *RY 2021 Annual External Quality Review Technical Report*, as well as IPRO's assessment of NACC's response.

Table 32: NACC Response to Previous EQR Recommendations

Recommendation for NACC	NACC Response/Actions Taken	IPRO Assessment of Entity's Response[1]
Quality improvement projects		
Continue to target high-risk pregnant EIs (those with a BMI of at least 30) with nutritional and healthy lifestyle counseling, exploring alternative ways of conveying the information in a way that is meaningful to EIs.	NACC has one full-time and one part-time Registered Dietitians on staff to counsel EIs on nutritional and healthy lifestyle counseling. The Registered Dietitians obtain Continuing Education Credits on best practices. Insights into alternative modes of education are discussed within the Quality Department for consideration. In 2022, NACC provided nutritional and healthy lifestyle counseling to 91.5% of EIs with a BMI greater than or equal to 30. Additionally, 92.8% of these EIs gained less than 40lbs during their pregnancy. These interventions have been successful, and we expect this trend to continue. NACC will continue to monitor the Maternity Data Fields report to ensure outcomes do not decline. Given the high success rate, we hope to see this improve, however 100% compliance is unlikely.	Partially addressed
Ensure comprehensive ITM data are collected and reported quarterly to inform intervention progress.	ITM data is collected and reported quarterly. This data is evaluated for increasing, stagnating, or declining trends. If results are found to be stagnating or declining, the intervention is then evaluated for causes relating to the trend. NACC will continue to monitor ITM data to ensure outcomes do not decline. Our current methods have been effective in identifying interventions needing an evaluation and we anticipate this to continue. We would like to note that due to the 90-day delay in maternity data, there is a significant lag when identifying interventions needing an evaluation and implementing changes.	Addressed
Ensure numerator and denominator components of rates (indicators, ITMs, etc.) convey the same units.	NACC plans to develop a worksheet to be used when completing QIP Reports. This information will include notes regarding matching denominators as well as other important areas to consider. Currently, column A on QIP reports contain a description of the data. However, a worksheet would be beneficial as an aid. NACC plans to implement this by the next QIP reporting period. We anticipate this will help ensure that numerator and denominator components are as accurate as possible.	Addressed

Recommendation for NACC	NACC Response/Actions Taken	IPRO Assessment of Entity's Response[1]
Compliance review		
Ensure that all needs identified in the Psychosocial Health Risk Assessment are addressed in the care plan; that all care plans include a rationale for each intervention; that all care plans have an evaluation of effectiveness; document all referrals/consultations to specialists in the care plan to ensure appropriate tracking/follow-up; that all care plans are reviewed/evaluated at each encounter with the EI; that care plans are updated based on a change in EI's needs; that maternity EIs have an encounter at the second and third trimesters; and that Psychosocial Health Risk Assessments are completed, and risk stratification scores are justified.	After the audit review, the Management Team determined that additional education and training were needed to address the insufficient documentation and substandard audit results. During the individual and group education and retraining with the care coordination staff, the Management Team worked together using the Medicaid Operational guidelines to retrain on Care Plan development, time frame requirements for Maternity encounters, and the purpose of the Psychosocial Health Risk Assessment and Risk stratification. The goal of the retraining was to address misunderstandings and review the required documentation needed to support compliance. In addition to education and retraining, changes were made to improve work processes within our HIMS. NACC streamlined workflow processes and created care plan template examples. Additionally, internal changes to the care teams were made to correct the problems. The Clinical Supervisors and Management Team conduct monthly chart audits using the Medicaid approved audit tool to monitor and track progress and intervene when individual or group trends are noted. Re-training and education are conducted annually and on an as needed basis. The next steps for continued noncompliance and substandard performance include individual retraining and disciplinary corrective action plans. With the additional efforts in training and intervention, NACC expects care coordination tasks and documentation to improve.	Partially addressed
Ensure contract language is included in all applicable policies and procedures.	All policies and procedures are written according to the contract language and are submitted annually and as needed to Alabama Medicaid Agency for approval prior to implementation. Once feedback from AMA is reviewed and corrections are made, the policy is resubmitted for approval. Policies are procedures are not implemented until a final approval from AMA is received. We will continue with this process until instructed otherwise by the Alabama Medicaid Agency.	Addressed
Ensure CMC training takes place as required per the ACHN contract.	Upon hire and annually, the Clinical Director, Medically Complex Pharmacist, CMC RN, and SW train all clinical staff that work with the CMC population in accordance with the ACHN contract. Annual training was last held on March 2nd, 2022. The HR Manager and The Clinical Supervisors Team review annual training records to track individual and group compliance. The next steps for continued noncompliance and substandard performance include individual retraining and disciplinary corrective action plans.	Addressed

Recommendation for NACC	NACC Response/Actions Taken	IPRO Assessment of Entity's Response[1]
Continue working with providers to bolster MMM attendance.	Currently, NACC sends multiple emails and faxes each quarter, and makes phone calls to providers who are not attending. NACC continues to encourage practices to provide contact information for not just the providers but for support staff as well to reiterate the message. At the conclusion of the MMMs in each quarter, letters to providers regarding their current MMM participation status are sent with cost effectiveness and quality measures scorecards. MMM information and requirements are posted on the NACC website. NACC has put a substantial effort in reaching providers and plans to add an additional method but despite the high-level of attention given to this, NACC anticipates participation to decrease should the in-person requirement resume. NACC has decided to add to our efforts by creating postcards that will be sent quarterly to providers reiterating the participation requirements and MMM dates. MMM dates and requirements will be included on newsletters as well. On February 13th, 2023, the email distribution list was audited to identify email addresses that were no longer working and added email addresses from providers who had requested continuing medical education from past MMMs. Additionally, an email was sent to encourage practices to provide additional addresses of office staff to ensure messages are received. Reviewing the email distribution list has been and will continue to be an ongoing task.	Partially addressed
Performance measures		
Review and trend performance for Antidepressant Medication Management, Engagement in Treatment for AOD, Well-Child Visits in the First 15 Months of Life, Timeliness of Prenatal Care, Cervical Cancer Screening, Adult BMI Assessment, 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.	The above-mentioned reports are reviewed quarterly for increasing, stagnating, and decreasing trends. NACC has asked our HIMS provider to add additional demographic information to the reports. NACC intends to use this information to identify demographic subgroups that are disproportionately impacted. Actions to improve in these areas are developed and implemented. We will continue these efforts but will also add the review of demographic subgroups effective immediately. The added attention to demographic subgroups is a new task and we anticipate that addressing the disparities will need to be adapted over time to create effective initiatives.	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.

NACC: North Alabama Community Care; EQR: external quality review; QIP: quality improvement project; EI: eligible individual; BMI: body mass index; ITM: intervention tracking measure; AMA: Alabama Medicaid Agency; RN: registered nurse; HR: human resources; HIMS: Health Information Management System; MMM: medical management meeting; AOD: alcohol and other drug; QI: quality improvement; CMC: children with medical complexities.

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

Table 33 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 2022 EQR activities as they relate to **quality**, **timeliness**, and **access**.

Table 33: Strengths, Opportunities for Improvement, and EQR Recommendations for All ACHN Entities

ACHN Entity	Strengths	Weaknesses	Recommendations	Standards
Quality improvement projects				
ACN Mid-State	**ABO**: The entity observed an increase in the percentage of live deliveries with low birth weight from baseline to the second interim remeasurement. Of all EIs referred to in-house monitoring, 100% were successfully enrolled. All care coordinators received education for basic nutrition for diabetes/hypertension management to better support and educate EIs. All EIs who completed a social determinants of health screening identified as having a need were connected to a community resource. The percentage of postpartum EIs engaged in family planning increased from 9.2% to 27.8%. **CO:** The percentage of annual BMI assessments completed for EIs 3–19 years of age improved significantly. **SUD:** There was progress made in the percentage of EIs referred to peer support specialist, as well as the percentage of EIs with a prescription for MAT who were enrolled in peer support.	**ABO:** While implementation of interventions (evidenced by ITM performance) seems to be progressing well, the annual performance indicator did not improve during interim period 1 and worsened during interim period 2. **CO:** Only 1 of 4 indicators demonstrated improvement from baseline (2019) to interim remeasurement 2 (2020). The percentage of EIs with an annual well visit and with a diagnosis of being overweight or obese saw a decline in performance. **SUD:** After initial improvement during measurement period 1, there was a decline in performance in the percentage of EIs with a new episode of AOD abuse or dependence who engaged in treatment during measurement period 2.	**ABO:** To demonstrate an improvement, the target rate should be adjusted so that it is lower than the baseline (a lower rate is desirable). **CO:** The numerator and denominator values associated with the measures for the baseline period are missing. The descriptions should be replaced with values. **SUD:** 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.	Quality

ACHN Entity	Strengths	Weaknesses	Recommendations	Standards
ACN Southeast	**ABO:** An improvement in the percentage of pregnant EIs with a prenatal visit in the first trimester was observed from baseline (2019) to interim remeasurement 2 (2021), as well as in the percentage of live births weighing less than 2,500 grams. The number of biomonitoring referrals and enrollment increased from 2020 to 2021. Those who completed the biomonitoring program demonstrated a longer gestational period (> 37 weeks), as well as greater birth weight (> 2,500 grams), than those who were lost to follow-up. **CO:** The entity fully met all but one of the QIP proposal validation requirements. **SUD:** The ACHN entity again observed an increase in the number of EIs who were assessed by SpectraCare in emergency departments and is continuing to spread this pilot across several counties.	**ABO:** The percentage of infants 0–15 months of age with 6 well-child visits demonstrated a decline in performance. **CO:** Declines in performance were observed in the percentage of EIs 3–6 years of age with a well-child visit, as well as the percentage of EIs aged 3–6 years with a BMI > 85th percentile. The performance of the percentage of EIs aged 3– 6 years with a BMI between 5th and 85th percentile indicator was not able to be evaluated due to lack of a baseline measure. **SUD:** There was a decline in the percentage of EIs with an SUD diagnosis who received treatment from baseline (2019) to interim remeasurement 1 (2020), as well as a further decline to interim measurement period 2 (2021). The southeast region faced access issues, given the lack of facilities that provide SUD treatment services (only 4 out of the 13 counties in southeast region have residential treatment facilities).	**ABO:** The entity should continue to focus on improving the rate of well-child visits for infants. **CO:** The entity should ensure all interventions have accurate dates stated in the report. Further, the entity should ensure all data are contemporaneous and accurate. **SUD:** The entity should ensure appropriate version control of the spreadsheet, if not already doing so.	Quality
GCTC	**ABO:** GCTC exceeded their target of 50% for their third indicator (percentage of critical-risk EIs who completed 37 weeks of gestation). GCTC will continue to focus on their biomonitoring efforts going forward.	**ABO:** Two indicators (percentage of live births weighing less than 2,500 grams and the percentage of EIs that received prenatal care in the first trimester) demonstrated a decline in performance. **CO:** There was a decline in performance in the percentage of annual BMI assessments completed for EIs 3–17 years of age, as well	**ABO:** For Indicator 3, the corresponding target rate of 50% was based off of brainstorming and should be modified accordingly 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.	Quality

ACHN Entity	Strengths	Weaknesses	Recommendations	Standards
	CO: The entity met 24 of 27 requirements for QIP validation. Three requirements not met were related to results reporting. **SUD**: Two of the 3 indicators exceeded their targets in interim measurement period 2.	as the percentage of EIs 7–11 years of age that had an annual PCP visit and the percentage of EIs 7–11 years of age with a diagnosis of being overweight. **SUD:** The three active performance indicators in place for 2021 (the percentage of EIs aged 18 years and older with a new episode of an AOD who enroll in care coordination; the percentage of EIs aged 18 years and older with an OUD and first MAT prescription filled that agreed to PEIR referral; and the percentage of eligible providers that participated/completed the OUD Educational Outreach and Survey and reported increased knowledge/understanding of OUD, prescribing guidelines, treatment options and community resources) could not be assessed due to lack of baseline data.	**CO:** The ACHN 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. **SUD:** 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.	
MCA-C	**ABO:** Improvement shown in ITMs 1a and 1b from Q2 to Q3 of CY 2021. **CO:** There was evidence of improvement in annual performance indicators. **SUD:** Improvement was observed in Indicator 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	**ABO:** Data were available to assess indicator performance only for the percentage of students enrolled in the targeted high school that completed the Making Proud Choices curriculum (78%). **CO:** The ACHN entity is no longer measuring Indicator 3 due to the lack of babies reaching 15 months of age during the measurement period. **SUD:** There were no data to evaluate progress on any of the ITMs.	**ABO:** 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. **CO:** 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.	Quality

ACHN Entity	Strengths	Weaknesses	Recommendations	Standards
	days of the diagnosis) and Indicator 2 (number of EIs who initiate treatment and had two or more additional services within 30 days of initiation visit).		**SUD:** 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.	
MCA-E	**ABO:** The percentage of women who smoke during pregnancy declined from baseline (2019) to remeasurement (2022). There was an improvement in performance for the low birth weight indicator (percentage of live births weighing less than 2,500 grams increased from baseline to remeasurement). **CO:** There was a significant improvement in the percentage of children aged 3–17 years who had an outpatient visit with a PCP/ob/gyn practitioner and had evidence of BMI documentation during the MY. **SUD:** The entity met 100% of the requirements for QIP validation.	**ABO:** After an initial improvement, there was a decrease in measurement period 2 of the percentage of EIs that had a postpartum visit 21–56 days following delivery. **CO:** There was an increase in the percentage of children with a diagnosis of being overweight or obese and thus a decline in performance. **SUD:** There was a decrease in the percentage of EIs that initiated AOD treatment from baseline (2019) to remeasurement (2021). The performance of Indicator 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) remained constant.	**ABO:** 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. **CO:** The ACHN entity should consider updating their target rate for Indicator 1 (90.0%), given the 95.6% rate achieved. **SUD:** 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.	Quality
MCA-NW	**ABO:** There was improvement demonstrated in the Timeliness of Prenatal Care indicator. **CO:** The percentage of EIs 3–17 years of age who had an outpatient visit with a PCP or an ob/gyn practitioner and who had evidence of BMI documentation during the MY saw a significant improvement.	**ABO:** There were no data available to evaluate the effectiveness of the interventions, and several miscalculations were noted in the ITM rates. **CO:** Many interventions were redesigned and initiated in 2021 resulting in a lack of baseline and interim measurement period 2 data. Also, claims data are still indicated as the method of barrier identification for Barriers 2 and 3. However, this is not likely	**ABO:** The entity should ensure all calculations and rounding are correct and consistent. **CO:** 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	Quality

ACHN Entity	Strengths	Weaknesses	Recommendations	Standards
	SUD: There was an improvement in the percentage of EIs that engaged (continued) in AOD treatment. The peer support specialists successfully provided orientation to various providers in Tuscaloosa County with the goal of continuing outreach until all providers in that county have been oriented to ROSS services, and then the focus will be Bibb County.	to have led to the identification of these barriers (lack of provider training on coding BMI correctly and lack of education on healthy eating habits). **SUD:** There were no data available to evaluate the effectiveness of the interventions, and several miscalculations were noted in the ITM rates.	success and limitations moving forward, especially since all previous interventions have been discontinued and new interventions will be active for the next year of this QIP. **SUD:** The entity should ensure all calculations and rounding are correct and consistent.	
NACC	**ABO:** Indicator 2 (percentage of pregnant EIs that failed their GTT receiving nutritional and healthy lifestyle counseling) and Indicator 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) both showed substantial improvement over baseline. **CO:** All three indicators showed improvement in interim year 2. Further, successful food box deliveries were observed throughout 2021, as well as the number of EIs returning a questionnaire associated with this program. **SUD:** The percentage of EIs receiving brief interventions (ITM 5a) remained steady in CY 2021 and Q1 of 2022.	**ABO:** Indicator 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) showed a slight decrease in performance. **CO:** The percentage of EIs with documentation of BMI in their medical record declined from baseline (2019) to interim remeasurement (2021), as did the percentage of EIs still breastfeeding upon postpartum visit. **SUD:** Performance on the indicator (percentage of EIs aged 13 years and over with a new episode of SUD receiving SUD treatment) could not be evaluated since data/rates prior to 2021 are not included in the second year report. Provider training on the referral process as well as provider incentive for completing MAT certification appeared to have a minimal impact on referrals to NACC and MAT certification, respectively, according to the ITMs. Further, an exceptionally low percentage of EIs	**ABO:** 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. **CO:** 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 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. **SUD:** 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	Quality

ACHN Entity	Strengths	Weaknesses	Recommendations	Standards
		identified with SUD contacted ROSS for support. Of those EIs that providers had referred to NACC, an increasing percentage received brief intervention throughout 2021.	"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.	
Compliance review				
ACN Mid-State	ACN Mid-State achieved full compliance in 6 of 7 domains.	One requirement with regard to Care Coordination was partially addressed by the General Care Coordination Policy. Two requirements related to Quality Management were partial.	ACN Mid-State should include the requirement in staff training and implement all parts of the contract requirement. 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.	Quality Timeliness Access
ACN Southeast	ACN Southeast achieved full compliance in 6 of 7 domains.	Of the 20 quality management requirements reviewed for ACN Southeast, 18 were full and 2 were partial. The partial determinations reflected requirements related to evaluating the effectiveness of interventions and planning/initiation of activities for increasing or sustaining improvement.	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.	Quality Timeliness Access

ACHN Entity	Strengths	Weaknesses	Recommendations	Standards
GCTC	GCTC achieved full compliance in all requirements reviewed except Quality Management, where three requirements were partial.	Of the 21 requirements reviewed for GCTC, 3 were partial. Two of the partial determinations reflected requirements related to evaluating the effectiveness of interventions and planning/initiation of activities for increasing or sustaining improvement, and the other was related to the Regional Medical Management Committee composition requirements. Opportunity for improvement: • Care coordinators should document in the task notes when letters are being mailed out to the EI.	In maternity care coordination, the entity should adhere to the encounter schedule to ensure completion of all care coordination activities. Care coordinators should follow the protocol for when an EI is unable to be reached to prevent premature case closure.	Quality Timeliness Access
MCA-C	All requirements were addressed in MCA-C's policies and procedures except Quality Management, where 20 of 21 requirements were full and 1 was partial.	Care Coordination file review demonstrated several areas of deficiency. A requirement related to attendance at medical management meetings was partial.	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. It is recommended that MCA-C continue to work with providers to encourage participation in the medical management meetings.	Quality Timeliness Access
MCA-E	MCA-E achieved full compliance in 5 of 7 domains. In the domain of Quality Management, MCA-E was in full compliance with 20 of 21 requirements. In the domain of Subcontracting, MCA-E was in full compliance with 3 of 7 requirements.	Maternity care coordination file review demonstrated several areas of deficiency. Three of 15 files did not meet all requirements. The entity did not achieve 100% attendance at medical management meetings. Four subcontracting requirements were partial due to a contract that was updated after the review period.	In maternity care coordination, the ACHN entity should ensure that the care plan accurately documents all encounters including evaluations and follow-ups. It is recommended that MCA-E continue to work with providers to encourage participation in the medical management meetings.	Quality Timeliness Access

ACHN Entity	Strengths	Weaknesses	Recommendations	Standards
MCA-NW	MCA-NW achieved full compliance in 5 of 7 domains. In the domain of Quality Management, MCA-NW was in full compliance with 19 of 22 requirements.	Care Coordination file review demonstrated several areas of deficiency: • General care coordination: 5 of 15 files reviewed received full compliance for all requirements. • Maternity care coordination: 12 of 15 files reviewed received full compliance for all requirements. Four subcontracting requirements were partial due to a contract that was updated after the review period.	With regard to care coordination, the entity should: • Adhere to the encounter schedule in order to conduct all necessary care coordination activities timely (and for maternity care coordination, as well). • 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.	Quality Timeliness Access
NACC	NACC achieved full compliance in all domains reviewed except Quality Management, where three requirements received partial determinations.	The entity received partial determinations with requirements related to 1) evaluation of the effectiveness of the interventions, 2) planning and initiation of activities for increasing or sustaining improvement, and 3) attendance at medical management meetings. In general care coordination, 13 of 15 files received full compliance, and in maternity care coordination, 10 of 15 received full compliance.	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. File review: • 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. • Maternity care coordination: Entity should consider exploring ways to automate the tracking system to facilitate follow-up reminders for care coordinators.	Quality Timeliness Access

ACHN Entity	Strengths	Weaknesses	Recommendations	Standards
Performance measures				
ACN Mid-State	Child and Adult BMI Assessment, as well as Asthma Medication Ratio (adult and child), were at or above the statewide average (SWA), which was above the 95th percentile benchmark.	The entity demonstrated a rate below the SWA for Well-Child Visits in the First 15 Months, child access to primary care, Antidepressant Medication Management, and Initiation and Engagement of Treatment for AOD	Review and trend performance for Antidepressant Medication Management, Initiation and Engagement of Treatment for AOD, Well-Child Visits in the First 15 Months of Life, 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.	Quality Timeliness Access
ACN Southeast	The entity was above the SWA for both Adult and Child BMI Assessment and Asthma Medication Ratios. The entity was also above the SWA for Cervical Cancer Screening.	ACN Southeast demonstrated a rate below the SWA for Antidepressant Medication Management, Child Access to Care and Initiation and Engagement of Treatment for AOD. The entity was above the SWA for Live Births Less Than 2,500 Grams.	Review 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.	Quality Timeliness Access
GCTC	The entity exceeded the SWA for Adult BMI Assessment, Cervical Cancer Screening, Timeliness of Prenatal Care, and Initiation and Engagement of Treatment for AOD.	GCTC demonstrated a rate below the SWA for Well-Child Visits in the First 15 Months of Life, Antidepressant Medication Management, Asthma Medication Ratio, and Child Access to Care. The entity was above the SWA for Live Births Weighing Less Than 2,500 Grams.	Review 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.	Quality Timeliness Access
MCA-C	MCA-C exceeded the SWA for Asthma Medication Ratio (Child and Adult), and for Adult and Child BMI Assessment.	MCA-C demonstrated a rate below the SWA for Well-Child Visits in the First 15 Months of Life, Antidepressant Medication Management, Initiation and Engagement in Treatment for AOD, Timeliness of Prenatal Care, and Child Access to Care (2 of 4 categories).	Review and trend performance for Antidepressant Medication Management, Initiation and Engagement of Treatment for AOD, Well-Child Visits in the First 15 Months of Life, Timeliness of Prenatal Care, and develop or modify interventions to specifically target performance for	Quality Timeliness Access

ACHN Entity	Strengths	Weaknesses	Recommendations	Standards
			these measures. Further, determine if a particular demographic subgroup is disproportionately impacted.	
MCA-E	MCA-E exceeded the SWA for Adult and Child BMI Assessment, Antidepressant Medication Management, Asthma Medication Ratio (child and adult), Child Access to Care, and Well-Child Visits in the First 15 Months of Life.	MCA-E was below the SWA for Initiation and Engagement of Treatment for AOD, and Timeliness of Prenatal Care, and Cervical Cancer Screening.	Review and trend performance for Initiation and Engagement of Treatment for AOD, and Timeliness of Prenatal Care. Further, determine if a particular demographic subgroup is disproportionately impacted.	Quality Timeliness Access
MCA-NW	The entity was above the SWA for Adult BMI Assessment, Antidepressant Medication Management, Child Access to Care, and Initiation and Engagement of Treatment for AOD.	The entity was below the SWA for Well-Child Visits in the First 15 Months of Life, Timeliness of Prenatal Care, Asthma Medication Ratio, Cervical Cancer Screening, and BMI Assessment for Children.	Review and trend performance for Well-Child Visits in the First 15 Months of Life, Timeliness of Prenatal Care, and Asthma Medication Ratio, and develop or modify interventions to specifically target performance for these measures. Further, determine if a particular demographic subgroup is disproportionately impacted.	Quality Timeliness Access
NACC	NACC demonstrated a rate above the SWA for Asthma Medication Ratio (child and adult), Antidepressant Medication Management, Child Access to Care, Initiation and Engagement of Treatment for AOD and Child BMI Assessment. The entity also performed below the SWA for Live Births Weighing Less Than 2,500 Grams.	NACC demonstrated a rate below the SWA for Timeliness of Prenatal Care, Cervical Cancer Screening and Adult BMI Assessment.	Review and trend performance for Timeliness of Prenatal Care, Cervical Cancer Screening and Adult BMI Assessment, and develop or modify interventions to specifically target performance for these measures. Further, determine if a particular demographic subgroup is disproportionately impacted.	Quality Timeliness Access

EQR: external quality review; ACHN: Alabama Coordinated Health Network; ACN: Alabama Care Network; QIP: quality improvement project; BMI: body mass index; EI: eligible individual; SUD: substance use disorder; AOD: alcohol and other drugs; ITM: intervention tracking measure; GCTC: Gulf Coast Total Care; PCP: primary care provider; MCA-C: My Care Alabama Central; Q: quarter; MCA-E: My Care Alabama East; MCA-NW: My Care Alabama Northwest; MAT: medication-assisted therapy; NACC: North Alabama Community Care; MCT: multidisciplinary care team; OUD: opioid use disorder; PEIR: People Engaged in Recovery; CY: calendar year; ob/gyn: obstetrician/gynecologist; MY: measurement year; ROSS: Recovery Organization of Support Specialists; GTT: glucose tolerance test; CAP-CH: Children and Adolescents' Access to Primary Care Practitioners.