External Quality Review Annual Technical Report

Reporting Year 2022

Review Period: January 1, 2020–December 31, 2021

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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 quality outcomes, timeliness of, and access to the 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, PIHP,[1] PAHP,[2] or PCCM[3] 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 technical report 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) 2021 EQR activities for 7 PCCM-Es contracted to furnish Medicaid services in the state. During the period under review, CY 2021 (January 1, 2021–December 31, 2021), AMA's PCCM-Es included Alabama Care Network Mid-State (ACN Mid-State); Alabama Care Network Southeast (ACN Southeast); 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 technical report focuses on the 3 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).

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

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

(iii) ***CMS Mandatory Protocol 3:* Review of Compliance with Medicaid and CHIP Managed Care Regulations –** This activity determines MCE compliance with its 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 of this report. 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 2020 and 2021 EQR activity findings to assess the performance of Alabama Coordinated Health Network (ACHN) entities in providing quality, timely, and accessible healthcare services to Medicaid members. The individual entities were evaluated against state and national benchmarks for measures related to the quality, access, and timeliness 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 2020 and 2021 demonstrated that AMA and the entities share a commitment to improvement in providing high-quality, timely, and accessible care for eligible individuals (EIs). Program strengths included the following:

Quality Improvement Projects

All 7 entities demonstrated an improvement in at least 1 QIP performance indicator from baseline (CY 2019) to first year remeasurement (CY 2020). Over the course of CY 2021, the entities continued to track their intervention progress in an effort to sustain the results from CY 2020 and refined interventions to target performance indicators that either declined or remained stagnant from baseline. In the domain of quality, there were 7 performance indicators that demonstrated an improvement. In the domain of timeliness, there were 6 performance indicators that demonstrated an improvement. In the domain of access, there were 4 performance indicators that demonstrated an improvement.

Systems Performance Review

A comprehensive systems performance review is conducted once every 3 years. The most recent review of the ACHN entities covered the SFY 2021 review period of October 1, 2020, through September 30, 2021. All entities demonstrated at least 1 requirement that was partial/non-compliant in 2020 and was in full compliance in 2021. ACN Mid-State, ACN Southeast, and GCTC received an overall compliance determination of "Full" for the Grievance topic area. MCA-C, MCA-E, MCA-NW and NACC received an overall compliance determination of "Full" for the Provider Participation and HIMS topic areas.

Performance Measures

(NCQA National Medicaid Benchmarks are referenced in this section, unless stated otherwise.)

Minimum Performance Standards

ACHN entities must achieve at least half of the annual quality metrics to be eligible for the 50% Quality Bonus Payment. The quality bonus for FY 2022 was calculated based on the CY 2020 services (obtained from the claims data). All 7 ACHN entities received this Quality Bonus Payment.

Performance Measures – Quality, Timeliness and Access

In the domain of quality, the statewide average was above the 90th percentile for Asthma Medication Ratio (Child and Adult). In the domain of access, the statewide average was above the 90th percentile for Child BMI Assessment. The statewide average did not exceed the 25th percentile for the measures associated with the timeliness domain.

Opportunities Related to Quality, Timeliness and Access

Quality Improvement Projects

Of the 45 indicators being evaluated across QIP projects, 15 demonstrated a decline in performance from baseline (CY 2019) to interim remeasurement (CY 2020). Seven (7) of these indicators were in quality, 5 were in access, and 3 were in timeliness. ACN Mid-State demonstrated a decline in performance for their LBW measure, annual well visits (for children 3–6 and 7–11), and children 3–11 with a diagnosis of overweight or obese. ACN Southeast demonstrated in decline in performance for their LBW measure, well child visits (for children 0–15 months and 3–6 years of age), and EIs with an SUD diagnosis who received treatment. GCTC demonstrated a decline in performance for their LBW measure, pregnant EIs receiving prenatal care in the first trimester, and EIs 7–11 with an annual PCP visit. MCA-E demonstrated a decline in the percentage of births with a postpartum visit between 21 and 56-days following delivery. MCA-E also demonstrated an increase in the percentage of children with a diagnosis of overweight or obese. MCA-NW demonstrated a decline in the percentage of live births that received a prenatal care visit in the first trimester. NACC demonstrated a decline in performance for EIs 3–6 years of age with a documentation of BMI in their medical record.

Systems Performance Review

Each of the ACHN entities achieved an overall review determination of “Partial”, indicating that one or more of the topic areas reviewed during the 2021 SPR did not demonstrate full compliance. All the entities received a “Partial” determination for the Care Coordination, EI Rights/Materials/Enrollment, Quality Management, and Subcontracting topic areas. MCA-C, MCA-E, MCA-NW and NACC received a review determination of “Partial” for the Grievance topic Area. ACN Mid-State, ACN Southeast, and GCTC received a review determination of “Partial” for the Provider Participation and HIMS topic areas.

Performance Measures – Quality, Access, and Timeliness

(NCQA National Medicaid Benchmarks are referenced in this section unless stated otherwise.)

In the domain of quality, the statewide average was below the 10th percentile for Antidepressant Medication Management and Initiation and Engagement of Treatment for AOD (Initiation and Continuation phases).

In the domain of timeliness, the statewide average was between the 10th and 25th percentile for Well-Child Visits in the First 15 Months of Life and below the 10th percentile for Timeliness of Prenatal Care. In the domain of access, the statewide average was below the 10th percentile for Cervical Cancer Screening and Child Access to Care (12–24 months of age and 25 months to 6 years of age). The statewide average was between the 10th and 25th percentile for Child Access to Care (12–19 years of age) and between the 25th and 50th percentile for Adult BMI Assessment and Child Access to Care (7–11 years of age).

Recommendations for ACHN entities and AMA

The following recommendations are based on the opportunities identified above in the **Opportunities Related to Quality, Timeliness and Access section** of this report**.**

In the domain of quality, IPRO recommends the following:

QIPs

- **ACN Mid-State**, **ACN Southeast**, and **GCTC** should evaluate the LBW measure at the member level to understand factors that might be influencing this rate to increase over time. The entities could perform a pareto analysis, for instance, to understand if there are a few key factors that could be targeted (e.g., obesity, maternal social support, co-morbidities, etc.). Further, the entities could stratify those who delivered a low birthweight baby by demographic factors (i.e., geography, race, ethnicity, etc.) to evaluate whether there are susceptible subpopulations that could benefit from being targeted with tailored interventions.
- **ACN Mid-State**, **ACN Southeast**, and **GCTC** should 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.
- **ACN Mid-State** and **ACN Southeast** should continue evaluating 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.
- **ACN Southeast** should further explore why it is that EIs with a diagnosis of SUD are not receiving treatment and then tailor interventions accordingly. The entity should consider provider barriers, EI barriers, and entity-level barriers to inform subsequent interventions.
- **GCTC** should 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.
- **MCA-E** should evaluate access among women seeking postpartum care to ensure there is an adequate volume of providers. Upon ruling out access issues, the entities should explore barriers faced by women in the postpartum period and work with this population to overcome these barriers in order to bolster visit attendance 21–56 days following delivery.
- **MCA-E** should continue targeting children with a diagnosis of overweight or obese and understand barriers faced by this population (and their caregivers) to accessing care, healthy foods, exercise equipment and/or space, etc.
- **MCA-NW** should 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.
- **NACC** should 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.
- **MCA-C** has demonstrated an improvement within each topic area. They are encouraged to continue thinking about how to sustain and expand their interventions and efforts, targeting the maximum number of EIs as possible.

SPR

- **Each ACHN entity** should address the recommendations made in the SPR finding reports issued March 2022. Entity-specific care coordination file review finding recommendations are detailed below:
  - **ACN Mid-State** should 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 are addressed in the care plan; that all EIs enrolled in family planning receive

information/education about STD prevention; and that the Health Risk and Psychosocial Assessment take place within 5 business days from the date of the screening.

- **ACN Southeast** should ensure that rationales for interventions are included within the care plan; that all medical conditions identified in the Health Risk and Psychosocial 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.
- **GCTC** should ensure that consent is obtained prior to provision of family planning care coordination activities; that all medical conditions identified in the Health Risk and Psychosocial 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 (e.g., health status, needs, caregiver status, health care event, etc.); and that the multidisciplinary care team (MCT) meeting takes place during calendar months 7–12 and every 6 months thereafter for high-risk EIs.
- **MCA-C** should ensure that all care plans contain the 5 required components (i.e., 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.
- **MCA-E** should ensure that all EIs have a care plan on file; that all care plans contain the 5 required components (i.e., 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.
- **MCA-NW** should ensure that all EIs have a care plan on file; that all care plans contain the 5 required components (i.e., 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.
- **NACC** should 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; that all care plans include documentation of all referrals/consultations to specialists 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.

Performance Measures

- **Each ACHN entity** should review and trend their performance for Antidepressant Medication Management 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.

- **ACN Mid-State, ACN Southeast, GCTC, and MCA-C** should review and trend their performance for Initiation of Treatment for AOD 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 initiation of treatment for AOD.
- **Each ACHN entity** should review and trend their performance for Engagement in Treatment for AOD 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 engagement in treatment for AOD.

In the domain of timeliness, IPRO recommends the following:

Performance Measures

- **ACN Mid-State**, **GCTC**, **MCA-C**, **MCA-NW**, and **NACC** should review and trend their performance for Well-Child Visits in the First 15 Months of Life 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.
- **GCTC**, **MCA-C**, **MCA-E**, **MCA-NW**, and **NACC** should review and trend their performance for Timeliness of Prenatal Care 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.

In the domain of access, IPRO recommends the following:

Performance Measures

- **Each ACHN entity** should review and trend their performance for Cervical Cancer Screening and Adult BMI Assessment 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.
- **ACN Mid-State**, **ACN Southeast**, **GCTC**, **MCA-C**, **MCA-NW**, and **NACC** should review and trend their performance for Child Access to Care 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 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 Alabama Medicaid Agency (AMA). The Medicaid program provides healthcare coverage for approximately 971,000 individuals enrolled in the ACHN program. There are 7 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 primary care case management (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 Homes to provide PCCM services to Health Home enrollees. The Maternity Care Program was established in 1988 and 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 whose income was at or below 141% of the Federal Poverty Level (FPL) were eligible. A standard income disregard of 5% of the FPL is applied if the individual is not eligible for coverage due to excess income. In 2015, AMA began coverage of vasectomies and care coordination for Medicaid-eligible males aged 21 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 7 regions as of December 2021.

Table 1: Medicaid Enrollment and Assignment by ACHN Entity

ACHN Entity	Number of EIs Enrolled in ACHN (1/1/21–12/31/21)	Number of EIs Assigned to Region (12/1/21–12/31/21)
ACN Mid-State	19,051	148,309
ACN Southeast	16,788	132,520
Gulf Coast Total Care (GCTC)	21,578	162,827
My Care Alabama Central (MCA-C)	19,836	128,494
My Care Alabama East (MCA-E)	16,090	135,845
My Care Alabama Northwest (MCA-NW)	14,715	126,976
North Alabama Community Care (NACC)	12,833	135,688

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 Homes Program to design and implement a new approach for improving healthcare 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, the Agency 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 Agency'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 3 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, QIP progress and evaluation, and 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; review utilization data with PCPs, as needed, to achieve quality goals of the ACHN; review and assist the ACHN entity in implementing and evaluating QIPs; and discuss and, when appropriate, resolve any issues with the PCPs or the ACHN encounter in providing Care Coordination services to their EIs. The Consumer Advisory Committee is designed to advise the ACHN entity on ways it can be more efficient in providing quality care to its 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 the 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 Check
WCC-CH	Child BMI
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	Child Access to Care [four age strata]
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 (age 3–6)
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 or other drugs
CHL	Chlamydia screening in women

PCP: primary care provider; ER: emergency room.

At the end of each fiscal year, 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 to remedy any noncompliance, when necessary.

AMA conducts ongoing monitoring and supervision as required by 42 C.F.R. § 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 corrective action plans (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 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, ACHNs are required to submit accurate and complete case management data monthly. AMA will use the case management data in its monitoring activities as well as for capitation rate development.

Table 4: ACHN Reporting Requirements

ACHN Report Title	Frequency of Reporting
CAC 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 ACHNs. 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 an onsite visit to ensure the entity is meeting the RFP or other contractual obligations in addition to efficiently and effectively serving the Medicaid population and improving health outcomes. These visits are performed on a quarterly basis. These visits provide an insight into day-to-day operations and allow the Health Systems Manager to visually 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 Federal regulations at 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

IPRO recommends that 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 3 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 managed care entities to conduct PIPs that focus on both clinical and non-clinical 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. Update reports are provided quarterly and assessed by IPRO and AMA. QIP proposals were submitted November 2019, with re-submissions requested, and final review and approval by March 2020. Interim year 1 reports were due April 2021, interim year 2 reports are due April 2022, and final reports are due April 2023.

Beginning October 1, 2019, AMA required each of the ACHN entities to perform 1 QIP for each of the following topics: adverse birth outcomes, childhood obesity, and substance use disorder. These QIPs are scheduled to conclude December 31, 2022. 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 quality improvement projects (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 *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 QIPs that were underway 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. During the conduct of the QIPs, 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 PIP, as well as to score the compliance of each PIP 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 (listed above). Note that there are also sub-elements reviewed, the detail of which is provide in **Table 7**. 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 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 1 or more validation findings that indicate a bias in the QIP results.

IPRO's assessment of indicator performance will be based on the following 4 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 **Table 7**–**Table 9.**

Table 7: MY 2020 Adverse Birth Outcomes QIP Validation Results

Validation Element	ACNM	ACNS	GCTC	MCA-C	MCA-E	MCA-NW	NACC
	Adverse Birth Outcomes						
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
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	Met	Met	Met	Met	Met	Met	Met

Validation Element	ACNM	ACNS	GCTC	MCA-C	MCA-E	MCA-NW	NACC
	Adverse Birth Outcomes						
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)	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
21. Interventions were modified and/or successes spread as informed by interpretation of ITMs	Met	Met	Met	N/A	Met	Met	Met
Results							
22. In the Results table, the numerators, denominators and rates of the annual performance indicators are correctly reported	Met	Met	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	Met	Partially Met
24. Improvement shown in annual performance indicators or quarterly ITMs?	Partially Met	Met	Partially Met	Not Met	Partially Met	Partially 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	N/A

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

MY: measurement year; QIP: quality improvement project; ACNM: ACN Mid-State; ACNS; ACN 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: MY 2020 Childhood Obesity QIP Validation Results

Validation Element	ACNM	ACNS	GCTC	MCA-C	MCA-E	MCA-NW	NACC
	Childhood Obesity						
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	Not 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

Validation Element	ACNM	ACNS	GCTC	MCA-C	MCA-E	MCA-NW	NACC
	Childhood Obesity						
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	Partially Met	Met	Met	Met	Met	Partially 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	Partially 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	N/A

Validation Element	ACNM	ACNS	GCTC	MCA-C	MCA-E	MCA-NW	NACC
	Childhood Obesity						
Results							
22. In the Results table, the numerators, denominators and rates of the annual performance indicators are correctly reported	Met	Met	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	Partially Met	Partially Met	Met	Partially Met
24. Improvement shown in annual performance indicators or quarterly ITMs?	Partially Met	Met	Partially Met	Partially 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)	N/A	Met	Met	Met	Met	Met	N/A
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	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: ACN Mid-State; ACNS: ACN 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: MY 2020 Substance Use Disorder QIP Validation Results

Validation Element	ACNM	ACNS	GCTC	MCA-C	MCA-E	MCA-NW	NACC
	Substance Use Disorder						
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

Validation Element	ACNM	ACNS	GCTC	MCA-C	MCA-E	MCA-NW	NACC
	Substance Use Disorder						
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	Partially 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	N/A	N/A	N/A	N/A	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 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	Met	Met	Met	Met	Met	Partially Met	Met

Validation Element	ACNM	ACNS	GCTC	MCA-C	MCA-E	MCA-NW	NACC
	Substance Use Disorder						
data stratified by clinical/demographic characteristics to identify susceptible subpopulations)							
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	Partially Met
21. Interventions were modified and/or successes spread as informed by interpretation of ITMs	Met	Met	Met	Met	Met	Met	Not met
Results							
22. In the Results table, the numerators, denominators and rates of the annual performance indicators are correctly reported	Met	Met	Met	Met	Met	Partially Met	N/A
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	Partially Met	Met
24. Improvement shown in annual performance indicators or quarterly ITMs?	Partially Met	Met	Met	Met	Met	Met	Not 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	N/A
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	Met	Met	Met	Met	Partially 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: ACN Mid-State; ACNS: ACN 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 following validation elements for the Adverse Birth Outcomes QIP did not achieve full compliance:

ACN Mid-State

Improvement shown in annual performance indicators or quarterly ITMs? (Partially met)

- Improvement was not observed in annual performance indicators and/or quarterly ITMs. While improvement over time was observed across several ITMs, there was a decline in performance among those related to EIs who scheduled a follow-up appointment after delivery of a low birthweight baby, as well as those who attended a follow-up appointment after delivery. Further, there was a decline in the performance of the indicator of percentage of live deliveries with low birth weight.

Gulf Coast Total Care

Improvement shown in annual performance indicators or quarterly ITMs? (Partially met)

- Improvement was not observed in the percentage of live births weighing less than 2,500 grams or in the percentage of pregnant EIs that received prenatal care in the first trimester.

Identification of study limitations (i.e., factors that that threaten internal/external validity) (Partially met)

- It is stated in the interim report that "The findings support the premise that EIs with hypertension, diabetes, and preterm delivery history are at greater risk for complications and preterm/low birth weight delivery." While this may be true, it is not supported by the ACHN's findings.

My Care Alabama Central

Improvement shown in annual performance indicators or quarterly ITMs? (Not met)

- Improvement was not observed in either the performance indicators or quarterly ITMs.

My Care Alabama East

Target rates are reported in the Results table (Partially met)

- Entity should consider adjusting target rates for Indicators 1 and 2 (as the target rates have been achieved during the interim period).

Improvement shown in annual performance indicators or quarterly ITMs? (Partially met)

- A decline in performance was observed in the percentage of deliveries 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 and 56 days after delivery from baseline to the interim period.

My Care Alabama Northwest

Barriers to improvement identified through data analysis and quality improvement processes (Partially met)

- The barriers cited do not correspond with the method of barrier identification. For instance, "Prenatal/Postpartum visit rates" is listed as the method of identification behind barriers related to lack of education of prenatal care visits and lack of knowledge about postpartum visits.

Improvement shown in annual performance indicators or quarterly ITMs? (Partially met)

- Improvement was not observed in annual performance indicators and/or quarterly ITMs.
- No meaningful longitudinal comparison can be made from the limited data points reflected in the interim report.

North Alabama Community Care

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 stated within the Results table; however, the interim rates exceeded these targets, and thus goals should be adjusted accordingly going forward.

Improvement shown in annual performance indicators or quarterly ITMs? (Partially met)
- Certain ITMs cannot be interpreted effectively due to a low denominator, and a few ITMs declined in performance over the course of CY 2020.
- Indicator improvement cannot be determined, as there are no baseline data associated with this project.

Childhood Obesity

Through the validation process, IPRO determined that the following validation elements for the Childhood Obesity QIP did not achieve full compliance:

ACN Mid-State

Robust EI and provider interventions undertaken to address identified causes/barriers (Partially met)
- While there are interventions that address scheduling children for well visits and distributing MyPlate materials/jump ropes/Frisbees®, there have not been many children impacted by these interventions (evidenced by the ITMs, and the corresponding numerators).

Improvement shown in annual performance indicators or quarterly ITMs? (Partially met)
- ITMs did not show improvement, and 3 of 4 interventions did not show improvement.

Gulf Coast Total Care

Interventions have corresponding monthly or quarterly ITMs, with numerator/denominator (Partially met)
- The entity needs to align ITMs and barriers with descriptions and timeframes.

Improvement shown in annual performance indicators or quarterly ITMs? (Partially met)
- Indicators did not demonstrate improvement.

My Care Alabama Central

Target rates are reported in the Results table (Partially met)
- The target for Indicator 3 is not stated in the Results table. Further, target rates should be reviewed across indicators; adjustments may be warranted, given that interim rates exceeded these targets.

Improvement shown in annual performance indicators or quarterly ITMs? (Partially met)
- One indicator demonstrated improvement. One (1) did not have data available for baseline, and the other did not have data available for either baseline or interim remeasurement. ITM data were scarce, with the majority of measures only having data for Q1 2021.

My Care Alabama East

Target rates are reported in the Results table (Partially met)
- The entity should consider updating their target rate (28.4%) for their indicator (the percentage of children 3–17 years of age with a documented BMI) based on their interim rate of 69.2%.

My Care Alabama Northwest

Barriers to improvement identified through data analysis and quality improvement processes (Partially met)
- The entity should describe in the “Method of Barrier Identification” section exactly how the barrier was identified.

Robust EI and provider interventions (Partially met)

- Both interventions listed in the document seem to be addressing the same barrier. The entity should consolidate interventions under 1 barrier heading if they are addressing the same barrier. The entity should consistently number all barriers, interventions, and ITMs.

Interventions have corresponding monthly or quarterly ITMs, with numerator/denominator (Partially met)

- The rates for some of the ITMs are not calculated correctly.
- MCA-NW should ensure all ITMs address the indicated Intervention, as listed in the report.

North Alabama Community Care

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. (Not met)

- Goals should be adjusted in response to the updated baseline rates provided (note that in the proposal submission, there were no baseline data, and thus goals based on AMA historical data were appropriate at that time).
- There are inconsistencies between the various tables in the report in how goals are stated.

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; however, they are not consistent with the targets stated in other tables, nor are they appropriate given the baseline rates (for instance, Indicator 1, percentage of EIs 3-6 with documentation of BMI in record, has a baseline of 89.5% and a goal of 70%).

Improvement shown in annual performance indicators or quarterly ITMs? (Partially met)

- Several ITMs did not demonstrate improvement. One (1) of 3 indicators did not demonstrate improvement.

Substance Use Disorder

Through the validation process, IPRO determined that the following validation elements for the Substance Use Disorder QIP did not achieve full compliance:

ACN Mid-State

Improvement shown in annual performance indicators or quarterly ITMs? (Partially met)

- Decline in performance shown in the percentage of EIs with a buprenorphine, Suboxone®, or methadone prescription with successful contact, and in the percentage of EIs who kept their follow-up appointment.

ACN Southeast

Goal sets a target improvement rate that is bold, feasible, and based upon baseline data and strength of interventions. The rationale for target rate is provided. (Partially met)

- The baseline rate for Indicator 1 in Table 2: Goals does not coincide with the numerator and denominator components provided.

My Care Alabama Northwest

Barriers to improvement identified through data analysis and quality improvement processes (Partially met)

- The method of barrier identification is not appropriate for 1 of the barriers listed within the report. Without supporting data and analysis of such, the barrier identification method given constitutes only an assumption.

Interventions have corresponding monthly or quarterly ITMs, with numerator/denominator (Partially met)

- There are several ITMs that are missing data, and the numbering of barriers, interventions, and ITMs are not in alignment.

In the Results table, the numerators, denominators, and rates of the annual performance indicators are correctly reported (Partially met)

- There were slight indicator calculation issues, given rounding errors.

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)

- Interim rates for Indicators 1 and 2 have surpassed target rates; thus, targets should be adjusted in light of interim performance.

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Interventions have corresponding monthly or quarterly ITMs, with numerator/denominator (Partially met)

- Two of the ITMs have the same denominator description (number of EIs in Cullman, Jackson, Limestone, Madison, Marshall, and Morgan counties with a substance use disorder diagnosis); however, they have a different number reflected for this denominator.
- Q4 2020 data are missing for several ITMs.
- The numerator and denominator units do not match for 1 ITM. It is not appropriate to have 2 different units (i.e., EIs versus PCPs); they should be consistent.

Interventions were modified and/or successes spread as informed by interpretation of ITMs (Not met)

- There is no evidence that ITMs were used to inform next steps in intervention development/planning.

Improvement shown in annual performance indicators or quarterly ITMs? (Not met)

- The indicator rate is not reported and ITM data are limited (only 2 quarters of data available in most cases, and there do not appear to be trends that indicate and improvement in the progress of interventions).

Interpretation of extent to which QIP is successful, and the factors associated with success (Partially met)

- NACC states that not starting the ROSS referrals until September 2020 made it difficult to interpret success or failure of the QIP. There is no interpretation based on other interventions, however.
- The ACHN should review the barriers associated with the interventions that had been terminated, and determine if there are other activities they can take part in to address these barriers.

QIP summaries, including aim, interventions, and overall performance are reported in **Table 10–Table 16** for each ACHN entity.

Table 10: ACN Mid-State QIP Summaries, 2020–2021

ACN Mid-State QIP Summaries
QIP 1: Adverse Birth Outcomes Validation Summary: N/A (the project will not be completed until 12/31/2022)
Aim ACN Mid-State will implement for pregnant EIs and EIs 18–44 years of age an in-house monitoring program to educate and provide self-management for EIs diagnosed with hypertension and/or diabetes to reduce preterm birth and improve birth outcomes from baseline to final measurement.

ACN Mid-State QIP Summaries
Interventions in 2020/2021 • Implemented the use of hypertension/diabetes monitoring for management of diabetes and hypertension for EIs identified as childbearing age 18–44 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. • Maternity care coordinators completed a social determinants of health screening at initial assessment of all new pregnant EIs. • Referred postpartum EIs to family planning. • Implemented an education video series to promote healthy birth outcomes and decrease infant mortality. Topics included breastfeeding, count the kicks, safe sleep, 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 interim remeasurement (2020). 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 that were identified as having a need were connected to a community resource.
QIP 2: Childhood Obesity Validation Summary: N/A (the project will not be completed until 12/31/2022)
Aim ACN Mid-State will assist EIs in scheduling well visits with emphasis on good nutrition/physical activity for those EIs with BMI > 85th percentile to reduce the number of overweight and obese children in the Mid-State Region by 2%. **Interventions in 2020/2021** • Utilized AMA data to identify the ZIP Codes® with largest percentage of EIs 3–11 years of age with a diagnosis of overweight or obese. • Utilized AMA data to identify EIs 3–11 years of age with a BMI > 85th percentile without a well visit. • Provided MyPlate materials for nutrition education, and jump rope and Frisbee to promote physical activity. • Implemented a virtual 6-week Eating Smart Being Active Program administered by Alabama Corporative Extension (ACE) for EIs age 6–14 with BMI > 85th percentile. • Assisted primary care providers (PCPs) in contacting EIs/parents to educate them on the importance of well-child visits and to assist in scheduling. **Performance Improvement Summary** One of 4 indicators demonstrated improvement from baseline (2019) to interim remeasurement (2020). The percentage of annual BMI assessments completed for EIs 3–19 years of age improved significantly, while the percentage of EIs with an annual well visit and with a diagnosis of overweight or obese saw a decline in performance.
QIP 3: Substance Use Disorder Validation Summary: N/A (the project will not be completed until 12/31/2022)
Aim Implement support during recovery to improve the percentage of EIs 18–64 years of age with SUD to improve primary and mental health care, or support through community resources to increase patient engagement and retention in SUD treatment. **Interventions in 2020/2021** • 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.

ACN Mid-State QIP Summaries
• Referred pregnant EIs identified at assessment by maternal care coordinator with history/active SUD to Peer Support Specialist. • Refer family members of EIs diagnosed with SUD to University of Alabama Family Wellness Program. **Performance Improvement Summary** The performance indicators established at the outset of the project were changed due to data collection/availability issues, and thus improvement cannot be interpreted. However, improvement was seen in the percentage of EIs enrolled in primary and mental health care as well as community resources. There was also progress made in the percentage of EIs with a prescription for medication-assisted therapy who were enrolled in peer support. In 2022, the ACHN will implement a school-based SUD prevention program for middle school students, as well as provide continuing medical education credits for providers for SUD.

ACN: Alabama Care Network; QIP: quality improvement project; N/A: not applicable; EI: eligible individual; BMI: body mass index; AMA: Alabama Medicaid Agency; PCP: primary care provider; SUD: substance use disorder; ACHN: Alabama Coordinated Health Network.

Table 11: ACN Southeast QIP Summaries, 2020–2021

ACN Southeast QIP Summaries
QIP 1: Adverse Birth Outcomes Validation Summary: N/A (the project will not be completed until 12/31/2022)
Aim • Improve the rate of pregnant EIs who have a prenatal visit in the first trimester from 64.9% to 67.8% with a focus on Macon and Russell counties, which had a rate of late prenatal care of 40.4% and 40.3%, respectively, in 2017. • Decrease the percentage of live births < 2,500 grams from baseline of 9.5% to 9.3%. • Increase the percentage of well-child visits in the first 15 months of life from 64.2% to 65.0% with a focus on Barbour and Coffee counties. **Interventions in 2020/2021** • Worked with delivering health care professional (DHCP) offices and maternity EIs to schedule initial visit within first trimester. • Incentive package of diapers at delivery provided to EIs who attended 80% of prenatal and postpartum visits. • Pregnant EIs with hypertension or diabetes diagnosis referred to internal biomonitoring program. • ACN Southeast staff member assigned to a pediatric office to case-manage office population. • Distributed safe sleep information to caregiver of EI (as opposed to birth parent—change made in 2021). • Targeted case management of EIs 0–15 months of age. **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 interim remeasurement (2020). The other performance indicators associated with this project (the percentage of live births weighing less than 2,500 grams and the percentage of infants 0–15 months of age 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 will not be completed until 12/31/2022)
Aim Provide education and support for breastfeeding, nutritional and physical activity education for EIs 3–6 with BMI > 85th percentile, and gardening materials to children in pre-k, kindergarten, and first grade in order to decrease the percentage of children with BMI > 85th percentile and increase well-child visits.

ACN Southeast QIP Summaries
Interventions in 2020/2021 • 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 **Performance Improvement Summary** While the performance indicator (percentage of EIs 3–6 years of age with a well-child visit) demonstrated a decline in performance, there were some notable advancements made in the process measures. A total of 3,297 children have participated in the school gardening project to date. There were 2 elementary schools that declined gardening supplies, stating that the teachers had been overwhelmed with COVID-19 scheduling challenges; however, both schools requested contact for the next school year. A steady increase throughout 2021 was observed in the percentage of EIs who were breastfeeding at 3 months or more postpartum, as well as the percentage of EIs 3–6 years of age with a BMI > 85th percentile who received nutritional and physical activity education.
QIP 3: Substance Use Disorder Validation Summary: N/A (the project will not be completed until 12/31/2022)
Aim Develop an infrastructure within ACNS to increase the percent of EIs who initiate SUD treatment within 14 days of a new episode diagnosis from 39.6% to 40.0% and continue in treatment with at least 2 alcohol and other drugs (AOD) services within 34 days from 5.6% to 6.5%, in addition to supporting existing EIs with SUD to enroll EI into treatment. **Interventions in 2020/2021** • Assisted with transportation resources for SUD treatment when non-emergent transportation reimbursement was not available. • Provided funding for residential housing costs for EIs who participate in recovery programs at non-billing SUD programs (e.g., community and faith-based programs). • Partnered with SpectraCare Mental Health in Houston County to financially support dedicated SUD staff members. • Began education in local schools regarding substance use prevention. **Performance Improvement Summary** There was a slight decline in the percentage of EIs with an SUD diagnosis who received treatment from baseline (2019) to interim remeasurement (2020). 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 have residential treatment facilities). The ACHN did observe 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. Going forward, the ACHN will focus on prevention efforts within the local school districts.

ACN: Alabama Care Network; QIP: quality improvement project; N/A: not applicable; BMI: body mass index; EI: eligible individual; COVID-19: 2019 novel coronavirus; ACNS: Alabama Care Network Southeast; SUD: substance use disorder; ACHN: Alabama Coordinated Health Network.

Table 12: Gulf Coast Total Care QIP Summaries, 2020–2021

Gulf Coast Total Care QIP Summaries
QIP 1: Adverse Birth Outcomes Validation Summary: N/A (the project will not be completed until 12/31/2022)
Aim GCTC will implement a critical care protocol to specifically target EIs that are at additional risk for pre-term 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 in the Southwest region. **Interventions in 2020/2021** • Identified EIs through psychosocial assessment with 1 of the critical risk diagnoses (hypertension, diabetes, or previous pre-term delivery) to enroll in biomonitoring. • Improved EI knowledge regarding critical risk diagnosis and care plan adherence through biomonitoring activities. **Performance Improvement Summary** While 2 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 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.
QIP 2: Childhood Obesity Validation Summary: N/A (the project will not be completed until 12/31/2022)
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 2020/2021** • 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 and PCP attribution lists to target practices with a large number of EIs 7–11 years of age with Z68.53 or Z68.54 diagnosis code. • Using AMA data, identified EIs that have Z68.53 or Z68.54 diagnosis code, and provided a list of these patients to the practice to which they were attributed. • Assisted PCPs in educating EIs and their parent(s) on the importance of an annual PCP visit. **Performance Improvement Summary** There was an improvement in the percentage of annual BMI assessments completed for EIs 3–17 years of age; however, there was a decline in performance for the percentage of EIs 7–11 years of age that had an annual PCP visit. There was a new indicator established (the percentage of EIs 7–11 years of age with a diagnosis of overweight), the performance of which cannot be determined at this time, given lack of baseline data.
QIP 3: Substance Use Disorder Validation Summary: N/A (the project will not be completed until 12/31/2022)
Aim GCTC will increase by 2% the percentage of EIs 18 and older initiating and continuing treatment for SUD. **Interventions in 2020/2021** • Identified EIs 18 years of age and older with a new AOD diagnosis, specifically for opioid use disorder (discrete ICD-10 F11 diagnoses). • Connected EIs with an opioid use disorder and receiving medication-assisted therapy (MAT) to People Engaged in Recover (PEIR) to help facilitate the incorporation of counseling and behavioral therapies into treatment plan and access other available community resources. • Through educational outreach, aimed to improve the comfort level of PCPs in managing EIs with an opioid use disorder (specifically ICD 10 code F11). The medical director, pharmacy manager and/or quality manager provided

Gulf Coast Total Care QIP Summaries
training on: pathophysiology of opioid use disorder, prescribing guidelines, MAT options, quality measures, and community resources. Eligible providers are ACHN-contracted providers whose attributed EI population majority is 18 years of age and older. • Certified recovery support specialist (CRSS) performed outreach within 24 hours of receipt of referral (phone call, letter) to EIs that have a new episode of opioid abuse or dependence diagnosis or received their first MAT prescription fill. CRSS assisted EIs in enrolling in care coordination and completing the adult placement assessment. • CRSS also assisted EIs with accessing outpatient treatment through barrier assessment and support, transporting or providing transportation assistance (bus passes, scheduling other transportation), following up with EI to confirm assessment completion, periodic contact for guidance/encouragement (phone calls), and connecting to other community resources/referrals. **Performance Improvement Summary** The 2 performance indicators in place in 2020 (the percentage of EIs initiating in treatment within 14 days of new AOD diagnosis, and the percentage of EIs who had two or more additional AOD services or MAT within 34 days of initiation) both demonstrated improvement. These indicators were replaced with 3 alternate indicators in 2021, the outcomes of which will be reported in the 2023 Annual Technical Report. The inability to establish partnerships with hospital systems in the region due to the 2019 novel coronavirus (COVID-19) pandemic posed significant limitations. Further, interventions informed by data related to the diagnoses of the population were hindered by the inability to access these data in a timely manner.

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; SUD: substance use disorder; ICD: International Classification of Diseases; MAT: medication assisted therapy; PEIR: People Engaged in Recovery; ACHN: Alabama Coordinated Health Network; CRSS: certified recovery support specialist; COVID-19: 2019 novel coronavirus.

Table 13: My Care Central QIP Summaries, 2020–2021

My Care Central QIP Summaries
QIP 1: Adverse Birth Outcomes Validation Summary: N/A (the project will not be completed until 12/31/2022)
Aim Implement a Family Planning clinic with Baptist Health and school-based education program to improve preconception wellness among Medicaid-eligible women of childbearing age. Focus will be on reducing the prevalence of STIs and improving pregnancy spacing through the use of family planning methods. **Interventions in 2020/2021** • Initiated an evidence-base Sexual/Reproductive Health Curriculum in a regional high school by embedding QIP staff within the health class. • Referred EIs to Baptist Health Family Medicine to complete cervical cancer screening • Referred EIs to Baptist Health Family Medicine to assist in family planning consultation and contraceptive acquisition. **Performance Improvement Summary** Both performance indicators (percentage of students that completed the Making Proud Choices curriculum, and the percentage of EIs who participate in women's health appointments at Baptist Health Family Medicine) had a baseline of 0%. Significant improvement was demonstrated by the end of 2020, wherein both indicators had achieved rates close to their target of 90%.

My Care Central QIP Summaries
QIP 2: Childhood Obesity Validation Summary: N/A (the project will not be completed until 12/31/2022)
Aim To improve childhood obesity by behavioral modification in the mother by increasing education, breastfeeding, early access to the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) and utilizing the American Academy of Pediatrics feeding guidelines. **Interventions in 2020/2021** • QIP nurses provided in-home breastfeeding education and support to EI moms by assisting with enrollment in the Strong Momma program. • Support and education from QIP nurses to improve early prenatal (less than 28 weeks gestation) access to WIC. • Nurses will educate the EIs on the importance of the well-child visit in the first 15 months of life, based on the AAP guidelines, prenatally and through infancy. **Performance Improvement Summary** There was a steady improvement in the percentage of EI mothers who were provided breastfeeding education in 2021, as well as the percentage still breastfeeding over 30 days after initiation. Of the 3 indicators being used for this project, only 1 had baseline data and thus could be assessed for improvement: the percentage of EIs enrolled in WIC during the prenatal period increased significantly from baseline (2019) to remeasurement (2020).
QIP 3: Substance Use Disorder Validation Summary: N/A (the project will not be completed until 12/31/2022)
Aim Provide EIs with SUD diagnosis the increased opportunity to receive SUD treatment within a timely manner. **Interventions in 2020/2021** • Adult placement assessment (APA) completed by My Care Central or the Recovery Organization of Support Specialists (ROSS). • Peer support specialists provided transportation for EIs to initiate treatment and attend two or more AOD/MAT services 30 days after initiation. **Performance Improvement Summary** A very small number of EIs are being targeted by interventions, according to the ITMs. My Care Central indicated this was due to the COVID-19 pandemic and third-party limitations. The ACHN has been encouraged to develop interventions that target a higher volume of their SUD population. The percentage of EIs with an SUD diagnosis who initiated treatment remained constant from baseline (2019) to remeasurement (2020); however, there was a slight improvement in those who had two or more additional services following initiation.

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; ROSS: the Recovery Organization of Support Specialists; AOD: alcohol or other drugs; MAT: medication-assisted treatment; ITM: intervention tracking measure; COVID-19: 2019 novel coronavirus.

Table 14: My Care East QIP Summaries, 2020–2021

My Care East QIP Summaries
QIP 1: Adverse Birth Outcomes Validation Summary: N/A (the project will not be completed until 12/31/2022)
Aim • Implement the use of a smoking cessation mobile application, which will focus on behavioral change versus drug therapy to improve quit rates for pregnant EIs from baseline to final measurement. • Implement the process of incentivizing EIs for attendance of prenatal and postpartum visits to mitigate risks of smoking during pregnancy and increase the chance of a safe and healthy delivery.

My Care East QIP Summaries
Interventions in 2020/2021 • Provided support, resources, and education for EIs through completion of smoking cessation program for pregnant women via Quit Genius mobile app. • Incentivized EIs to attend prenatal and postpartum appointments to increase appointment compliance and education of pregnancy resources. Gift cards to stores supplying new baby essentials, postpartum mom essentials (mom pampering—idea for postpartum issues), gas cards, etc. were provided after verification of visits. **Performance Improvement Summary** The percentage of women who smoke during pregnancy declined from baseline (2019) to remeasurement (2020), and there was an increase in the percentage of EIs that had a postpartum visit 21–56 days following delivery. There was a decline in performance for the low birthweight indicator, wherein percentage of live births weighing less than 2,500 grams increased from baseline to remeasurement.
QIP 2: Childhood Obesity Validation Summary: N/A (the project will not be completed until 12/31/2022)
Aim In order to improve child access to care and BMI assessment, implement a program to incentivize EIs' parents for attendance of well-child visits; implement the HEAL (Healthy Eating, Active Living) Program curriculum in physical education classes for two elementary schools; and initiate a pilot program providing telehealth nutrition, physical activity, and behavior change by registered dietician nutritionist for children 6–12 years of age with a BMI > 85th percentile. **Interventions in 2020/2021** • 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 My Care East region. • Provided telehealth nutrition, physical activity, and behavior change by 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 3–17 years of age with a BMI assessed and documented. There was an increase in the percentage of children with a diagnosis of overweight or obese, and thus a decline in performance.
QIP 3: Substance Use Disorder Validation Summary: N/A (the project will not be completed until 12/31/2022)
Aim • Implement the use of peer support specialists to improve the percent of Initiation and Engagement of Treatment for alcohol and other drugs (AOD). • Implement the use of My Care East master's-level social workers to conduct timely adult placement assessments to improve entry into substance treatment facilities after detox. • Implement the use of community-building to 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. **Interventions in 2020/2021** • Implemented the use of peer support specialists to help improve the percent of EIs who initiate and engage in treatment for alcohol and other drug use. Peer specialists provided services throughout the entire continuum of care by providing emotional support and mentoring, linking EIs to information and resources, and assisting EIs with completing paperwork and helping with transportation. • Implemented the use of My Care East master's-level social workers to conduct timely adult placement assessments to improve entry into substance treatment facilities after detox.

My Care East QIP Summaries
Performance Improvement Summary There was a slight increase in the percentage of EIs that initiated AOD treatment from baseline (2019) to remeasurement (2020), as well as an increase in the percentage of EIs who had 2 or more services or medication treatment following initiation.

QIP: quality improvement project; N/A: not applicable; EI: eligible individual; BMI: body mass index; HEAL: Healthy Eating, Active Living; UAB: University of Alabama Birmingham; AOD: alcohol and other drugs.

Table 15: My Care Northwest QIP Summaries, 2020–2021

My Care Northwest QIP Summaries
QIP 1: Adverse Birth Outcomes Validation Summary: N/A (the project will not be completed until 12/31/2022)
Aim 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 • Increasing enrollment in family planning to improve birth spacing **Interventions in 2020/2021** Nurse Family Partnership (NFP) provided educational handouts on prenatal and postpartum care visits; information on healthy growth and development of the baby within the first week of delivery up to 2 years of age; and information related to contraceptive methods. **Performance Improvement Summary** While there was a decline in the percentage of EIs attending prenatal care visits from baseline (2019) to remeasurement (2020), there was notable progress within the ITMs in the counties that were being targeted by this QIP in 2021. Compliance with prenatal care visits was 100% for each quarter throughout 2021, and postpartum visit compliance ranged from 67% to 85%. Further, there was a steady increase in the percentage of EIs who sought contraception (particularly among the teenage cohort).
QIP 2: Childhood Obesity Validation Summary: N/A (the project will not be completed until 12/31/2022)
Aim Reduce childhood obesity by implementing the following activities and interventions: • Identify the attributed EIs from the University Medical Center (UMC) and Cahaba Medical Care Foundation (Cahaba) with a BMI of 95% or greater. • Identify the percentage of attributed EIs from UMC and Cahaba with a BMI of 95% or greater who receive nutrition and physical activity counseling. • Refer the attributed EIs identified by Cahaba and UMC with a BMI of 95% or greater to be enrolled to care coordination services • Partner with UMC and Cahaba to identify and refer EIs to the Support and Help in Nutrition and Exercise (SHINE) Clinic. • Distribute provider educational cheat sheet to improve BMI coding. **Interventions in 2020/2021** • Nutritional classes (via webinar) provided in partnership with Auburn Cooperative Extension Office. • Practices in Tuscaloosa and Bibb counties provided nutritional and activity counseling to EIs with BMI of 95% or greater and referred these EIs to My Care NW care coordination services. • Referred EIs with a BMI of 95% of greater to SHINE Clinic. • Delivered coding cheat sheets for providers to assist them with how to code BMI correctly.

My Care Northwest QIP Summaries
Performance Improvement Summary Many interventions were redesigned and initiated in 2021. The indicator associated with this QIP (the percentage of EIs 3–17 years of age who had an outpatient visit with evidence of BMI documentation) demonstrated a significant increase from baseline (2019) to remeasurement (2020). Over 50% of providers were given the BMI coding cheat sheet, nutritional and physical activity counseling was provided for 75% of EIs as of the last quarter of 2021, and 37% of those referred to targeted care coordination received this service.
QIP 3: Substance Use Disorder Validation Summary: N/A (the project will not be completed until 12/31/2022)
Aim Improve access to and initiation and engagement of treatment for alcohol and other drugs (AOD) by implementing the following interventions: • Utilize peer support specialists to assist EIs in initiating and engaging in treatment, and provide outreach to PCPs, DHCPs, and rehab facilities. • Implement the use of My Care Northwest master's-level social workers to conduct timely adult placement assessments to improve entry into substance treatment facilities. **Interventions in 2020/2021** • Assigned EIs to peer support specialists to assist with AOD treatment initiation. • Master's-level social workers trained in how to complete adult placement assessment to assist ROSS with getting the assessment completed in a timely manner. • Peer support specialists provided EIs with transportation to AOD/SUD treatment. **Performance Improvement Summary** The percentage of EIs that initiated AOD treatment remained constant from baseline (2019) to interim remeasurement (2020); 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. A very low percentage of EIs identified as in need of transportation services had received this assistance, due primarily to COVID-19 limitations and EI refusal to follow through on initiating treatment.

QIP: quality improvement project; N/A: not applicable; EI: eligible individual; NFP: Nurse Family Partnership; ITM: intervention tracking measure; UMC: University Medical Center; BMI: body mass index; SHINE: Support and Help in Nutrition and Exercise; NW: northwest; AOD: alcohol and other drugs; PCP: primary care provider; DHCP: delivering health care provider; ROSS: Recovery Organization of Support Specialists; SUD: substance use disorder; COVID-19: 2019 novel coronavirus.

Table 16: North Alabama Community Care QIP Summaries, 2020–2021

North Alabama Community Care QIP Summaries
QIP 1: Adverse Birth Outcomes Validation Summary: N/A (the project will not be completed until 12/31/2022)
Aim To decrease the rate of adverse birth outcomes in the Northeast Alabama region by managing maternal obesity and failed glucose tolerance test (GTT) during pregnancy, and to increase the amount of EIs with maternal obesity and failed GTTs that receive nutritional and healthy lifestyle counseling during their pregnancy. **Interventions in 2020/2021** • Provided nutritional counseling to pregnant EIs identified during their first prenatal visit as having a BMI of 30 or greater, and/or who failed their GTT. • Educated pregnant EIs with a BMI of 30 or greater on the benefits to the EI and unborn infant by participating in physician approved physical activities, smoking cessation, and breastfeeding.

North Alabama Community Care QIP Summaries
• Promoted inter-conception care by referring EIs with a BMI of 30 or greater and/or who failed their GTT to enrollment in Plan First services. **Performance Improvement Summary** There were no baseline data available for the 3 indicators associated with this project, and thus performance improvement from baseline to interim remeasurement cannot be determined. Nutritional counseling for EIs who failed their GTT increased from year 1 to year 2, indicating success in this area. Further, the percentage of EIs with a BMI of 30 or greater that were breastfeeding at the postpartum visit remained above 25% (with a high of 47% in Q1 of 2021).
QIP 2: Childhood Obesity Validation Summary: N/A (the project will not be completed until 12/31/2022)
Aim To prevent childhood obesity in the northeast region of Alabama, to improve the percentage of EIs 3-6 years of age with documentation of BMI in their medical record, and to improve the percentage of EIs 3–6 years of age with a BMI between 85% and 94% who receive nutritional and healthy lifestyle counseling. **Interventions in 2020/2021** • PCPs and pediatricians educated on the correct collection of BMI and reporting BMI on claims submissions. • PCP and pediatricians referred EIs 3–6 years of age with a BMI between 85%-94% to NACC for counseling. • Case management to assess EI readiness to change provided by NACC for EIs 3–6 years of age with a BMI between 85% and 94%. • Food boxes distributed for EIs 3–6 years of age with a BMI between 85% and 94% referred by 2 large pediatrician offices. Box distribution managed by dietician, community health workers, and Extension Services to focus on child nutrition, increasing physical activity, and reducing screen time. A pre- and post-questionnaire are being completed by those EIs accepting the box distribution to assess effectiveness of box contents. • Education provided by NACC maternity care coordinators to discuss the benefits of breastfeeding with first-time pregnant EIs. • First-time pregnant EIs identified as breastfeeding during the in-hospital care coordination visit received communication from NACC within 2 weeks of delivery to offer coordination with local lactation support services. **Performance Improvement Summary** The percentage of EIs with documentation of BMI in their medical record declined from baseline (2019) to interim remeasurement (2020), as did the percentage of EIs still breastfeeding upon postpartum visit. There was a decline as well in the percentage of EIs 3–6 years of age with a BMI between 85% and 94%, however this was a favorable decline. ITMs indicate that over the course of 2021 there was an increase in the percentage of EIs that were breastfeeding at their postpartum visit. Further, successful food box deliveries were observed throughout 2021, and the majority of EIs returned a questionnaire associated with this program (the results of which will be reviewed in 2022).
QIP 3: Substance Use Disorder Validation Summary: N/A (the project will not be completed until 12/31/2022)
Aim To decrease the rate of adverse health outcomes related to substance use disorders in the Northeast Alabama Medicaid population and increase the percentage of those who receive treatment. **Interventions in 2020/2021** • Hosted provider group training sessions and onsite education at providers' offices on the referral process to identify EIs with SUD. A conference on SUD was hosted by NACC in September 2020. • Incentivized physicians to become MAT-certified by reimbursing physicians for the time spent completing certification. • Provided brief intervention for EIs that were referred to NACC by providers, to educate them on the consequences of substance use and encourage substance use-free and healthy lifestyle choices.

North Alabama Community Care QIP Summaries
• Coordinated 8:00 a.m.–5:00 p.m. support with ROSS to address the support needs of EIs with a substance use disorder diagnosis and complete referrals to residential facilities for SUD treatment. **Performance Improvement Summary** 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, a very low percentage of EIs identified with SUD contacted ROSS for support. Of those EIs that providers had referred to NACC, an increasing percentage received brief intervention throughout 2021. The indicator (the percentage of EIs 13 years of age or older with a new episode of SUD receiving treatment) cannot be evaluated, given lack of baseline data.

QIP: quality improvement project; N/A: not applicable; GTT: glucose tolerance test; EI: eligible individual; BMI: body mass index; Q1: quarter 1; PCP: primary care provider; NACC: North Alabama Community Care; ITM: intervention tracking measure; SUD: substance use disorder; MAT: medication-assisted treatment; ROSS: Recovery Organization of Support Specialists.

IPRO's assessment of indicator performance from baseline (2019) to interim remeasurement (2020) was based on the following 3 categories (**Table 17**):

- Improvement in performance demonstrated (denoted by green highlight).
- Decline in performance demonstrated (denoted by red highlight).
- Unable to evaluate performance at this time, or performance remained constant (denoted by gray highlight).

Table 17 displays a summary of IPRO's improvement assessment for each project indicator by QIP topic by entity.

Table 17: Assessment of ACHN Entity QIP Indicator Performance

ACHN Entity	Indicator #	Indicator Description	Assessment of Performance, Baseline (2019) to Year 1 (2020)
QIP 1: Adverse Birth Outcomes			
ACN Mid-State	1	Percentage of live deliveries with low birth weight **Baseline: 9.7%; Interim: 11.3%; Target: 9.5%**	Decline in performance
ACN Southeast	1	Percentage of pregnant EIs who have a prenatal visit in the first trimester **Baseline: 64.9%; Interim: 76.5%; Target: 70.6%**	Improvement in performance demonstrated
	2	Percentage of live births weighing less than 2,500 grams **Baseline: 9.5%; Interim: 9.7%; Target: 9.1%**	Decline in performance
	3	Percentage of infants 0–15 months of age with 6 well-child visits **Baseline: 64.2%; Interim: 60.2%; Target: 65.0%**	Decline in performance
Gulf Coast Total Care	1	Percentage of live births weighing less than 2,500 grams **Baseline: 10.8%; Interim: 15.3%; Target: 9.3%**	Decline in performance
	2	Percentage of pregnant EIs that received prenatal care in the first trimester **Baseline: 68.9%; Interim: 52.6%; Target: 75.9%**	Decline in performance
	3	Percentage of EIs defined as critical risk who completed 37 weeks of gestation **Baseline: N/A; Interim: 52.8%; Target: 50.0%**	Unable to evaluate performance at this time
My Care Central	1	Percentage of students enrolled in targeted High School that completed the curriculum Making Proud Choices **Baseline: 0%; Interim: 84.0%; Target: 90.0%**	Improvement in performance
	2	Percentage of students who participate in Women's Health appointments at Behavioral Health Family Medicine Program and complete a screen **Baseline: 0%; Interim: 81.0%; Target: 90.0%**	Improvement in performance
My Care East	1	Percentage of pregnant women who smoke during pregnancy **Baseline: 26.4%; Interim: 15.4%; Target: 15.0%**	Improvement in performance
	2	Percentage of live births weighing less than 2,500 grams **Baseline: 8.8%; Interim: 7.5%; Target: 80.0%**	Improvement in performance
	3	Percentage of live births delivered on or between November 6 of the year prior to the MY and November 5 of the MY that had a postpartum visit 21–56 days after delivery **Baseline: 68.1%; Interim: 31.6%; Target: 72.9%**	Decline in performance
My Care Northwest	1	Percentage of live births delivered on or between Nov. 6 of the year prior to the MY and Nov. 5 of the MY that received a prenatal care visit in the first trimester, on the enrollment start date, or within 42 days of enrollment **Baseline: 61.2%; Interim: 55.8%; Target: 68.9%**	Decline in performance

ACHN Entity	Indicator #	Indicator Description	Assessment of Performance, Baseline (2019) to Year 1 (2020)
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: N/A; Interim: 90.6%; Target: 93.0%**	Unable to evaluate performance at this time
	2	Percentage of pregnant EIs that fail their GTT receiving nutritional and healthy lifestyle counseling **Baseline: N/A; Interim: 96.0%; Target: 98.0%**	Unable to evaluate performance at this time
	3	Percentage of pregnant EIs with a BMI greater than or equal to 30.0 at their first prenatal visit and/or EIs that fail their GTT enrolling in Plan First services after delivery **Baseline: N/A; Interim: 37.8%; Target: 50.0%**	Unable to evaluate performance at this time
QIP 2: Childhood Obesity			
ACN Mid-State	1	Percentage of annual BMI assessments completed for EIs 3–19 years of age **Baseline: 8.6%; Interim: 59.9%; Target: 70.0%**	Improvement in performance
	2	Percentage of EIs 3–6 years of age that had an annual well visit **Baseline: 61.1%; Interim: 52.7%; Target: 66.7%**	Decline in performance
	3	Percentage of EIs 7–11 years of age that had an annual well visit **Baseline: 74.9%; Interim: 42.4%; Target: 78.6%**	Decline in performance
	4	Percentage of EIs 3–11 years of age with diagnosis of overweight or obese **Baseline: 35.1%; Interim: 41.8%; Target: 34.1%**	Decline in performance
ACN Southeast	1	Percentage of EIs 3–6 years of age who had a well-child visit **Baseline: 61.6%; Interim: 58.3% ;Target: 76.3%**	Decline in performance
Gulf Coast Total Care	1	Percentage of EIs 3–17 years of age who have an annual BMI assessment completed **Baseline: 62.3%; Interim: 93.8%; Target: 95.0%**	Improvement in performance
	2	Percentage of EIs 7–11 years of age with a diagnosis code of overweight (ICD Z68.53) **Baseline: N/A; Interim: N/A; new in 2021 Target: 1% reduction**	Unable to evaluate performance at this time
	3	Percentage of EIs 7-11 years of age that had an annual PCP visit **Baseline: 89.1%; Interim: 63.4%; Target: 91.4%**	Decline in performance
My Care Central	1	Percentage of initiation of breastfeeding. Baby placed on the breast during hospital stay **Baseline: N/A; Interim: 67.6%; 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: 72.0%; Target: 59.1%**	Improvement in performance
	3	Percentage of increase in well child visits during first 15 months of life, 6 or more **Baseline: N/A; Interim: N/A; Target: 61.8%**	Unable to evaluate performance at this time
My Care East	1	Percentage of children 3–17 years of age who had an outpatient visit with a PCP or ob/gyn practitioner and had evidence of BMI documentation **Baseline: 6.7%; Interim: 69.2%; Target: 70.0%**	Improvement in performance

ACHN Entity	Indicator #	Indicator Description	Assessment of Performance, Baseline (2019) to Year 1 (2020)
	2	Percentage of children 3–17 years of age with a diagnosis of overweight or obese in East Region **Baseline: 1.6%; Interim: 2.99%; Target: 2.75%**	Decline in performance
My Care Northwest	1	Percentage of children 3–17 years of age who had a visit with PCP or ob/gyn practitioner and who had evidence of BMI documentation **Baseline: 11.7%; Interim: 62.7%; Target: 65.0%**	Improvement in performance
North Alabama Community Care	1	Percentage of EIs 3–6 years of age with documentation of BMI in their medical record **Baseline: 89.5%; Interim: 72.1%; Target: 73.0%**	Decline in performance
	2	Percentage of EIs 3–6 years of age with a BMI between 85% and 94% **Baseline: 16.0%; Interim: 14.7%; Target: 14.0%**	Improvement in performance
	3	Percentage of first-time pregnant EIs that are breastfeeding at postpartum visit **Baseline: 31.3%; Interim: 45.6%; Target: 46.0%**	Improvement in performance
QIP 3: Substance Use Disorder			
ACN Mid-State	1	Percentage of EIs age 18–64 with a new episode of AOD abuse or dependence who engaged in AOD treatment **Baseline: 1.4%; Interim: 12.5%; Target: 41.1%**	Improvement in performance
ACN Southeast	1	Percentage of EIs with an SUD diagnosis who receive treatment in measurement year **Baseline: 13.9%; Interim: 12.6%; Target: 14.5%**	Decline in performance
Gulf Coast Total Care	1	Percentage of EIs 18 years of age or older with new episode of AOD abuse or dependence who enroll in care coordination **Baseline: N/A; Interim: N/A; new in 2021 Target: 10.0%**	Unable to evaluate performance at this time
	2	Percentage of EIs 18 years of age or older with an OUD and first MAT prescription filled (no prior claim in past 60 days) and agreed to PEIR referral **Baseline: N/A; Interim: N/A; new in 2021 Target: 20.0%**	Unable to evaluate performance at this time
	3	Percentage of eligible providers who completed Opioid Use Disorder Educational Outreach and Survey and increased knowledge/understanding of Opioid Use Disorder, prescribing guidelines, treatment options and community resources **Baseline: N/A; Interim: N/A; new in 2021 Target: 50.0%**	Unable to evaluate performance at this time
My Care Central	1	Percentage of EIs with a SUD diagnosis who initiated SUD treatment within 14 days of diagnosis **Baseline: 32.2%; Interim: 32.3%; Target: 37.4%**	Performance remained consistent
	2	Percentage of EIs who initiated treatment and had two or more additional services within 30 days of initiation visit **Baseline: 2.9%; Interim: 3.6%; Target: 5.2%**	Improvement in performance

ACHN Entity	Indicator #	Indicator Description	Assessment of Performance, Baseline (2019) to Year 1 (2020)
My Care East	1	Percentage of beneficiaries 18 years of age or older with a new episode of AOD abuse or dependence who initiated treatment within 14 days of the diagnosis **Baseline: 33.1%; Interim: 33.5%; Target: 36.3%**	Improvement in performance
	2	Percentage of beneficiaries 18 years of age or older with a new episode of AOD abuse or dependence who initiated treatment and had 2 or more additional AOD services or MAT within 34 days of the initial visit **Baseline: 3.8%; Interim: 4.4%; Target: 6.4%**	Improvement in performance
My Care Northwest	1	Percentage of EIs 18 years of age or older with a new episode of AOD abuse or dependence who initiated treatment within 14 days of the diagnosis **Baseline: 41.0%; Interim: 41.1%; Target: 41.1%**	Performance remained constant
	2	Percentage of EIs 18 years of age or older with a new episode of AOD abuse or dependence who initiated treatment and had 2 or more additional AOD services or MAT within 34 days of the initial visit. **Baseline: 13.3%; Interim: 20.6%; Target: 20.6%**	Improvement in performance
North Alabama Community Care	1	Percentage of EIs 13 years of age or older with a new episode of SUD receiving treatment **Baseline: N/A; Interim: 4.6%; Target: 4.8%**	Unable to evaluate performance at this time

ACHN: Alabama Coordinated Health Network; QIP: quality improvement project; ACN: Alabama Care Network; EI: eligible individual; N/A: not available; MY: measurement year; GTT: glucose tolerance test; BMI: body mass index; ICD: International Classification of Diseases; 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; green: improvement in performance demonstrated; red: decline in performance demonstrated; gray: unable to evaluate performance at this time/performance remained constant.

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

Objectives

Per *42 CFR §438.358* a review must be conducted within the previous 3-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 2021 System Performance Review (SPR), to evaluate SFY 2021 (October 1, 2020–September 30, 2021).

Technical Methods of Data Collection and Analysis

The SPR was an assessment of ACHN entity compliance with the ACHN RFP, the ACHN Operations Manual, and *42 CFR Part 43*8. Each ACHN entity was assessed for its compliance with contractual requirements related to Care Coordination, EI Rights, EI Materials, EI Enrollment and 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 met 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 2021 SPR were reviewed in 2020 and deemed fully compliant. This does not indicate these requirements were in compliance for 2021, 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 (15) 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 5-file over-sample.

IPRO's assessment was conducted in alignment with the CMS *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 18**. 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 18: SPR Areas and Corresponding Materials Reviewed

Area	Document Review	File Review
Care Coordination	✓	✓
EI Materials/Rights/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 "non-compliant" were used for each element under review. Definitions of these review determinations are presented in **Table 19**.

Table 19: SPR Determination Definitions

Review Determination	Definition
Full	The entity has met or exceeded the requirement.
Partial	The entity had partially met the requirement.
Non-compliant	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 8 experienced IPRO compliance officers, clinical and non-clinical, 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 1-day video conference call with each entity, which included a review of elements in each of the review tools that scored less than 100% 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 was conducted in accordance with state standards.

Description of Data Obtained

To conduct the SFY 2021 SPR, IPRO utilized the SFY 2020 SPR findings to inform the deeming strategy. IPRO also utilized information contained within the ACHN entities policies and procedures, their information system 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 1 or more of the requirements reviewed during the 2021 SPR did not demonstrate full compliance. **Table 20** displays the ACHN entities' compliance determinations.

Table 20: 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	Partial	Partial	Partial	Partial	Partial	Partial	Partial
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	Partial	Partial	Partial	Partial	Partial	Partial
Provider selection	**438.214**	Provider Participation	Partial	Partial	Partial	Full	Full	Full	Full
Practice guidelines	**438.236**								
Grievance and appeal systems	**438.228**	Grievances	Full	Full	Full	Partial	Partial	Partial	Partial
Subcontractual relationships and delegation	**438.230**	Subcontracting	Partial	Partial	Partial	Partial	Partial	Partial	Partial
Health information systems	**438.242**	Health Information Management Systems	Partial	Partial	Partial	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: ACN Mid-State; ACNS: ACN 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

Details of this ACHN entity's performance are included in a separate report (*ACN Mid-State SPR Care Coordination Final Findings*).

Care Coordination

- All requirements were addressed in the ACN Mid-State's policies and procedures.
- Three (3) family planning files and 10 general care coordination files did not contain rationales for the selected interventions within the care plan.
- One (1) family planning file did not contain evidence of evaluation of the plan.
- One (1) family planning file did not contain evidence that the medical condition identified in the Health Risk and Psychosocial Assessment was documented in the care plan or task notes.
- One (1) family planning file did not contain evidence of education regarding STD prevention.
- One (1) general file demonstrated that the Health Risk and Psychosocial Assessment took place more than 5 business days from the date the screening was completed.

EI Rights/Materials/Enrollment

- Of the 52 requirements reviewed for ACN Mid-State, 32 were full, 2 were partial, and 18 were non-compliant. All partial and non-compliant review determinations reflected new requirements. ACN Mid-State incorporated this new language into policies/procedures and submitted for AMA review and approval in February 2022.
- There were 9 partial or non-compliant findings last year (2020) that were all found in full compliance in 2021.

Grievances

- Of the 9 requirements reviewed for ACN Mid-State, all were determined to be in full compliance.
- There were 4 partial findings last year (2020) that were all found in full compliance in 2021.
- All of the 10 files reviewed were attributed to complaints related to the EI's PCP/DHCP.

HIMS

- Of the 28 requirements reviewed for ACN Mid-State, 26 were full and 2 were partial. ACN Mid-State incorporated the language from the 2 (new) HIMS requirements into policies/procedures and submitted for AMA review and approval in February 2022.
- There was 1 partial requirement last year (2020) that was found in full compliance in 2021.

Provider Participation

- Of the 13 requirements reviewed for ACN Mid-State, 6 were full, 4 were partial, and 3 were not applicable. The partial determinations reflected new requirements. The not applicable determinations reflected language that was in the ACHN Operations Manual but not contained in the RFP and thus not subject to review. ACN Mid-State incorporated the new language into policies/procedures and submitted for AMA review and approval in February 2022.

Quality Management

- Of the 37 requirements reviewed for ACN Mid-State, 34 were full and 3 were partial. The partial determinations reflected requirements related to the QIPs. ACN Mid-State will work to engage a larger volume of EIs, analyze interventions to determine if they are adequately impacting their indicators, and seek to sustain interventions beyond the time period of the QIP.

Subcontracting

- Of the 8 requirements reviewed for ACN Mid-State, 1 was full, 6 were partial, and 1 was non-compliant. ACN Mid-State incorporated language into policies/procedures and submitted for AMA review and approval in February 2022, in response to the partial and non-compliant findings.

ACN Southeast

Details of this ACHN entity's performance are included in a separate report (*ACN Southeast SPR Care Coordination Final Findings*).

Care Coordination

- All requirements were addressed in ACN Southeast's policies and procedures.
- Four (4) family planning files did not contain evidence of education regarding STD prevention.
- One (1) family planning file did not contain evidence that the medical conditions identified in the Psychosocial Assessment were documented in care plan or task notes.
- One (1) family planning file and 3 general files did not contain rationales for the selected interventions within the care plan.
- One (1) family planning file did not contain evidence of 2 successful telephone calls over a 12-month period.
- One (1) general file did not contain evidence of a standardized depression screening or substance use screening.

EI Rights/Materials/Enrollment

- Of the 49 requirements reviewed for ACN Southeast, 29 were full, 2 were partial, and 18 were non-compliant. All partial and non-compliant review determinations reflected new requirements. ACN Southeast incorporated this new language into policies/procedures and submitted to AMA for review and approval in February 2022.
- There were 6 partial or non-compliant findings last year (2020) that were all found in full compliance in 2021.

Grievances

- Of the 8 requirements reviewed for ACN Southeast, all were determined to be in full compliance.
- There were 4 partial findings last year (2020) that were all found in full compliance in 2021.
- One (1) of the 17 files reviewed was attributed to dissatisfaction with the case manager or other PCCM-E staff. All others (16) were attributed to complaints related to the EI's PCP/DHCP.

HIMS

- Of the 28 requirements reviewed for ACN Southeast, 26 were full and 2 were partial. ACN Southeast incorporated the language from the 2 (new) HIMS requirements into policies/procedures and submitted for AMA review and approval in February 2022.
- There was 1 partial requirement last year (2020) that was found in full compliance in 2021.

Provider Participation

- Of the 13 requirements reviewed for ACN Southeast, 6 were full, 4 were partial, and 3 were not applicable. The partial determinations reflected new requirements. The not applicable determinations reflected language that was in the ACHN Operations Manual but not contained in the RFP and thus not subject to review. ACN Southeast incorporated the new language into policies/procedures and submitted for AMA review and approval in February 2022.

Quality Management

- Of the 37 requirements reviewed for ACN Southeast, 34 were full and 3 were partial. The partial determinations reflected requirements related to the QIPs. ACN Southeast will include rationales for each of their goals, analyze interventions to determine if they are adequately impacting their indicators, and seek to sustain interventions beyond the time period of the QIP.

Subcontracting

- Of the 8 requirements reviewed for ACN Southeast, 1 was full, 6 were partial, and 1 was non-compliant. ACN Southeast incorporated language into policies/procedures and submitted for AMA review and approval in February 2022 in response to the partial and non-compliant findings.

GCTC

Details of this ACHN entity's performance are included in a separate report (*GCTC SPR Care Coordination Final Findings*).

Care Coordination

- Of the 82 requirements reviewed for GCTC, 81 were full and 1 was partial. The partial determination reflected a requirement related to training of (and by) the social worker, pediatric nurse, and pharmacist who work with the children with medical complexity (CMC) population. GCTC indicated they will conduct additional CMC training within the 90 days following the SPR and maintain a record of attendance as well as content.
- One (1) family planning file demonstrated that EI consent took place 21 days after family planning risk screening tool was conducted.
- One (1) family planning file did not have medical conditions identified in the Health Risk and Psychosocial Assessment documented in the care plan or task notes.
- Three (3) family planning files, 4 general files, and 7 maternity files did not contain all 5 care plan components (assessment/identified needs, goals, interventions, rationales, and evaluation); all were missing rationales, and 1 was lacking an evaluation.
- In 1 family planning file, the care plan was closed due to inability to reach the EI (despite no documentation of outreach attempts to the EI). The goal was reviewed afterwards and considered "met", despite no evidence that interventions were ever executed. In this scenario, the care plan was evaluated but follow-up and monitoring did not occur.
- Five (5) family planning files did not contain evidence of a discussion with the EI on the prevention of STDs.
- One (1) family planning file did not contain evidence of a discussion with the EI on testicular self-exams.
- Five (5) family planning files did not meet the initial and follow-up encounters requirements (1 due to premature closing of the case after 1 documented attempt at outreach, and 4 due to the case being closed without any documented attempts of outreach).
- One (1) general file did not contain evidence that a letter was sent to inform the EI of conducting a health risk and psychosocial assessment (three attempts to contact EI within 30 days to conduct assessment, 1 must be a written letter).
- One (1) general file did not have care plan updated, despite the EI's change in condition.
- One (1) general file did not contain evidence of an MCT occurring within the specified timeframe (calendar months 7–12 and every 6 months thereafter).
- Four (4) maternity files did not contain an evaluation to determine the effectiveness of care plan to determine if goals were met/outcomes were desirable. One (1) maternity file demonstrated that the care plan was not reviewed or evaluated at the hospital delivery encounter.

EI Rights/Materials/Enrollment

- Of the 50 requirements reviewed for GCTC, 24 were full, 3 were partial, and 18 were non-compliant. All partial and non-compliant review determinations reflected new requirements. GCTC incorporated this new language into policies/procedures and submitted to AMA for review and approval in February 2022.
- There were 6 partial or non-compliant findings last year (2020) that were all found in full compliance in 2021.

Grievances

- Of the 9 requirements reviewed for GCTC, all were determined to be in full compliance.
- There were 4 partial findings last year (2020) that were all found in full compliance in 2021.
- Of the 24 files reviewed, 23 were attributed to complaints related to PCP/DHCP and 3 were attributed to dissatisfaction with the case manager (note 2 of these 3 cases were double counted, as they also contained complaints related to PCP/DHCP).

HIMS

- Of the 28 requirements reviewed for GCTC, 26 were full and 2 were partial. GCTC incorporated the language from the 2 (new) HIMS requirements into policies/procedures and submitted for AMA review and approval in February 2022.
- There was 1 partial requirement last year (2020) that was found in full compliance in 2021.

Provider Participation

- Of the 13 requirements reviewed for GCTC, 6 were full, 4 were partial, and 3 were not applicable. The partial determinations reflected new requirements. The not applicable determinations reflected language that was in the ACHN Operations Manual but not contained in the RFP and thus not subject to review. GCTC incorporated the new language into policies/procedures and submitted for AMA review and approval in February 2022.

Quality Management

- Of the 38 requirements reviewed for GCTC, 34 were full and 4 were partial. Three (3) partial determinations reflected requirements related to the QIPs, and 1 was related to the Medical Management Meeting (MMM) attendance by providers. GCTC will analyze interventions to determine if they are adequately impacting their indicators and carry out Plan-Do-Study-Act (PDSA) cycle testing, and then apply lessons learned to current interventions. Further, GCTC will engage providers through their website, weekly emails, and 1-on-1 calls to remind them of contractual obligation of MMM participation.

Subcontracting

- Of the 8 requirements reviewed for GCTC, 1 was full, 6 were partial, and 1 was non-compliant. GCTC incorporated language into policies/procedures and submitted for AMA review and approval in February 2022 in response to the partial and non-compliant findings. Further, the entity indicated they will add language to applicable subcontracts.

MCA-C

Details of this ACHN entity's performance are included in a separate report (*MCA-C SPR Care Coordination Final Findings*).

Care Coordination

- All requirements were addressed in the MCA-C policies and procedures.
- Two (2) family planning files, 10 general files, and 3 maternity files did not contain all 5 care plan components (assessment/identified needs, goals, interventions, rationales, and evaluation).
- Two (2) general files did not contain evidence of a standardized depression screen or substance use screen.

- Four (4) maternity files did not contain an evaluation to determine the effectiveness of the care plan to determine if goals were met/outcomes were desirable.
- One (1) maternity file did not have evidence of a first follow-up encounter (in the second or third trimester).
- Two (2) maternity files did not contain evidence of the inpatient delivery encounter.
- Three (3) maternity files did not contain evidence of successful follow-up encounters in the EI's care plan.

EI Rights/Materials/Enrollment

- Of the 45 requirements reviewed for MCA-C, 35 were full, 2 were partial, 3 were non-compliant, and 5 were not applicable. All partial and non-compliant review determinations reflected new requirements. MCA-C indicated that this new language will be incorporated into policies/procedures and submitted to AMA for review and approval in April 2022.

Grievances

- Of the 5 requirements reviewed for MCA-C, 4 were full and 1 was partial. MCA-C will update the grievance form on their website to include the various types of complaints that can be filed.
- Of the 9 files reviewed, all were attributed to complaints related to PCPs/DHCPs.

HIMS

- Of the 28 requirements reviewed for MCA-C, all were in full compliance.
- There was 1 partial requirement last year (2020) that was found in full compliance in 2021.

Provider Participation

- Of the 13 requirements reviewed for MCA-C, 10 were full and 3 were not applicable. The not applicable determinations reflected language that was in the ACHN Operations Manual but not contained in the RFP and thus not subject to review.

Quality Management

- Of the 38 requirements reviewed for MCA-C, 34 were full and 4 were partial. Three (3) partial determinations reflected requirements related to the QIPs, and 1 was related to the MMM attendance by providers. MCA-C will re-evaluate their adverse birth outcome indicators as well as their goals for their childhood obesity project. Further, the entity will incorporate QIP requirement language into their policy and continue to work with providers to encourage participation in MMMs (by evaluating barriers and offering a recorded "make-up" session).

Subcontracting

- Of the 8 requirements reviewed for MCA-C, 5 were full and 3 were partial. MCA-C indicated that contract requirements will be incorporated policies/procedures and submitted for AMA review and approval in April 2022.

MCA-E

Details of this ACHN entity's performance are included in a separate report (*MCA-E SPR Care Coordination Final Findings*).

Care Coordination

- All requirements were addressed in the MCA-E policies and procedures.
- One (1) family planning file did not contain a care plan.
- Two (2) family planning files, 9 general files, and 1 maternity file did not contain all 5 care plan components (assessment/identified needs, goals, interventions, rationales, and evaluation).
- One (1) family planning file did not contain evidence of the evaluation process (given that there were no scheduling and education updates).

- Two (2) family planning files did not contain documentation of successful telephone calls or follow-up encounters.
- One (1) general file did not contain evidence of a standardized depression screen.
- One (1) general file contained a care plan that did not address all of the EI's prioritized physical or mental health concerns through formal interventions and/or referrals.
- One (1) general file did not contain evidence of an MCT invitation (this individual was high risk with frequent hospitalizations).
- One (1) general file did not contain evidence of an encounter between the second and third calendar months.
- One (1) general file did not contain evidence of monthly contacts/encounters (this individual was high risk).
- One (1) general file did not contain evidence of documentation of any encounter during calendar months 7–12 (this individual was high risk).

EI Rights/Materials/Enrollment

- Of the 45 requirements reviewed for MCA-E, 35 were full, 2 were partial, 3 were non-compliant, and 5 were not applicable. All partial and non-compliant review determinations reflected new requirements. MCA-E indicated that this new language will be incorporated into policies/procedures and submitted to AMA for review and approval in April 2022.

Grievances

- Of the 5 requirements reviewed for MCA-E, 4 were full and 1 was partial. MCA-E will update the grievance form on their website to include the various types of complaints that can be filed.
- Of the 6 files reviewed, 1 was attributed to complaints related to the case manager, and 5 were attributed to complaints related to the EI's PCP/DHCP.

HIMS

- Of the 28 requirements reviewed for MCA-E, all were in full compliance.
- There was 1 partial requirement last year (2020) that was found in full compliance in 2021.

Provider Participation

- Of the 13 requirements reviewed for MCA-E, 10 were full and 3 were not applicable. The not applicable determinations reflected language that was in the ACHN Operations Manual but not contained in the RFP and thus not subject to review.

Quality Management

- Of the 38 requirements reviewed for MCA-E, 36 were full and 2 were partial. One (1) partial determination reflected a QIP-related requirement, and 1 was related to the MMM attendance by providers. MCA-E will incorporate QIP requirement language into their policy and continue to work with providers to encourage participation in MMMs (by evaluating barriers and offering a recorded "make-up" session).

Subcontracting

- Of the 8 requirements reviewed for MCA-E, 1 was full and 7 were partial. MCA-E indicated that contract requirements will be incorporated policies/procedures and submitted for AMA review and approval in April 2022. Further, the entity indicated that contract requirements would be incorporated within the non-compliant subcontract once the term of that contract was up.

MCA-NW

Details of this ACHN entity's performance are included in a separate report (*MCA-NW SPR Care Coordination Final Findings*).

Care Coordination

- All requirements were addressed in the MCA-NW policies and procedures.
- One (1) family planning file did not contain a care plan.
- Two (2) family planning files, 7 general files, and 2 maternity files did not contain all 5 care plan components (assessment/identified needs, goals, interventions, rationales, and evaluation).
- One (1) family planning file did not contain evidence of the evaluation process (given that there were no scheduling and education updates).
- One (1) family planning file did not contain documentation of successful telephone calls or follow-up encounters.
- One (1) general file did not contain evidence of medication reconciliation.
- Two (1) general files did not contain evidence that the care plan was updated based upon a change in EI's needs (health status, needs, caregiver status, health care event, etc.) within the expected 90-day time period.
- Four (4) general files did not contain evidence that the calendar month 0–1 encounters were met.
- Three (3) general files did not contain evidence that the calendar month 2–3 encounters were met.
- Two (2) general files did not contain evidence that the calendar month 4–6 encounters were met.
- Four (4) general files did not contain evidence that the MCT was conducted in the required 60-day time period for high-risk EIs.

EI Rights/Materials/Enrollment

- Of the 45 requirements reviewed for MCA-NW, 35 were full, 2 were partial, 3 were non-compliant, and 5 were not applicable. All partial and non-compliant review determinations reflected new requirements. MCA-NW indicated that this new language will be incorporated into policies/procedures and submitted to AMA for review and approval in April 2022.

Grievances

- Of the 5 requirements reviewed for MCA-NW, 4 were full and 1 was partial. MCA-NW will update the grievance form on their website to include the various types of complaints that can be filed.
- Of the 18 files reviewed, all were attributed to complaints related to the EI's PCP/DHCP, and 1 was also attributed to denial of care coordination services.

HIMS

- Of the 28 requirements reviewed for MCA-NW, all were in full compliance.
- There was 1 partial requirement last year (2020) that was found in full compliance in 2021.

Provider Participation

- Of the 13 requirements reviewed for MCA-NW, 10 were full and 3 were not applicable. The not applicable determinations reflected language that was in the ACHN Operations Manual but not contained in the RFP and thus not subject to review.

Quality Management

- Of the 38 requirements reviewed for MCA-NW, 34 were full and 4 were partial. Three (3) partial determinations reflected QIP-related requirements, and 1 was related to the MMM attendance by providers. MCA-NW will incorporate QIP requirement language into their policy, continue to track the progress of interventions (adjusting those not having the intended impact), and continue to build on

successful interventions. Further, the entity will continue to work with providers to encourage participation in MMMs (by evaluating barriers and offering a recorded "make-up" session).

Subcontracting

- Of the 8 requirements reviewed for MCA-NW, 1 was full and 7 were partial. MCA-NW indicated that contract requirements will be incorporated policies/procedures and submitted for AMA review and approval in April 2022. With regard to the 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

Details of this ACHN entity's performance are included in a separate report (*NACC SPR Care Coordination Final Findings*).

Care Coordination

- Of the 83 requirements reviewed for NACC, 82 were full and 1 was partial. The partial determination reflected a requirement related to training of (and by) the social worker, pediatric nurse, and pharmacist who work with the children with medical complexity (CMC) population. NACC indicated they will conduct additional CMC training in March 2022, which will become part of the annual training going forward.
- One (1) family planning file did not contain evidence that a need identified during the psychosocial assessment was addressed in the care plan.
- Three (3) family planning files, 6 general files, and 11 maternity files did not contain all 5 care plan components (assessment/identified needs, goals, interventions, rationales, and evaluation).
- In several maternity files, the task notes identified a high BMI for the EI, with a referral to an RD; however, this was not included in the care plan. This requirement involves addressing all EI needs, and as the entity is already identifying a potential issue and addressing it with a referral/consultation, this is an opportunity to enhance care plans by including this item for tracking.
- One (1) maternity file did not contain evidence of the care plan being reviewed or evaluated at each encounter with the EI.
- Three (3) maternity files did not contain evidence of a revised/updated care plan based on a change in EIs' needs.
- One (1) maternity file demonstrated a missed encounter within the second trimester.
- One (1) maternity file demonstrated a missed encounter within the third trimester.
- Three (3) maternity files demonstrated an incomplete assessment and risk stratification score without justification.

EI Rights/Materials/Enrollment

- Of the 45 requirements reviewed for NACC, 43 were full, 1 was partial, and 1 was non-compliant. The partial and non-compliant review determinations reflected new requirements. NACC indicated that this new language has been incorporated into policies/procedures. Further, they have received approval by Medicaid to post information related to the non-compliant requirement (inform EIs that information is available in paper form without charge, and that the entity will provide this information to the EI, per request, within 5 days) to NACC's website.
- There were 2 partial requirements last year (2020) that were found in full compliance in 2021.

Grievances

- Of the 5 requirements reviewed for NACC, 4 were full and 1 was partial. NACC has updated the grievance form on their website to include the various types of complaints that can be filed and has submitted to AMA for approval.
- Of the 25 files reviewed, all were attributed to complaints related to the EI's PCP/DHCP, and 1 was also attributed to denial of care coordination services.

HIMS

- Of the 28 requirements reviewed for NACC, all were in full compliance.

Provider Participation

- Of the 13 requirements reviewed for NACC, all were in full compliance.

Quality Management

- Of the 38 requirements reviewed for NACC, 34 were full, 3 were partial, and 1 was not applicable. Two (2) partial determinations reflected QIP-related requirements and 1 was related to the MMM attendance by providers. NACC will continue to track the progress of interventions, adjusting those not having the intended impact and/or developing new interventions. Regarding the MMM, NACC has implemented a "participation" letter that will be emailed each quarter to each PCP practice. This letter outlines their attendance at the MMMs, their cost effectiveness results, their quality measure results and a copy of their score cards.
- There was 1 partial requirement last year (2020) that was found in full compliance in 2021.

Subcontracting

- Of the 8 requirements reviewed for NACC, 1 was full, 2 were partial, and 5 were non-compliant. NACC indicated that contract requirements have been incorporated into policies/procedures and that any subcontract that was missing requirement language would be submitted to their legal department for review and modification.

V. Validation of Performance Measures

Objectives

AMA selects ACHN performance measures (PMs) to assess access to care, effectiveness of care, and use of services. PM validation for reporting year 2021 covered measurement year 2020 (January 1, 2020, to December 31, 2020). 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 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 the CMS protocol *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 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 file includes 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, and 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 from AMA the following documentation related to PM calculation:

- Information Systems Capabilities Assessment (ISCA);
- AMA source code for the measures;
- member-level detail files;
- preliminary rates;
- response to IPRO findings to preliminary rates; and
- final rates.

In addition, IPRO received an ISCA worksheet completed by AMA, which was organized into the following 5 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 Information Systems Capabilities Assessment (ISCA) of its Information Systems. IPRO conducted the ISCA in accordance with *Appendix A* of the CMS EQR Protocols. 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 the CY 2020 period, IPRO assigned measures to 1 or more of the 3 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	--	--
CAP-CH (Children and Adolescents' Access to Primary Care Practitioners)	--	--	X
Timeliness of Prenatal Care	--	X	--
Initiation and Engagement of Treatment for Alcohol and Other Drugs (Initiation)	X	X	--
Initiation and Engagement of Treatment for Alcohol and Other Drugs (Continuation)	X	X	--

ACHN: Alabama Coordinated Health Network; BMI: body mass index.

Table 22 displays the performance measures for MY 2020 for all entities and the percentile achieved for the NCQA 2020 benchmark.

In the domain of **quality**, the statewide average was above the 90th percentile for Asthma Medication Ratio (Child and Adult). The statewide average was below the 10th percentile for Antidepressant Medication Management and Initiation and Engagement of Treatment for AOD (Initiation and Continuation phases).

In the domain of **timeliness**, the statewide average was between the 10th and 25th percentile for Well-Child Visits in the First 15 Months of Life, and below the 10th percentile for Timeliness of Prenatal Care.

In the domain of **access**, the statewide average was above the 90th percentile for Child BMI Assessment. The statewide average was below the 10th percentile for Cervical Cancer Screening, and Child Access to Care (12–24 months of age and 25 months to 6 years of age). The statewide average was between the 10th and 25th percentile for Child Access to Care (12–19 years of age), and between the 25th and 50th percentile for Adult BMI Assessment and Child Access to Care (7–11 years of age).

Table 22: ACHN Performance Measures – MY 2020

Measure	ACNM	ACNS	GCTC	MCA-C	MCA-E	MCA-NW	NACC	ACHN 2020 Statewide Average	ACHN 2020 vs. NCQA 2020 Benchmark Percentile
Well-Child Visits in the First 15 Months of Life (HEDIS)	50.2%	60.2%	50.9%	56.7%	59.6%	49.3%	57.0%	54.6%	10th–25th
Child BMI Assessment (HEDIS)	92.0%	94.9%	93.8%	92.9%	95.6%	91.9%	94.7%	93.7%	> 90th
Adult BMI Assessment (HEDIS)	85.9%	86.5%	86.2%	87.7%	90.7%	89.2%	88.7%	87.8%	25th–50th
Cervical Cancer Screening[1] (HEDIS)	45.3%	42.0%	44.2%	43.7%	37.7%	40.4%	38.7%	41.9%	< 10th
Asthma Medication Ratio (Child) (HEDIS)	82.5%	86.8%	82.3%	87.6%	89.4%	84.0%	89.4%	86.2%	> 90th
Asthma Medication Ratio (Adult) (HEDIS)	67.1%	81.5%	75.2%	75.0%	76.1%	73.6%	78.0%	75.1%	> 90th
Antidepressant Medication Management (HEDIS)	25.8%	23.7%	23.9%	22.5%	26.1%	25.0%	26.4%	24.8%	< 10th
Live Births Less Than 2,500 Grams (CMS)	12.1%	10.6%	12.3%	12.2%	8.2%	11.4%	11.3%	11.2%	N/A
CAP-CH (HEDIS)	79.5%[2]	89.7%[2]	87.2%[2]	89.2%[2]	91.6%[2]	89.1%[2]	88.5%[2]	87.6%[2]	< 10th
	73.3%[3]	84.7%[3]	76.7%[3]	80.4%[3]	88.7%[3]	81.0%[3]	83.2%[3]	80.9%[3]	< 10th
	82.2%[4]	91.9%[4]	86.0%[4]	87.6%[4]	94.5%[4]	88.8%[4]	90.7%[4]	88.6%[4]	25th–50th
	80.9%[5]	90.5%[5]	84.5%[5]	84.4%[5]	91.3%[5]	86.4%[5]	88.1%[5]	86.4%[5]	10th–25th
Timeliness of Prenatal Care (HEDIS)	65.7%	70.4%	64.2%	51.6%	53.5%	61.7%	55.9%	60.5%	< 10th
Initiation and Engagement of Treatment for Alcohol and Other Drugs (Initiation) (HEDIS)	33.6%	37.2%	39.7%	37.1%	29.2%	42.4%	41.4%	36.7%	< 10th
Initiation and Engagement of Treatment for Alcohol and Other Drugs (Continuation) (HEDIS)	3.6%	6.4%	5.0%	4.3%	3.1%	7.5%	4.0%	4.7%	< 10th

[1] There was change in the exclusion criteria was made following performance measure validation, however we feel the effect on the rate is minimal.

[2] Rate reflects the percentage of members 12–24 months with PCP visit.

[3] Rate reflects the percentage of members 25 months–6 years with PCP visit.

[4] Rate reflects the percentage of members 7–11 years with PCP visit.

[5] Rate reflects the percentage of members 12–19 years with PCP visit.

ACHN: Alabama Coordinated Health Network; MY: measurement year; ACNM: ACN Mid-State; ACNS: ACN 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; CMS: Centers for Medicare and Medicaid Services; CAP-CH: Children and Adolescents' Access to Primary Care Practitioners; PCP: primary care provider.

VI. MCP Responses to the Previous EQR Recommendations

Title 42 CFR § 438.364 External quality review results (a)(6) require each annual technical report include "an assessment of the degree to which each MCO, PIHP, PAHP, or PCCM entity has effectively addressed the recommendations for QI made by the EQRO during the previous year's EQR." **Table 23–Table 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 23 displays ACN Mid-State's progress related to the *RY 2021 Annual External Quality Review Technical Report,* as well as IPRO's assessment of ACN Mid-State's response.

Table 23: 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]
Capture intervention tracking measures for each intervention across the 3 QIP topic areas.	ACN Mid-State developed ITMs across each active intervention throughout CY 2021, which were reviewed by IPRO during PIP validation and found to be appropriate measures for tracking intervention progress. All recommendations were received and acted upon. Mid-State has developed a team for each QIP to increase performance improvement and reach a higher volume of Medicaid EIs.	Addressed
Update policies to include verbiage related to their health education activities and targeted implementation dates at a frequency and format determined by the Agency.	Policy updated to include verbiage related to health education activities, targeted implementation dates at a frequency, and format determined by the Agency and resubmitted in April 2021 after Medicaid and IPRO recommended changes. Policy officially approved by Medicaid 4/22/21.	Addressed
Update policies to include verbiage related to the review and approval by the Agency of EI materials.	Policy updated to include verbiage related to the review and approval by the Agency of the EI materials and resubmitted in April 2021 after Medicaid and IPRO recommended changes. Policy officially approved by Medicaid 4/22/21.	Addressed
Update policies to include verbiage related to addressing updates from the Agency.	Policy updated to include verbiage related to addressing updates from the Agency and resubmitted in April 2021 after Medicaid and IPRO recommended changes. Policy officially approved by Medicaid 4/22/21.	Addressed
Revise Policy ACHN 015 to include language that addresses incorporating their website to the Agency or State website.	Policy updated with language that addresses incorporating website to the Agency or State website and resubmitted in April 2021 after Medicaid and IPRO recommended changes. Policy officially approved by Medicaid 4/22/21.	Addressed
Revise EI Materials policy to include language that addresses the use of electronic methods of communication.	Policy updated with language to address the use of electronic methods of communication and resubmitted in April 2021 after Medicaid and IPRO recommended changes. Policy officially approved by Medicaid 4/22/21.	Addressed
Revise Policy ACHN 015 to include website language. ACN Mid-State should also review the formalized	Policy updated to include website language and resubmitted in April 2021 after Medicaid and IPRO recommended changes. Policy officially approved by Medicaid 4/22/21.	Addressed

Recommendation for ACN Mid-State	ACN Mid-State Response/Actions Taken	IPRO Assessment of Entity Response[1]
process to ensure regular updates.		
Revise Policy ACHN 015 to include language that addresses incorporating their website to the Agency or State website.	Policy updated to include language that addresses incorporating website to the Agency or State website and resubmitted in April 2021 after Medicaid and IPRO recommended changes. Policy officially approved by Medicaid 4/22/21.	Addressed
Add language indicating that "failure to input Maternity data and/or Care Coordination documentation for each EI with a 95% accuracy rate into the Health Information System/Database will result in sanctions" to their HIMS policy.	Policy updated to include language "failure to input Maternity data and/or Care Coordination documentation for each EI with a 95% accuracy rate into the Health Information System/Database will result in sanctions" and resubmitted in April 2021 after Medicaid and IPRO recommended changes. Policy officially approved 4/14/21.	Addressed
Add language to HIMS policy indicating that the HIMS system must provide the Agency a monthly extract of data in the format prescribed by the Agency.	Policy updated to include language that the HIMS system will provide the Agency with a monthly extract of data in the format prescribed by the Agency and resubmitted in April 2021 after Medicaid and IPRO recommended changes. Policy officially approved 4/14/21.	Addressed
Revise complaints and grievances policy and procedure to reflect the activities outlined in the requirement pertaining to corrective action plans.	Policy updated to reflect corrective action plan language and resubmitted in April 2021 after Medicaid and IPRO recommended changes. Policy officially approved 4/22/21.	Addressed
Ensure that high-risk face-to-face postpartum visits are executed, where applicable. Additionally, follow-up visits in the second/third trimester should be implemented for EIs.	Implemented weekly high-risk postpartum visit report in January of 2021 to help monitor when visits are due. Report includes all EIs due for a postpartum visit. It identifies the primary care coordinator as well as the date range (28–56-day mark) for completing the visit. Implemented a monthly follow-up visit report in to help monitor when 2nd and 3rd trimester visits are due. It shows the EDC, initial assessment, and 1st and 2nd visit completed dates. Supervisors review this report and manipulate in way that their care coordinators will know what maternity encounters are due for each EI.	Addressed
Conduct testing to ensure that the new calculation for psychosocial assessment score and risk stratification will fulfill the requirement related to maternal health risk identification strategy.	Medicaid required updates to maternity forms in 2021. Deployment of these updates was released in May of 2021 after Jira testing which included testing of automated score calculation of Psychosocial Risk Assessment Worksheet totals. Option was added to manually adjust risk assessment stratification of low or high dependent upon patient circumstances and clinical judgement.	Addressed

Recommendation for ACN Mid-State	ACN Mid-State Response/Actions Taken	IPRO Assessment of Entity Response[1]
Ensure that internal training provided to ACN Mid-State's maternity staff encompasses identification of maternal health risks as well as how to address these risks.	Formal training was provided to the maternity team in both March 2021 and June 2021 which included emphasis on identifying maternal health risks as well as incorporating appropriate goals and interventions to address those risks. Additional training was also provided regarding when and how to refer to General Care Coordination when significant needs are identified, and higher frequency of follow-up is necessary for EI.	Addressed
Ensure that EI-specific risks are addressed in care plans.	Formal training was provided to the maternity team in both March 2021 and June 2021 which included emphasis on identifying maternal health risks as well as incorporating appropriate goals and interventions to address those risks. Leadership also performs monthly chart audits to ensure risks are being addressed in care plans.	Addressed
Bolster care coordination by including other providers and external agencies whenever warranted, to meet the requirement that the maternal health care plan must include the PCPs/community agencies as appropriate.	Formal training was provided to the maternity team in both March 2021 and June 2021 regarding when and how to refer to General Care Coordination when significant needs are identified and to assist in establishing with PCPs and community resource agencies to ensure Social Determinants of Health are addressed timely. The Social Determinants of Health Screening has also been incorporated into our Infant Mortality QIP.	Addressed
Ensure that EIs eligible for a delivery encounter receive a delivery visit or missed delivery visit within 20 calendar days.	Implemented a delivery visit report in January of 2021 that is sent out every Wednesday. It helps to help monitor when visits are due and lists all EIs with a past EDC or EDC in the next 2 weeks that have not had a delivery visit completed. It also lists if attempts for the visit have been made. Leadership also performs monthly chart audits to ensure appropriate visits are being performed.	Addressed
Ensure that counseling is conducted appropriately for contraception and family planning services, and postpartum care.	Mid-State has created 2 family planning only care coordinator positions and provided formal training in both March 2021 and June 2021. Training focused on ensuring the priority 1 items were addressed with all EIs. Also provided training for Maternity EIs on offering and enrolling (when EIs accept) into Family Planning Care Coordination at delivery or postpartum visit for high-risk Maternity EIs. Mid-State has incorporated the Medicaid approved forms for each visit into our HIMS and use those to guide the education at each visit. The Follow-Up Visit Form, the Delivery Visit Form and the High-Risk Postpartum Home Visit Form includes education on these topics.	Addressed

[1] IPRO assessments are as follows: **addressed**: MCP's quality improvement (QI) response resulted in demonstrated improvement; **partially addressed**: MCP's QI response was appropriate but improvement was not yet observed; **remains an opportunity for improvement**: MCP'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; CY: calendar year; EI: eligible individual; ACHN: Alabama Coordinated Health Network; HIMS: health information management system; PCP: primary care provider; EDC: estimated date of confinement.

ACN Southeast Response to Previous EQR Recommendations

Table 24 displays ACN Southeast's progress related to the *RY 2021 Annual External Quality Review Technical Report,* as well as IPRO's assessment of ACN Southeast's response.

Table 24: ACN Southeast Response to Previous EQR Recommendations

Recommendation for ACN Southeast	ACN Southeast Response/Actions Taken	IPRO Assessment of Entity Response[1]
Increase the distribution of MyPlate educational materials and expand the percentage of schools that received gardening materials.	ACNS expanded the number of schools from 45 schools in calendar year 2020, to 53 schools in the first 2 quarters in 2021. In the third quarter, we expanded the number of elementary schools/head start programs to 82 which represents all of our thirteen counties. In 2020 ACNS distributed MyPlate educational materials to eligible individuals who were enrolled into care coordination. In the second quarter of 2021 we began providing nutritional and physical activity to EIs ages 3-6 with BMI > 85th percentile regardless of enrollment status.	Addressed
Update EI Materials policies to include missing language related to using electronic methods of communication with an EI if the EI has provided an email address to the PCCM-E and has not requested to not receive electronic methods of communication.	EI policies were to include missing language related to using electronic methods of communication with an EI if the EI has provided an email address to the PCCM-E and has not requested to receive electronic methods of communication. Alabama Medicaid approved the updated policy.	Addressed
Ensure that all planned health education activities, along with implementation dates, are provided to the Agency and that their policies indicate they are at a frequency and format determined by the Agency.	ACNS updated the policy to include the verbiage and Alabama Medicaid approved the updated policy.	Addressed
Ensure that language related to the Agency or State standards for website structure, coding, and presentation is incorporated into their policies and procedures.	ACNS updated our policy to include this verbiage. Alabama Medicaid approved the updated policy	Addressed
Ensure that language related to approval of website content, and that this content is accurate, current, and designed in a way that EIs and providers can easily locate information, is	ACNS updated our policy to include this verbiage. Alabama Medicaid approved the updated policy.	Addressed

Recommendation for ACN Southeast	ACN Southeast Response/Actions Taken	IPRO Assessment of Entity Response[1]
incorporated into their policies and procedures.		
Incorporate language into HIMS policies that reflects the requirement that failure to input maternity data and/or care coordination documentation for each EI with a 95% accuracy rate into the Health Information System/Database will result in sanctions.	ACNS policy to include this verbiage. Alabama Medicaid approved the updated policy.	Addressed
Ensure the reporting extract requirement is added to their HIMS policy.	ACNS updated our policy to include this verbiage. Alabama Medicaid approved the updated policy.	Addressed
Revise its complaints and grievances policy and procedure to reflect the activities outlined in the requirement pertaining to corrective action plans.	ACNS updated our policy to include this verbiage. Alabama Medicaid approved the updated policy.	Addressed
Ensure that risk assessments are conducted within the contractually mandated timeframes.	ACNS utilizes a report called Southeast Screening Contact Report that enables supervisors to determine when staff members are not reaching out to EIs in a timely manner to complete assessments. This report is reviewed twice a month to determine compliance from day of screening to first successful contact. Supervisors complete at least 5 audits on each staff member each month for timeliness compliance. Supervisors meet one-on-one with each staff member not in compliance with timeliness to provide coaching.	Addressed
Ensure that additional assessments (related to PHQ, substance abuse screening, etc.) are conducted appropriately for each EI according to contract requirements.	ACNS supervisors conduct at least 5 audits each month on all staff members to determine compliance with additional assessment such as PHQ (Patient Health Questionnaire) and substance use screening. Supervisors meet with each employee monthly to review audit findings and will coach employees that are deficient. ACNS is working on a report that will be generated weekly that will determine EIs that have an assessment completed without a PHQ or substance use screen completed. This is still in progress.	Partially addressed: 1 general care coordination file did not have evidence of a PHQ or substance use screening conducted
Ensure that high-risk face-to-face postpartum visits are executed, where applicable. Additionally, follow-up visits in the second/third trimester should be implemented for EIs.	For the high-risk post-partum, ACNS utilizes a weekly report called Post-Partum (PP) Visit Needed Report. This report includes all EIs that are in the timeframe of needing a PP visit. The report is sent to each care coordinator to give them the 28-day mark and the 56-day mark, so each care coordinator knows when the visit is due. EIs remain on the report until the visit is completed. For the follow-up visit in the second and third trimester, ACNS utilizes a report called MCC Report Southeast that shows the EDC, initial assessment, first and second visit completed dates.	Addressed

Recommendation for ACN Southeast	ACN Southeast Response/Actions Taken	IPRO Assessment of Entity Response[1]
	Supervisor reviews this report monthly and sends to care coordinators so they will know they have a maternity encounter coming up. ACNS supervisors also audit at least 5 charts a month for each care coordinator to determine compliance with follow-up encounters. Supervisors meet with each employee monthly to review audit findings and will coach employees that are deficient in follow-up encounters.	
Ensure that maternal health screenings are conducted in a timely manner	ACNS has trained our care coordinators to complete the maternal health screen the first time they talk to EI on the phone (even if they don't do the assessment the same day). Supervisors check care coordinators' screen pending lists weekly and review cases to ensure screening form is started if contact has been made with EI. ACNS supervisors conduct at least 5 audits each month on all staff members to determine compliance with timeliness of maternal health screenings. Supervisors meet with each employee monthly to review audit findings and will coach employees that are deficient in timelines of maternal health screenings.	Addressed
Ensure that all aspects of an EI's medical history are addressed to inform a thorough, patient-/caregiver-centered care plan.	ACNS trains care coordinators to enter a care plan goal for each medical condition identified at time of assessment or address the condition in task notes. ACNS utilizes a post-partum depression report to identify those EIs with a history of post-partum depression that does not have an associated goal. ACNS supervisors conduct at least 5 audits each month on all staff members to determine compliance with the patient/caregiver-centered care plan including medical history. Supervisors meet with each employee monthly to review audit findings and will coach employees that are deficient in addressing medical history in the person-centered care plan.	Partially addressed: 1 family planning file demonstrated that EI's medical conditions were not addressed in their care plan
Ensure that EIs eligible for a delivery encounter should receive a delivery visit or missed delivery visit within 20 calendar days.	ACNS utilizes a delivery-visits needed report that is sent out every Wednesday. It lists all EIs with a past EDC or EDC coming up in the 2 weeks that have not had a delivery visit completed. It also lists if attempts for the visit have been made. ACNS supervisors conduct at least 5 audits each month on each staff member to determine compliance with delivery encounters. Supervisors meet with each employee monthly to review audit findings and will coach employees that are deficient in completion of delivery encounters.	Addressed
Ensure that counseling on contraception and family planning services, and appropriate postpartum care, is conducted appropriately for maternal health care coordination.	ACNS has incorporated the Medicaid approved forms for each visit into our HIMS and use those to guide the education at each visit. The follow up visit form, the delivery visit form and the high-risk postpartum home visit form includes education on these topics. ACNS also requires care plans to include goals on all maternity cases to include the post-partum goal and birth control goal.	Addressed
Ensure that a complete medication list is included in each EI's record.	ACNS utilizes the No Med List Report that identifies those high-risk maternity EIs with no medication list. This report is distributed to staff if a deficiency is noted.	Addressed

Recommendation for ACN Southeast	ACN Southeast Response/Actions Taken	IPRO Assessment of Entity Response[1]
	ACNS supervisors conduct at least 5 chart audits each month on each care coordinator to determine compliance with the creation on a medication list. Supervisors meet with each employee monthly to review audit finding and will coach employees that are deficient in completion of medication list.	

[1] IPRO assessments are as follows: **addressed**: MCP's quality improvement (QI) response resulted in demonstrated improvement; **partially addressed**: MCP's QI response was appropriate but improvement was not yet observed; **remains an opportunity for improvement**: MCP'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; EI: eligible individual; BMI: body mass index; PCCM-E: primary care case management entity; HIMS: health information management system; PHQ: Patient Health Questionnaire; PP: post-partum; EDC: estimated date of confinement.

Gulf Coast Total Care Response to Previous EQR Recommendations

Table 25 displays GCTC's progress related to the *RY 2021 Annual External Quality Review Technical Report*, as well as IPRO's assessment of GCTC's response.

Table 25: GCTC Response to Previous EQR Recommendations

Recommendation for GCTC	GCTC Response/Actions Taken	IPRO Assessment of Entity Response[1]
Conduct root-cause analysis to identify barriers to EI compliance with biomonitoring.	The Quality Committee reviewed reasons that EIs reported as barriers to biomonitoring compliance. The frequency of calls was cited as a barrier. Changes were made to the frequency of phone calls to encourage compliance. EI compliance with biomonitoring has improved. Maternity care coordinators are more deliberate when explaining biomonitoring to EIs during the psychosocial assessment. A high percentage of EIs agree to biomonitoring.	Addressed
Capture intervention tracking measures for each intervention across the Childhood Obesity and Substance Use Disorder QIPs.	ITMs were reviewed with Data Analyst to ensure they were capturing appropriate data. This is an ongoing process.	Addressed
Ensure that all planned health education activities, along with implementation dates, are provided to the Agency and that their policies indicate they are at a frequency and format determined by the Agency.	Bi-annual DHCP meetings are held in February and August annually. All quarterly Medical Management Meeting topics, speakers, and materials are submitted to AMA for approval. All planned PCP educational activities and materials are submitted to AMA for approval.	Addressed
Update EI Materials policy to include language related to the	Language was added to the EI Material Policy #15 (revised April 2021).	Addressed

Recommendation for GCTC	GCTC Response/Actions Taken	IPRO Assessment of Entity Response[1]
requirement about the use of electronic methods of communication (specifically, only if EI has provided an email address and has not requested to no longer receive electronic communication, if the EI has requested or approved electronic transmittal, or if all HIPAA requirements are satisfied with respect to PHI).		
Ensure their policy is updated to reflect language that "If the Agency determines that the PCCM-E's web presence will be incorporated to any degree to the Agency's or the State's web presence, the PCCM-E must conform to any applicable Agency or State standard for website structure, coding, and presentation."	Language was added to the EI Material Policy #15 (revised April 2021).	Addressed
Update policies to ensure language related to website content is included (specifically, how content must be approved in advance by the Agency, and is to be accurate, current, and designed so that EIs and Providers may easily locate all relevant information. If directed by the Agency, the PCCM-E must establish appropriate links on the PCCM-E's website that direct users back to the Agency's website).	Language was added to the EI Material Policy #15 (revised April 2021).	Addressed
Revise its complaints and grievances policy and procedure to reflect the activities outlined in the	Complaints and Grievances Policy #24 (revised February 2021 and November 2021).	Addressed

Recommendation for GCTC	GCTC Response/Actions Taken	IPRO Assessment of Entity Response[1]
requirement pertaining to corrective action plans.		
Incorporate language into HIMS policies reflecting the requirement that failure to input maternity data and/or care coordination documentation for each EI with a 95% accuracy rate into the Health Information System/Database will result in sanctions.	Language was added to HIMS Policy #45 (revised February 2021).	Addressed
Add the reporting extract requirement to their HIMS policy.	Added to HIMS Policy #45 (revised February 2021)	Addressed
Develop a roster for provider participation in the Medical Management Meetings, to ensure active participation requirements are being met.	Roster developed using AMA Roster Template. The Roster is used to report Quarterly Medical Management Meetings attendance to AMA. PCPs that do not comply with the Medical Management participation requirement are easily identified to follow up.	Addressed
Ensure that the MCT meets regularly as the EI's risk stratification designates, is comprised of professionals from a variety of disciplines, has discussions focused on the EI's recovery and wellbeing, and documents meetings in detail.	MCT Policy #6 was revised February 2021. MCTs are held as needed based on risk stratification and include a variety of disciplines such as pharmacists, providers, nurses, social workers, behavioral health disciplines. The training was held with all care coordination staff reinforcing MCT requirements. A process for written patient notification of scheduled MCT was implemented as well as designated dates/times reserved weekly for MCTs. A monthly report is generated to assist staff in identifying upcoming required MCTs due. Auditing of charts is performed monthly and confirms compliance with this requirement.	Partially addressed: 1 file did not contain documentation of an MCT occurring within the specified timeframe for high-risk EI; calendar months 7–12 and every 6 months thereafter.
Ensure that the MCT continue to discuss and consult with applicable parties and monitor behavioral health issues.	MCT Policy #6 was revised February 2021. Training was held with all care coordination staff reinforcing MCT requirements. A process for written patient notification of scheduled MCT was implemented as well as designated dates/times reserved weekly for MCTs. MCTs are held as needed based on risk stratification and include a variety of disciplines such as pharmacists, providers, nurse, social workers, behavioral health disciplines. A monthly report is generated to assist staff in identifying upcoming required MCTs due. Auditing of	Addressed

Recommendation for GCTC	GCTC Response/Actions Taken	IPRO Assessment of Entity Response[1]
	charts are performed monthly and confirm compliance with this requirement.	
Take into account all of the EI's risk factors and past health risks when conducting the initial assessment as they need to be included in the care plan.	Maternal Health Care Plan Development Policy #31 Revised February 2021. Several meetings/training were held with all care coordination staff reinforcing Medicaid requirements for Care Plans to include mandatory components and patient needs/conditions identified in assessment, resulting in a developed Care Plan. Follow-up monthly audits conducted over the past 6-8 months have demonstrated increased compliance with this item.	Addressed
Review the EI's medical history and include documentation of this history in the care plan.	Care Planning Policy #2 Revised February 2021. Several meetings/trainings were held with all care coordination staff reinforcing Medicaid requirements for Care Plans to include mandatory components as well as patient needs/conditions identified in assessment must result in a developed Care Plan. Follow-up monthly audits conducted over the past 6-8 months have demonstrated increased compliance with this item.	Partially addressed: 1 family planning file did not have medical condition documented in care plan or task notes
Ensure that EIs eligible for a delivery encounter should receive a delivery visit or missed delivery visit within 20 calendar days.	Provision for Maternity Care Coordination Policy #28 revised February 2021. Improvement: Hospital and DHCP offices are more compliant in notifying of delivery. Improved access to hospital EHR and delivery census. Several meetings/training were held with maternity care coordination staff, reinforcing Medicaid-required encounters, timeframes, and patient care tracking procedures. Staff verbalized understanding. An increase in compliance with completed delivery visits was noted. The is forwarded to appropriate maternity care coordination staff daily for patient post-delivery follow-up while still hospitalized. Additionally, access to hospital EHR systems for our region's more extensive delivery facilities was obtained, enabling access and monitoring delivery census.	Addressed

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

GCTC: Gulf Coast Total Care; EQR: external quality review; EI: eligible individual; QIP: quality improvement project; ITM: intervention tracking measure; DHCP: delivering healthcare professional; AMA: Alabama Medicaid Agency; PCP: primary care provider; HIPAA: Health Insurance Portability and Accountability Act; PHI: protected health information; PCCM-E: primary care case management entity; HIMS: health information management system; MCT: multidisciplinary care team; EHR: electronic health record.

My Care Alabama Central Response to Previous EQR Recommendations

Table 26 displays MCA-C's progress related to the *RY 2021 Annual External Quality Review Technical Report*, as well as IPRO's assessment of MCA-C's response.

Table 26: MCA-C Response to Previous EQR Recommendations

Recommendation for MCA-C	MCA-C Response/Actions Taken	IPRO Assessment of Entity Response[1]
Ensure that provider participation is logged throughout the year so that participation in at least 2 quarterly meetings and 1 exercise with the Network Medical Director is evidenced.	Provider participation is logged and submitted to the Agency via the Monthly and Quarterly PCP and DHCP Participation reports.	Addressed
Add the EI right to use any hospital or other setting for emergency care to their policies, and ensure it is expressed to EIs through written materials.	This requirement is satisfied in the below policies as well as the General, maternity and Family Planning consents: MCAC Tool 4 II.I.3.j Exhibit C Care Plan Policy 4 20 21 MCAC 18 II.V.1 Emergency Calls 02.26.21	Addressed
Conduct root-cause analysis to uncover why so few EIs with a diagnosis of substance use disorder are initiating treatment.	MCA-C has had internal team meetings to discuss early access to treatment and the barriers to seeking treatment. We have also worked with local providers to try to improve timeliness of initiating treatment. We have identified barriers and are working to help EI's navigate those barriers.	Addressed
Add language to Care Plan Policy that incorporates processes to support Care Coordination for EIs, specifically with regard to reducing the potential for risks of catastrophic or severe illness.	Language was added to following policy: MCAC Tool 4 II.I.3.j Exhibit C Care Plan Policy 4 20 21	Addressed
Incorporate language within policies related to maternal health care coordination including family planning, interconception care, prenatal care, and postnatal care.	Language was added to following policy: Final MCAC Exhibit J.7-8 FP Care Coordination Activities 8 27 21	Addressed
Incorporate language within policies related to the requirement that states "The PCCM-E must advise all DHCPs and include language in the ACHN DHCP Participation Agreement of the	Language was added to following policy: Final MCAC 5 II.I.4.ef EI Notification 7 29 21	Addressed

Recommendation for MCA-C	MCA-C Response/Actions Taken	IPRO Assessment of Entity Response[1]
requirement for Pregnant Women to participate in the network for maternity Care Coordination for the Agency to consider the EI's maternity care a covered service."		
Add the following language to EI-facing materials: "EIs must be allowed to change a DHCP once without cause within the first ninety (90) Calendar Days of selecting a DHCP and at any time for just cause, which is defined as a valid complaint submitted orally or in writing to the PCCM-E.	Language was added to following policy: MATERNITY Consent RR HIPAA Final	Addressed
Ensure that materials communicating EI rights and responsibilities and appropriate telephone numbers are provided to EIs upon initial contact.	MCA-C developed materials to address this requirement in a written format. This has been added to our policy and all materials are available via our website or hard copy handout.	Addressed
Ensure that evidence is provided of communicating (verbally and with written materials) to EIs that it is their right to change DHCPs, with and without cause at the initial contact and at least once per year.	MCA-C developed materials to address this requirement in a written format. This has been added to our policy and all materials are available via our website or hard copy handout.	Addressed
Ensure that all risk assessments are conducted within the contractually-required timeframe.	MCA-C developed a process to screen and stratify EIs who are determined to need Care Coordination services into appropriate categories of risk which will determine the timeframe of the assessment. Trainings were held on 6/6/21 and 11/11/21.	Addressed
Ensure that the MCT is meeting within the required timeframes.	MCA-C has implemented a MCT process, which includes real-time reporting that will allow us to better monitor the timeliness of MCT meetings. MCA-C has also conducts ongoing training with staff about the MCT process and timeframes. Training held 8/7/2020 and 3/23/21.	Addressed
Ensure that high-risk face-to-face postpartum visits are executed, where applicable. Additionally,	MCAC implemented ongoing reporting of high-risk maternity EIs that are entering their 2nd and 3rd trimesters. MCA-C implemented ongoing report of high-risk maternity EIs that have delivered and are due for a postpartum visit. Trainings held 6/9/21.	Partially addressed: 1 maternity file did not have a

Recommendation for MCA-C	MCA-C Response/Actions Taken	IPRO Assessment of Entity Response[1]
follow-up visits in the second/third trimester should be implemented for EIs.		follow-up encounter documented in the second/third trimester.
Ensure care plans are addressing EI-specific risks in the care plan, and are patient/caregiver centered with a team approach.	MCA-C trained and continues to reinforce the importance of a patient centered and comprehensive care plans. MCAC also supports training to include appropriate documentation of service referral needs and/or refusal of services. Training help 6/22/21.	Addressed
Ensure that EIs eligible for a delivery encounter should receive a delivery visit or missed delivery visit within 20 calendar days.	MCA-C continues to reinforce that the EIs eligible for a delivery visit or missed visit will receive a visit within 20 calendar days. Trainings held 6/9/21.	Addressed
Ensure that all necessary documentation (the medication list in particular) is included in an EI's record to ensure proper care coordination	Training has been provided regarding medication list and required documentation. Pharmacy staff has trained staff on required information for completed Med Review. Staff will continue to follow up and review medication list policy. Training conducted 6/16/21, 11/11/21 and 12/16/21.	Addressed

[1] IPRO assessments are as follows: **addressed**: MCP's quality improvement (QI) response resulted in demonstrated improvement; **partially addressed**: MCP's QI response was appropriate but improvement was not yet observed; **remains an opportunity for improvement**: MCP's QI response did not address the recommendation, improvement was not observed, or performance declined.
MCA-C: My Care Alabama Central; EQR: external quality review; PCP: primary care provider; DHCP; delivering healthcare provider; EI: eligible individual; PCCM-E: primary care case management entity; ACHN: Alabama Coordinated Health Network; MCT: multidisciplinary care team.

My Care Alabama East Response to Previous EQR Recommendations

Table 27 displays MCA-E's progress related to the *RY 2021 Annual External Quality Review Technical Report*, as well as IPRO's assessment of MCA-E's response.

Table 27: MCA-E Response to Previous EQR Recommendations

Recommendation for MCA-E	MCA-E Response/Actions Taken	IPRO Assessment of Entity Response[1]
Add the EI right to use any hospital or other setting for emergency care to their policies and ensure it is expressed to EIs through written materials.	This requirement is satisfied in the below policies as well as the General, Maternity and Family Planning consents: MCAE Tool 4 II.I.3.j Exhibit C Care Plan Policy 4 2021 MCAE 18 II.V.1 Emergency Calls 02.26.21	Addressed

Recommendation for MCA-E	MCA-E Response/Actions Taken	IPRO Assessment of Entity Response[1]
Continue to work with providers to educate them on the requirements related to active participation, as well as how attendance in the Medical Management Meetings affects the quality bonus or provider participation rates, in order to ensure active participation status is met for all providers.	In FY 2021, in order to increase provider participation in the MMMs, each Care Coordinator was assigned a PCP/DHCP for monthly outreach, which included MMM reminders (this outreach is tracked weekly by the Quality Care Manager and applied quarterly to their incentive bonus goals); The Quality Care Manager also proactively reached out on a quarterly basis to these providers to engage them and remind them on requirements for active participation for the ACHN and how it would affect quality bonus. Further, we mailed hard copy invitations to each PCP in Q3 2021 as a tertiary reminder method for the MMM. Outreach was also done to providers at risk for not meeting requirements. An additional resource where providers can access 1 meeting per year via the ACHN website (HUB) to count toward attendance was also implemented.	Partially Addressed (SFY 2021 SPR demonstrated that MMM participation still in need of improvement)
Add language to their Care Plan Policy that incorporates processes to support Care Coordination for EIs, specifically with regard to reducing the potential for risks of catastrophic or severe illness.	Language was added to following policy: MCAE Tool 4 II.I.3.j Exhibit C Care Plan Policy 4 20 21	Addressed
Develop language within policies to comprehensively address the requirement related to the implementation of a program to integrate and manage all maternal health Care Coordination, including family planning, interconception care, prenatal care, and postnatal care.	Language was added to following policy: Final_MCAE Exhibit J.7-8 FP Care Coordination Activities 8 27 21	Addressed
Add language to policies that fully captures the following requirement: "The PCCM-E must advise all DHCPs and include language in the ACHN DHCP Participation Agreement of the requirement for Pregnant Women to participate in the network for maternity Care Coordination for the Agency to consider the EI's maternity care a covered service."	Language was added to following policy: Final MCAE 5 II.I.4.ef EI Notification 7 29 21	Addressed

Recommendation for MCA-E	MCA-E Response/Actions Taken	IPRO Assessment of Entity Response[1]
Ensure that an EI's right to change a DHCP once without cause in the first 90 days of selection and at any time for just cause (defined as a valid complaint submitted orally or in writing to the PCCM-E) is conveyed in written format to EI (within EI materials and/or on My Care East website). Furthermore, the related requirement that the PCCM-E must inform the EI of this right at initial contact and at least once per year should also be evidenced within MCA-E documentation.	Language was added to following policy: MATERNITY Consent RR HIPAA Final	Addressed
Ensure that materials communicating EI rights and responsibilities, and appropriate telephone numbers, are provided to EIs upon initial contact.	MCAE developed materials to address this requirement in a written format. This has been added to our policy and all materials are available via our website or hard copy handout.	Addressed
Ensure that all risk assessments are conducted within the designated 90-day time period.	Risk reassessments are to be conducted every 6 months now, but care plan evaluations are to be conducted every 90 days. MCAE developed a process whereas on or before the beginning of each month, a list of upcoming patients who are due for the 90-day care plan evaluation are sent to the care coordinators. Training held on 6/30/2021.	Addressed
Ensure that an MCT is established for every EI in active care to ensure successful care coordination.	Medicaid updated the MCT process which is only to be conducted on high stratified EIs; Training with care coordinators held on 3/10/2021. Opportunities for improvement are identified during Supervisor Caseload and Chart Reviews with individual care coordinator education conducted as needed.	Partially Addressed: SFY 2021 file review demonstrated that 1 general care coordination file did not contain an MCT invitation to the EI.
Ensure that all post-hospitalization risk assessments are conducted within the required timeframe of 10 calendar days, to ensure appropriate home-based	Transitional Care Requirement training held on 1/29/2021. It is also a requirement on our internal audits.	Addressed

Recommendation for MCA-E	MCA-E Response/Actions Taken	IPRO Assessment of Entity Response[1]
support and services are available.		
Ensure that medication reconciliation is conducted at discharge to facilitate proper transitional care, and that designated timeframes are observed.	Transitional Care Requirement training held on 1/29/2021. MCAE conducts the medication reconciliation at enrollment to ensure the EI has picked up medications and is taking them as prescribed.	Addressed
Ensure that required timeframes for providing EIs with medical management education post-discharge are observed in order to ensure successful transitional care.	Transitional Care Requirement training held on 1/29/2021. MCAE also conducts ongoing training with care coordinators regarding required timeframes (an element of the Supervisor Chart Audit tool).	Addressed
Ensure that high-risk face-to-face postpartum visits are executed, where applicable. Additionally, follow-up visits in the second/third trimester should be implemented for EIs.	MCAE implemented a process whereas the Maternity Care Coordination Supervisor delivers a monthly report to care coordinators of high-risk maternity EIs that are entering their 2nd and 3rd trimesters and high-risk maternity EIs that have delivered and are due for a postpartum visit.	Addressed
Ensure that there is a system in place to identify EIs with missing assessments and care plans, as these are critical for successful care. Additionally, documentation should be included in every EI's file to justify risk ratings.	Care coordination supervisors identify gaps when conducting chart audits and caseload reviews with individual education regarding documentation for risk justification and care plan components conducted as needed; additionally, MCAE has implemented a process whereas a report is sent out monthly to care coordinators that shows when task titles have not been marked as complete.	Partially Addressed: SFY 2021 file review demonstrated that 1 family planning care coordination file did not contain a care plan.
Ensure that there is a system in place to identify EIs missing maternal health screenings in order to conduct them as expediently as possible. Required timeframes also need to be observed for the execution of the screening.	MCAE has developed a process whereas outreach is documented at each attempt, with a minimum of 3 attempts; after 3 attempts, DHCP is notified of the inability to contact and the case is closed until EI reaches out; additionally, MCAE has implemented a process wherein a report is sent out monthly to care coordinators that shows when a maternal health screening has not been completed/has not received a score.	Addressed
Implement a system to identify EIs with missing maternal health risk assessments and missing	MCAE has implemented a process whereas a report is sent out monthly to care coordinators that shows when a maternal health screening has not been completed/has not received a score.	Addressed

Recommendation for MCA-E	MCA-E Response/Actions Taken	IPRO Assessment of Entity Response[1]
maternal health care plans.		
Ensure that there is a system in place to identify EIs with missing care plans and ensure that the care plans address all EI needs and EI-specific risks.	Care coordination supervisors identify gaps when conducting chart audits and caseload reviews with individual education regarding missing care plans and care plan components conducted as needed; Care Plan Training held 6/30/21.	Partially Addressed: SFY 2021 file review demonstrated that 1 family planning care coordination file did not contain a care plan, and that 1 general file did not contain a care plan that addressed all the EI's health concerns.
Include the PCP in the creation of EI care plans.	PCPs are contacted within 14 days of each general enrollment and notified of the care plans that have been developed; at that time, PCPs have the opportunity to add to the care plan as needed. PCPs are also invited to MCT Meetings for high-risk EIs to address care plan needs/barriers.	Addressed
Ensure that EIs eligible for a delivery encounter should receive a delivery visit or missed delivery visit within 20 calendar days.	MCAE is structured where specific 1 family planning care coordination file did not contain a care plan are identified to receive hospital censuses and are therefore responsible for delivery encounters; MCAE conducts ongoing, targeted training with these care coordinators to reinforce the delivery visit timelines; MCAE has implemented a process whereas the Care Coordination Supervisor distributes an EDC report at the beginning of the month for EIs that are set to deliver, and then again at the end of the month for EIs who did not receive a delivery visit.	Addressed
Ensure that counseling (on contraception and family planning services and appropriate postpartum care) is provided to EIs, and if there are communication issues, these need to be documented within the record.	MCAE conducts ongoing training with care coordinators to reinforce that a family planning discussion with associated documentation is a required component at each encounter.	Addressed

Recommendation for MCA-E	MCA-E Response/Actions Taken	IPRO Assessment of Entity Response[1]
Attempt to obtain full documentation related to the medication list; however, if issues arise ensure, they are documented in the EI's record.	MCAE conducts ongoing training with care coordinators on the medication list, ensuring that any issues that arise are addressed and clearly documented. Training held 7/30/2020.	Addressed

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

MCA-E: My Care Alabama East; EQR: external quality review; EI: eligible individual; MMM: Medical Management Meeting; FY: fiscal year; PCP: primary care provider; DHCP: delivering healthcare provider; ACHN: Alabama Coordinated Health Network; SFY: state fiscal year; PCCM-E: primary care case management entity; HIPAA: Health Insurance Portability and Accessibility Act; Q3: third quarter; MCT: multidisciplinary care team; EDC: estimated date of confinement.

My Care Alabama Northwest Response to Previous EQR Recommendations

Table 28 displays MCA-NW's progress related to the *RY 2021 Annual External Quality Review Technical Report*, as well as IPRO's assessment of MCA-NW's response.

Table 28: MCA-NW Response to Previous EQR Recommendations

Recommendation for MCA-NW	MCA-NW Response/Actions Taken	IPRO Assessment of Entity Response[1]
Ensure that provider participation is logged throughout the year so that participation in at least 2 quarterly meetings and 1 exercise with the Network Medical Director is evidenced.	Our logs have been current and up to date.	Addressed
Evaluate the key drivers of contraceptive use among teenagers to bolster the percentage of those that utilize contraception.	MCA-NW identified the following key drivers: counseling on different contraception methods; how to use the method of choice effectively; access to the available contraceptive methods.	Addressed
Ensure intervention tracking measures are recorded for each intervention across quality improvement projects.	Intervention tracking measure have been recorded within all report templates.	Addressed
Add language to their Care Plan Policy that incorporates processes to support care coordination for EIs, specifically with regard to reducing the	Language was added to following policy: MCANW Tool 4 II.I.3.j Exhibit C Care Plan Policy 04.20.21	Addressed

Recommendation for MCA-NW	MCA-NW Response/Actions Taken	IPRO Assessment of Entity Response[1]
potential for risks of catastrophic or severe illness.		
Develop language within policies to comprehensively address the requirement related to the implementation of a program to integrate and manage all maternal health care coordination including family planning, interconception care, prenatal care, and postnatal care.	Language was added to following policy: Final MCANW 6 Exhibit J.7-8 FP Care Coordination Activities 8 27 21	Addressed
Develop language within policies to comprehensively address the following requirement: "The PCCM-E must advise all DHCPs and include language in the ACHN DHCP Participation Agreement of the requirement for pregnant women to participate in the network for maternity care coordination for the Agency to consider the EI's maternity care a covered service."	Language added to the Maternal Care Coordination; EI Notification policy and approved by the Agency on 07/29/21	Addressed
Ensure that an EI's right to change a DHCP once without case in the first 90 days of selection and at any time for just cause (defined as a valid complaint submitted orally or in writing to the PCCM-E) is conveyed in written format to EI (within EI materials and/or on MCA-NW website). Further, the related requirement that the PCCM-E must inform the EI of this right at initial contact and at least once per year should also be	Language was added to following policy: MATERNITY Consent RR HIPAA Final	Address

Recommendation for MCA-NW	MCA-NW Response/Actions Taken	IPRO Assessment of Entity Response[1]
evidenced within MCA-NW documentation.		
Ensure that materials communicating EI rights and responsibilities, and appropriate telephone numbers are provided to EIs upon initial contact.	MCANW developed materials to address this requirement in a written format. This has been added to our policy and all materials are available via our website or hard copy handout.	Addressed
Conduct root cause analysis to understand the decline in use of contraception among teenagers.	Root cause analysis was completed to determine the cause for a decline in the use of contraception among teenagers. The decline in the contraception use among teenagers is related to not following up with post-partum appointments; refusal to enroll into family planning care coordination services; and ACHN unable to make successful contact after delivery.	Addressed
Ensure that all required health risk screenings and assessments are conducted for each EI, and they take place during the required time period. Any difficulties contacting the EI should be documented in the record.	All efforts to meet timelines are addressed via supervision audits, reporting, and quality assurance.	Addressed
Ensure that the MCT meets within the required timeframes as outlined in the contract.	MCANW has implemented a MCT process, which includes real-time reporting that will allow us to better monitor the timeliness of MCT meetings. MCANW has also conducted ongoing training with staff about the MCT process and timeframes. MCANW 2022 MCT schedule: 1/14/22, 1/28/22, 2/11/22, 2/16/22, 2/25/22, 3/11/22, 3/25/22, 4/8/22, 5/6/22, 6/3/22, 7/1/22, 7/29/22, 8/26/22, 9/23/22, 10/21/22, 11/18/22, and 12/16/22.	Partially Addressed: SFY 2021 file review demonstrated that 4 general files did not contain evidence that the MCT was conducted within the 60-day time period for high-risk EIs.
Ensure that all EI needs are addressed to inform a thorough care plan that is patient/caregiver centered with a team approach.	MCANW trained and continues to reinforce the importance of a patient centered and comprehensive care plans. MCANW also supports training to include appropriate documentation of service referral needs and/or refusal of services.	Addressed
Ensure that high-risk face-to-face postpartum visits are executed, where applicable. Additionally, follow-up visits in the second/third trimester should be implemented for EIs.	MCANW implemented ongoing reporting of high-risk maternity EIs that are entering their 2nd and 3rd trimesters. MCANW implemented ongoing report of high-risk maternity EIs that have delivered and are due for a postpartum visit.	Addressed

Recommendation for MCA-NW	MCA-NW Response/Actions Taken	IPRO Assessment of Entity Response[1]
Ensure that maternal care plans are executed in the required timeframe as outlined in the contract.	MCANW has implemented supervisory chart audits to meet contract requirements with ad hoc HIMS reports to assist and quality nurse daily spot checks.	Addressed
Include PCP and community agencies in care plan creation and implementation process.	PCPs and other disciplines are invited per MCT contract requirements.	Addressed
Ensure that newborn care coordination is conducted for all EIs with a newborn delivery who did not receive prenatal care. EIs eligible for a delivery encounter should receive a delivery visit or missed delivery visit within 20 calendar days.	Maternity care coordination is driven to meet contractual requirements based on requirements and EIs willingness to enroll their newborn into services.	Addressed
Ensure that postpartum care counseling is conducted appropriately for maternal care coordination.	MCANW is conducting supervisory chart audits to ensure that contractual requirements are met with the use of ad hoc HIMS reports to assist. MCANW uses the quality nurse to assist with daily spot checks of charts. MCANW tracks DHCP post-partum visit measure to assist with oversight.	Addressed
Ensure that the medication list is included within the EI's record to enhance drug use information gathering.	Training has been provided regarding the medication list and required documentation. Pharmacy staff has trained staff on required information to complete medication review. Staff will continue to follow up and review the medication list policy.	Partially Addressed: SFY 2021 file review demonstrated that 1 general file did not contain evidence of medication reconciliation.

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

MCA-NW: My Care Alabama Northwest; EQR: external quality review; EI: eligible individual; PCCM-E: primary care case management entity; DHCP: delivering healthcare provider; ACHN: Alabama Coordinated Health Network; HIPAA: Health Insurance Portability and Accountability Act; MCT: multidisciplinary care team; SFY: state fiscal year; PCP: primary care provider; HIMS: health information management system.

North Alabama Community Care Response to Previous EQR Recommendations

Table 29 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 29: NACC Response to Previous EQR Recommendations

Recommendation for NACC	NACC Response/Actions Taken	IPRO Assessment of Entity Response[1]
Continue tracking their efforts around breastfeeding to see if the intervention is effective.	NACC quality team met with the maternity care coordinators re-educated on the Childhood Obesity QIP on September 29, 2021.	Addressed
Ensure intervention tracking measures are being captured and reported throughout the project period.	NACC developed a spreadsheet to capture data on a regular basis with formulas used for calculations. This spreadsheet was presented at a Quarterly IPRO meeting.	Addressed
Update documentation to include verbiage related to "targeted implementation dates (for planned health activities) at a frequency and in a format determined by the Agency."	Policy and Procedure of Outreach and Health Education Activity was updated to include this verbiage.	Addressed
Update policies related to when electronic methods of communication with an EI can be used by including the following from contract requirements: The EI has provided an email address to the PCCM-E and has not requested to no longer receive electronic methods of communication, and language and alternative format accommodations are available.	Policy and Procedure of Enrollee Rights was updated to include these requirements.	Addressed
Update University of Alabama's RMEDE documents with the accuracy rate requirement or add it to an internal NACC policy. NACC could also consider capturing their data validation process in a policy and procedure as another best practice	NACC shared this requirement with RMEDE, and it was added to the Design Documents that were submitted this year for the SPR.	Addressed

Recommendation for NACC	NACC Response/Actions Taken	IPRO Assessment of Entity Response[1]
Evaluate aspects of quality outside of the quality measures within the Quality Improvement Plan Evaluation (e.g., chart audits, QIPs, data collection/HIMS, grievances, etc.).	All suggestions were appreciated and included in the revised Quality Plan.	Addressed
Continue their outreach efforts to providers to ensure they meet the minimum attendance requirements to achieve active participation status in Medical Management Meetings.	NACC began to document when each communication went out and by which staff member. Follow up began in the 2nd quarter for outliers. Third and 4th quarter phone calls were made by staff and NACC's medical director.	Partially Addressed: SFY 2021 SPR demonstrated that MMM participation still in need of improvement.
Update the Transitional Care Program Description to reflect the review of hospital census reports daily (as opposed to "once per week at a minimum").	Transitional Care Program Description and Policy were revised to indicate that "The Care Coordinator will review the census on a daily basis."	Addressed
Ensure that risk assessments are conducted within the required timeframe, which could determine if goals have been met and if the case can be closed. Further, when an EI is unable to be reached, the entity should document all contact attempts to ensure due diligence is met.	Re-trained staff on active protocols: Documentation, Care Plan Training, and Contact Training. Targeted audit tool was created to track and monitor compliance with risk re-assessment.	Addressed
Ensure that closing of cases are warranted and fully reviewed before action, and that all outreach attempts are documented if communication with the EI is proving difficult. There is an opportunity to analyze how care plan goals are created, which would impact MCT involvement.	Re-trained staff on active protocols: Documentation, Care Plan Training, Contact Training, and MCT Training. Targeted audit tool was created to track and monitor compliance with risk re-assessment.	Addressed

Recommendation for NACC	NACC Response/Actions Taken	IPRO Assessment of Entity Response[1]
Ensure that the MCT is consulted for all aspects of the EI's needs, including behavioral health, in order to fully integrate and coordinate care.	Re-trained staff (specifically behavior health staff were consulted) on active protocol for MCT training. A targeted audit tool was created to track and monitor compliance with risk re-assessment.	Addressed
Ensure that all face-to-face Health Risk and Psychosocial Assessments are conducted within 10 calendar days of discharge.	After re-training of staff regarding timeframes, a targeted audit tool was utilized monthly for 6 months to ensure compliance.	Addressed
Ensure that medication reconciliation occurs within 10 calendar days of discharge	After re-training of staff regarding timeframes, a targeted audit tool was utilized monthly for 6 months to ensure compliance	Addressed
Ensure that education regarding medical management is conducted within 10 calendar days of discharge.	After re-training of staff regarding medical management (medication) timeframes, a targeted audit tool was utilized monthly for 6 months to ensure compliance.	Addressed
Ensure that high-risk face-to-face postpartum visits are executed, where applicable. Additionally, follow-up visits in the second/third trimester should be implemented for EIs.	After re-training of maternity staff regarding requirements and timeframes for high-risk Face-to-face postpartum visits, a targeted audit tool was utilized monthly for 6 months to ensure compliance.	Partially Addressed: SFY 2021 file review demonstrated that 1 maternity care coordination file demonstrated a missed encounter within the second trimester, and another file demonstrated a missed encounter in the third trimester.
Ensure that maternal health screenings take place within the required five business days of contact with the EI.	After re-training of maternity staff regarding requirements and timeframes for Maternal Health Screenings, a targeted audit tool was utilized monthly for 6 months to ensure compliance.	Addressed
Train care coordinators to ensure execution of the creation of the care plan within the required timeframe.	After multiple re-trainings of general and maternity staff regarding requirements and timeframes of the 5 care plan components, a targeted audit tool was utilized monthly for 6 months to ensure compliance.	Addressed (Note that SFY 2021 SPR demonstrated that all files were in compliance with care plans being executed,

Recommendation for NACC	NACC Response/Actions Taken	IPRO Assessment of Entity Response[1]
		however all 5 components were not evident. This is a recommendation for going forward.)
Follow up with care coordinators that were retrained on how to appropriately document and address EI risks and review EI records to determine if the training was successful, and that records contain evidence that risks are being addressed in the care plan.	Targeted tools were analyzed. When individual deficiencies were discovered, the individual care coordinator was again re-trained and audited further on the findings.	Partially Addressed: SFY 2021 SPR demonstrated that 1 family planning file did not contain evidence that a need identified during the Health Risk and Psychosocial Assessment was addressed in the care plan.
Train staff to better detect when additional support from providers or outside agencies should be included in care planning.	After multiple re-trainings of general and maternity staff regarding requirements and timeframes of the 5 care plan components and general training (PCP/Specialist referral protocol), a targeted audit tool was utilized monthly for 6 months to ensure compliance.	Addressed
Ensure that EIs eligible for a delivery encounter receive a delivery visit or missed delivery visit within 20 calendar days.	After re-training of maternity staff regarding requirements and timeframes for delivery encounter and missed delivery encounter within twenty (20) Calendar Days, a targeted audit tool was utilized monthly for 6 months to ensure compliance.	Addressed
Ensure that counseling for contraception/family planning and postpartum care is conducted appropriately for maternal health care coordination.	After re-training of maternity staff regarding requirements for contraception/family planning and postpartum care, a targeted audit tool was utilized monthly for 6 months to ensure compliance.	Addressed

[1] IPRO assessments are as follows: **addressed**: MCP's quality improvement (QI) response resulted in demonstrated improvement; **partially addressed**: MCP's QI response was appropriate but improvement was not yet observed; **remains an opportunity for improvement**: MCP'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 plan; EI: eligible individual; PCCM-E: primary care case management entity; RMEDE: Realtime Medical Electronic Data Exchange System; SPR: System Performance Review; HIMS: health information management system; SFY: state fiscal year; MMM: Medical Management Meeting; ; MCT: multidisciplinary care team; PCP: primary care provider.

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

Table 30 highlights each ACHN entity's performance strengths and opportunities for improvement, follow-up on prior EQRO recommendations, and this year's recommendations based on the aggregated results of SFY 2021 EQR activities as they relate to **quality**, **timeliness**, and **access**.

Table 30: Strengths and Opportunities for Improvement, and EQR Recommendations for All ACHN Entities

ACHN Entity	Strengths	Weaknesses	Recommendations	Standards
Quality Improvement Projects				
ACN Mid-State	ACN Mid-State demonstrated improvement in 1 of their Childhood Obesity QIP indicators (the percentage of annual BMI assessments completed for EIs 3–19 years of age), and in their SUD QIP indicator (the percentage of EIs 18–64 years of age who engaged in AOD treatment).	• There was a decline in the performance of ACN Mid-State's Adverse Birth Outcomes QIP indicator (low birth weight), as well as within 3 of their 4 indicators for their Childhood Obesity QIP. • While there are interventions that address scheduling children for well visits and distributing MyPlate materials/jump ropes/Frisbees, there have not been many children impacted by these interventions (evidenced by the ITMs, and the corresponding numerators within the SFY 2021 interim report). • Decline in performance of following ITMs: the percentage of EIs with a buprenorphine, Suboxone, or methadone prescription with successful contact, and the percentage of EIs who keep follow-up appointment.	• 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. • 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. • 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. • Ensure the maximum proportion of EIs feasible are being targeted by interventions for Childhood Obesity QIP, following pilot testing (assuming pilot test demonstrated efficacy). • Evaluate barriers to successfully contacting EIs with SUD diagnosis on a	Quality

ACHN Entity	Strengths	Weaknesses	Recommendations	Standards
			prescription, as well as barriers to EIs keeping their follow-up appointments.	
ACN Southeast	ACN Southeast demonstrated an improvement in performance for 1 of their Adverse Birth Outcomes QIP indicators (EIs with a prenatal visit in the first trimester).	• ACN Southeast demonstrated in decline in performance for their LBW measure, well-child visits (for children 0–15 months and 3–6 years of age), and EIs with an SUD diagnosis who received treatment. • The baseline rate for SUD indicator 1 in Table 2: Goals of the interim report does not coincide with the numerator and denominator components provided.	• 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. • 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. • 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. • Ensure tables reflect rates that coincide with numerator and denominator components.	Quality
GCTC	GCTC demonstrated an improvement in performance for their annual BMI assessment measure (for children 3–17 years of age).	• GCTC demonstrated a decline in performance for their LBW measure, pregnant EIs receiving prenatal care in the first trimester, and EIs 7–11 with an annual PCP visit.	• 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	Quality

ACHN Entity	Strengths	Weaknesses	Recommendations	Standards
		• The entity did not align ITMs and barriers with descriptions and timeframes within the SFY 2021 interim report.	demographic factors to evaluate whether there are susceptible subpopulations that could benefit from being targeted with tailored interventions. • 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. • 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. • Ensure all barriers, interventions, and ITMs are in alignment and that the timeframes for interventions are stated and consistent with GCTC's activities.	
MCA-C	MCA-C demonstrated an improvement in both of their Adverse Birth Outcomes QIP indicators (students who completed Making Proud Choices curriculum, and students who participate in women's health appointment), as well as an improvement in 1 of their Childhood Obesity QIP measures (percentage of women enrolled in WIC during the first trimester), and 1 of their SUD measures (the percentage of EIs who initiated treatment for SUD with 2 or more additional services within 30 days of initiation).	• The target for the Childhood Obesity QIP indicator 3 is not stated in the Results table. • ITM data were scarce, with the majority of measures only having data for Q1 2021.	• Target rates should be stated and reviewed across indicators, as adjustments may be warranted given that interim rates have exceeded these targets. • Ensure that ITM data are collected and reported quarterly, to inform intervention progress. • Continue thinking about how to sustain and expand interventions and efforts, targeting the maximum number of EIs as possible.	Quality

ACHN Entity	Strengths	Weaknesses	Recommendations	Standards
MCA-E	MCA-E demonstrated a reduction in the percentage of pregnant women who smoke, and in the percentage of live births weighing less than 2,500 grams. Further, the entity demonstrated an increase in the percentage of EIs who had a BMI assessment, and in the percentage of EIs that initiated and continued treatment for SUD.	MCA-E demonstrated a decline in the percentage of births with a postpartum visit between 21 and 56 days following delivery. MCA-E also demonstrated an increase in the percentage of children with a diagnosis of overweight or obese.	• 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. • 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.	Quality
MCA-NW	MCA-NW demonstrated an increase in the percentage of EIs who had a BMI assessment, and in the percentage of EIs with an AOD diagnosis who initiated treatment and had 2 additional services or MAT within 34 days of the initial treatment visit.	• MCA-NW demonstrated a decline in the percentage of births with a prenatal visit in the first trimester. • The barriers cited do not correspond with the method of barrier identification within the Adverse Birth Outcomes QIP. For instance, “Prenatal/postpartum visit rates” is listed as the method of identification behind barriers related to lack of education of prenatal care visits and lack of knowledge about postpartum visits. • No meaningful longitudinal comparison can be made from the limited data points reflected in the Adverse Birth Outcome QIP interim report.	• 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. • Ensure the method of barrier identification corresponds with the barrier that is cited. • Ensure comprehensive ITM data are collected and reported quarterly to inform intervention progress. • Consistently number all barriers, interventions, and ITMs and ensure ITMs are calculated appropriately.	Quality

ACHN Entity	Strengths	Weaknesses	Recommendations	Standards
		• Several of the ITMs within the Childhood Obesity QIP are not calculated correctly.		
NACC	NACC demonstrated a reduction in the percentage of EIs 3–6 years of age with a BMI between 85% and 94%, and an increase in the percentage of first-time pregnant EIs that were breastfeeding at their post-partum visit.	• NACC demonstrated a decline in performance for EIs 3–6 years of age with a documentation of BMI in their medical record. • Q4 2020 data are missing for several ITMs. • The numerator and denominator units do not match for 1 ITM. It is not appropriate to have 2 different units (i.e., EIs vs. PCPs); they should be consistent.	• 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. • Ensure comprehensive ITM data are collected and reported quarterly to inform intervention progress. • Ensure numerator and denominator components of rates (indicators, ITMs, etc.) convey the same units.	Quality
Compliance Review				
ACN Mid-State	• ACN Mid-State achieved full compliance in all requirements reviewed for the Grievances topic area. • Within EI Rights/Materials/ Enrollment, there were 9 partial or non-compliant findings in 2020 that were full in 2021. • Within Grievances, there were 4 partial findings in 2020 that were full in 2021. • Within HIMS, there was 1 partial finding in 2020 that was full in 2021.	• Care Coordination file review demonstrated several areas of deficiency. • Requirements within the EI Rights/Materials/Enrollment, HIMS, Provider Participation, and Subcontracting topic areas need to be included in policies and procedures.	• 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. • Ensure contract language is included in all applicable policies and procedures.	Quality, Access, Timeliness
ACN Southeast	• ACN Southeast achieved full compliance in all requirements reviewed for the Grievances topic area. • Within EI Rights/Materials/ Enrollment, there were 6	• Care Coordination file review demonstrated several areas of deficiency. • Requirements within the EI Rights/Materials/Enrollment, HIMS, Provider Participation,	• 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	Quality, Access, Timeliness

ACHN Entity	Strengths	Weaknesses	Recommendations	Standards
	partial or non-compliant findings in 2020 that were full in 2021. • Within Grievances, there were 4 partial findings in 2020 that were full in 2021. • Within HIMS, there was 1 partial finding in 2020 that was full in 2021.	and Subcontracting topic areas need to be included in policies and procedures.	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. • Ensure contract language is included in all applicable policies and procedures.	
GCTC	• GCTC achieved full compliance in all requirements reviewed for the Grievances topic area. • Within EI Rights/Materials/ Enrollment, there were 6 partial or non-compliant findings in 2020 that were full in 2021. • Within Grievances, there were 4 partial findings in 2020 that were full in 2021. • Within HIMS, there was 1 partial finding in 2020 that was full in 2021.	• Care Coordination file review demonstrated several areas of deficiency. • Training of staff working with the children with medical complexities (CMC) population was not fully evidenced. • Requirements within the EI Rights/Materials/Enrollment, HIMS, Provider Participation, and Subcontracting topic areas need to be included in policies and procedures. • MMM attendance was not at 100%.	• 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	Quality, Access, Timeliness

ACHN Entity	Strengths	Weaknesses	Recommendations	Standards
			calendar months 7-12 and every 6 months thereafter for high-risk EIs. • Ensure CMC training takes place as required per the ACHN contract. • Ensure contract language is included in all applicable policies and procedures. • Continue working with providers to bolster MMM attendance.	
MCA-C	• MCA-C achieved full compliance in all requirements reviewed for the Provider Participation and HIMS topic areas. • Within HIMS, there was 1 partial finding in 2020 that was full in 2021.	• Care Coordination file review demonstrated several areas of deficiency. • Requirements within the EI Rights/Materials/Enrollment, Grievances, and Subcontracting topic areas need to be included in policies and procedures. • MMM attendance was not at 100%.	• 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. • Ensure contract language is included in all applicable policies and procedures. • Continue working with providers to bolster MMM attendance.	Quality, Access, Timeliness
MCA-E	MCA-E achieved full compliance in all requirements reviewed for the Provider Participation and HIMS topic areas. • Within HIMs, there was 1 partial finding in 2020 that were full in 2021.	• Care Coordination file review demonstrated several areas of deficiency. • Requirements within the EI Rights/Materials/Enrollment, Grievances, and Subcontracting topic areas need to be included in policies and procedures. • MMM attendance was not at 100%.	• 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;	Quality, Access, Timeliness

ACHN Entity	Strengths	Weaknesses	Recommendations	Standards
			and that MCT invitations are sent to high-risk EIs, and documented in the file. • Ensure contract language is included in all applicable policies and procedures. • Continue working with providers to bolster MMM attendance.	
MCA-NW	MCA-NW achieved full compliance in all requirements reviewed for the Provider Participation and HIMS topic areas. • Within HIMS, there was 1 partial finding in 2020 that was full in 2021.	• Care Coordination file review demonstrated several areas of deficiency. • Requirements within the EI Rights/Materials/Enrollment, Grievances, and Subcontracting topic areas need to be included in policies and procedures. • MMM attendance was not at 100%.	• 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. • Ensure contract language is included in all applicable policies and procedures. • Continue working with providers to bolster MMM attendance.	Quality, Access, Timeliness
NACC	NACC achieved full compliance in all requirements reviewed for the Provider Participation and HIMS topic areas. • Within EI Rights/Materials/ Enrollment, there were 2 partial findings in 2020 that were full in 2021. • Within Quality Management, there was 1 partial finding in 2020 that was full in 2021.	• Care Coordination file review demonstrated several areas of deficiency. • Requirements within the Care Coordination, EI Rights/ Materials/Enrollment, Grievances, and Subcontracting topic areas need to be included in policies and procedures. • Training of staff working with the children with medical	• 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	Quality, Access, Timeliness

ACHN Entity	Strengths	Weaknesses	Recommendations	Standards
		complexities population was not fully evidenced. • MMM attendance was not at 100%.	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. • Ensure contract language is included in all applicable policies and procedures. • Ensure CMC training takes place as required per the ACHN contract. • Continue working with providers to bolster MMM attendance.	
Performance Measures				
ACN Mid-State	The statewide average (SWA) was above the 90th percentile for Asthma Medication Ratio (Child and Adult), and for Child BMI Assessment.	• The SWA was below the 10th percentile for Antidepressant Medication Management, Initiation and Engagement of Treatment for AOD, Timeliness of Prenatal Care, Cervical Cancer Screening, and Child Access to Care (12–24 months of age and 25 months–6 years of age). ACN Mid-State demonstrated a rate below the SWA for Initiation and Engagement of Treatment for AOD, and Child Access to Care. • The SWA was between the 10th and 25th percentile for Well-Child Visits in the First 15 Months of Life and Child Access to Care (12–19 years of age). ACN Mid-State demonstrated a rate below the SWA for both these measures. • The statewide average was between the 25th and 50th	• 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.	Quality, Access, Timeliness

ACHN Entity	Strengths	Weaknesses	Recommendations	Standards
		percentile for Adult BMI Assessment and Child Access to Care (7–11 years of age). ACN Mid-State demonstrated a rate below the SWA for both these measures.		
ACN Southeast	• The SWA was above the 90th percentile for Asthma Medication Ratio (Child and Adult), and for Child BMI Assessment. ACN Southeast demonstrated a rate higher than the SWA for all 3 of these measures. • ACN Southeast's rate for Live Births Less Than 2,500 Grams was lower than the SWA.	• The SWA was below the 10th percentile for Antidepressant Medication Management, Initiation and Engagement of Treatment for AOD, Timeliness of Prenatal Care, Cervical Cancer Screening, and Child Access to Care (12–24 months of age and 25 months–6 years of age). • ACN Southeast demonstrated a rate below the SWA for Antidepressant Medication Management, as well as Adult BMI. • The SWA was between the 10th and 25th percentile for Well-Child Visits in the First 15 Months of Life and Child Access to Care (12–19 years of age). • The SWA was between the 25th and 50th percentile for Adult BMI Assessment and Child Access to Care (7–11 years of age). ACN Southeast demonstrated a rate below the SWA for Adult BMI Assessment.	• 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.	Quality, Access, Timeliness
GCTC	The statewide average was above the 90th percentile for Asthma Medication Ratio (Child and Adult), and for Child BMI Assessment. GCTC slightly exceeded the SWA	• The SWA was below the 10th percentile for Antidepressant Medication Management, Initiation and Engagement of Treatment for AOD, Timeliness	• Review and trend performance for Antidepressant Medication Management, Initiation and Engagement of Treatment for AOD, Well-Child Visits in the First 15 Months	Quality, Access, Timeliness

ACHN Entity	Strengths	Weaknesses	Recommendations	Standards
	for both Asthma Medication Ratio (Adult) and Child BMI Assessment.	of Prenatal Care, Cervical Cancer Screening, and Child Access to Care (12–24 months of age and 25 months–6 years of age). GCTC demonstrated a rate below the SWA for Antidepressant Medication Management, and Child Access to Care. • The SWA was between the 10th and 25th percentile for Well-Child Visits in the First 15 Months of Life and Child Access to Care (12–19 years of age). GCTC demonstrated a rate below the SWA for both of these measures. • The SWA was between the 25th and 50th percentile for Adult BMI Assessment and Child Access to Care (7–11 years of age). GCTC demonstrated a rate below the SWA for both of these measures.	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.	
MCA-C	The SWA was above the 90th percentile for Asthma Medication Ratio (Child and Adult), and for Child BMI Assessment. GCTC exceeded the SWA for the Asthma Medication Ratio (Child) measure.	• The SWA was below the 10th percentile for Antidepressant Medication Management, Initiation and Engagement of Treatment for AOD, Timeliness of Prenatal Care, Cervical Cancer Screening, and Child Access to Care (12–24 months of age and 25 months–6 years of age). • MCA-C demonstrated a rate below the SWA for Antidepressant Medication Management, Engagement in	• 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.	Quality, Access, Timeliness

ACHN Entity	Strengths	Weaknesses	Recommendations	Standards
		Treatment for AOD, Timeliness of Prenatal Care, and Child Access to Care (25 months–6 years of age, 7–11 years of age, and 12–19 years of age). • The SWA was between the 10th and 25th percentile for Well-Child Visits in the First 15 Months of Life and Child Access to Care (12–19 years of age). MCA-C demonstrated a rate below the SWA for Child Access to Care. • The SWA was between the 25th and 50th percentile for Adult BMI Assessment and Child Access to Care (7–11 years of age). MCA-C demonstrated a rate below the SWA for both these measures.		
MCA-E	• The SWA was above the 90th percentile for Asthma Medication Ratio (Child and Adult), and for Child BMI Assessment. MCA-E exceeded the SWA for each of these measures. • MCA-E's rate for Live Births Less Than 2,500 Grams was lower than the SWA.	• The SWA was below the 10th percentile for Antidepressant Medication Management, Initiation and Engagement of Treatment for AOD, Timeliness of Prenatal Care, Cervical Cancer Screening, and Child Access to Care (12–24 months of age and 25 months–6 years of age). • MCA-E demonstrated a rate below the SWA for Initiation and Engagement of Treatment for AOD, Timeliness of Prenatal Care, and Cervical Cancer Screening. • The SWA was between the 25th and 50th percentile for Adult	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.	Quality, Access, Timeliness

ACHN Entity	Strengths	Weaknesses	Recommendations	Standards
		BMI Assessment and Child Access to Care (7–11 years of age).		
MCA-NW	The SWA was above the 90th percentile for Asthma Medication Ratio (Child and Adult), and for Child BMI Assessment.	• The SWA was below the 10th percentile for Antidepressant Medication Management, Initiation and Engagement of Treatment for AOD, Timeliness of Prenatal Care, Cervical Cancer Screening, and Child Access to Care (12–24 months of age and 25 months–6 years of age). MCA-NW demonstrated a rate below the SWA for Cervical Cancer Screening. • The SWA was between the 10th and 25th percentile for Well-Child Visits in the First 15 Months of Life and Child Access to Care (12–19 years of age). MCA-NW demonstrated a rate below the SWA for Well-Child Visits in the First 15 Months of Life. • The SWA was between the 25th and 50th percentile for Adult BMI Assessment and Child Access to Care (7–11 years of age).	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.	Quality, Access, Timeliness
NACC	The SWA was above the 90th percentile for Asthma Medication Ratio (Child and Adult), and for Child BMI Assessment. NACC demonstrated a rate above the SWA for each of these measures.	• The SWA was below the 10th percentile for Antidepressant Medication Management, Initiation and Engagement of Treatment for AOD, Timeliness of Prenatal Care, Cervical Cancer Screening, and Child Access to Care (12–24 months	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,	Quality, Access, Timeliness

ACHN Entity	Strengths	Weaknesses	Recommendations	Standards
		of age and 25 months–6 years of age). • NACC demonstrated a rate below the SWA for Engagement in Treatment for AOD, Timeliness of Prenatal Care, and Cervical Cancer Screening. • The SWA was between the 10th and 25th percentile for Well-Child Visits in the First 15 Months of Life and Child Access to Care (12–19 years of age). • The SWA was between the 25th and 50th percentile for Adult BMI Assessment and Child Access to Care (7–11 years of age).	determine if a particular demographic subgroup is disproportionately impacted.	

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; SFY: state fiscal year; LBW: low birthweight; GCTC: Gulf Coast Total Care; PCP: primary care provider; MCA-C: My Care Alabama Central; WIC: Special Supplemental Nutrition Program for Women, Infants, and Children; Q1: first quarter; MCA-E: My Care Alabama East; MCA-NW: My Care Alabama Northwest; MAT: medication-assisted therapy; NACC: North Alabama Community Care; Q4: fourth quarter; STD: sexually transmitted disease; HIMS: health information management system; PHQ: Patient Health Questionnaire; CMC: children with medical complexities; MMM: medical management meeting; MCT: multidisciplinary care team; CMC: children with medical complexity; SWA: statewide average.