# Peds PCP Quality Improvement Collaborative Session #3: 2/3/26

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Arizona State University

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# Targeted Investment Team

## ASU TIPQIC

- William Riley, PhD
- George Runger, PhD
- Matthew Martin, PhD
- Kailey Love, MBA, MS
- Taylor Vaughan, MPH
- El-Ham Ismail
- Samantha Basch, MS
- Francisca Dibarrart, PhD
- Min Jang, PhD

## AHCCCS Targeted Investment

- Julie Ambur
- Christina Quast
- Jane Otenyo

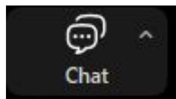
# Agenda

| Time | Topic | Presenter |
|---|---|---|
| 12:00 PM to 12:03 PM | Opening | Matthew Martin, PhD |
| 12:03 PM to 12:10 PM | Measure Overview & Network Performance | Kailey Love, MBA, MS<br>Matthew Martin, PhD |
| 12:10 PM to 12:30 PM | Measure Details: Definition, Coding, Targets, Attribution | George Runger, PhD<br>Taylor Vaughan, MPH |
| 12:30 PM to 12:40 PM | Common Barriers & Best Practices | Matthew Martin, PhD |
| 12:40 PM to 12:58 PM | Discussion | Matthew Martin, PhD |
| 12:58 PM to 1:00 PM | Closing | Kailey Love, MBA, MS |

# Learning Objectives

1. Describe strategies to facilitate population health management improvement.
2. Critically analyze the application of improvement methods and techniques to improve HEDIS quality metrics.
3. Evaluate strategies to identify and address upstream drivers of health for high risk populations
4. Explore process improvement strategies for population health management

# Guidelines




**Do not enter** your name or organization in the Chat. Zoom will automatically record your attendance. Please only use the chat for questions and comments.

At least one representative from each TI organization must have registered and attend the QIC session using that registration link for the required QIC sessions.

Participants will automatically be muted and videos off as they join.

When interested in participating in the discussion, please raise your hand and unmute yourself.

To: Everyone

Type message here...

Please drop your questions into the Chat. If we do not have time to address your question, we will compile all questions into a FAQ document and distribute post-event.

# Disclosure

## This is a CME activity

**Acknowledgment:** This CME event is not supported by any commercial entity.

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**Credit Statement:** Arizona State University designates this live activity for a maximum of 1-credit from the following:

- ***AMA PRA Category 1 Credit™ – CME – 1 credit hour per session***
- ***Nursing Continuing Professional Development – NCPD – 1 credit hour per session***
- ***Psychology – CEP – 1 credit hour per session***
- ***Social Work – ACE – 1 credit hour per session***
- ***Interprofessional Continuing Education – IPCE – 1 credit hour per session***

**Providers should only claim credit commensurate with the extent of their participation in the activity.*

# Measure Overview & Network Performance

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# Peds PCP QIC Curriculum Overview

| Peds PCP AOC Measures | TI Year 4: 10/1/2025 - 9/30/2026 | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | O | N | D | J | F | M | A | M | J | J | A | S |
| W30 - Part 2 | QIC | | | | | | QIC | | | | | |
| WCV | | | QIC | | | | | | QIC | | | |
| W30 - Part 1 | | | | | QIC | | | | | | QIC | |
| Optional Resources | Ongoing Performance Improvement Project (PIP) | | | | | | | | | | | |
| | Ongoing Technical Assistance & Consultation | | | | | | | | | | | |

- **QIC's** in October, December, and February are **required**
  - Each QIC will focus on the a HEDIS measure as indicated in the above table
- ***QIC's*** in April, June, and August are ***optional***
  - The focus of these sessions may shift based on performance and other priorities

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| Table 1<br>Targeted Investments (TI) 2.0<br>Year 4 Milestones and Incentive Percentages | | | |
|---|---|---|---|
| **MILESTONES** | **PEDS PCP** | | |
| | **INCENTIVE % OF ANNUAL PAYMENT** | | |
| **M1. Performance Measures** | **50** | | |
| | W30 - Part 1 | W30-Part 2 | WCV |
| | 15 | 20 | 15 |
| **M2. Screening and Referral Systems for Nonmedical Drivers of Health** | **25** | | |
| **M3. Closed Loop Referral System (CLRS)** | **15** | | |
| **M4. Quality Improvement Collaboratives (QICs)** | **10** | | |

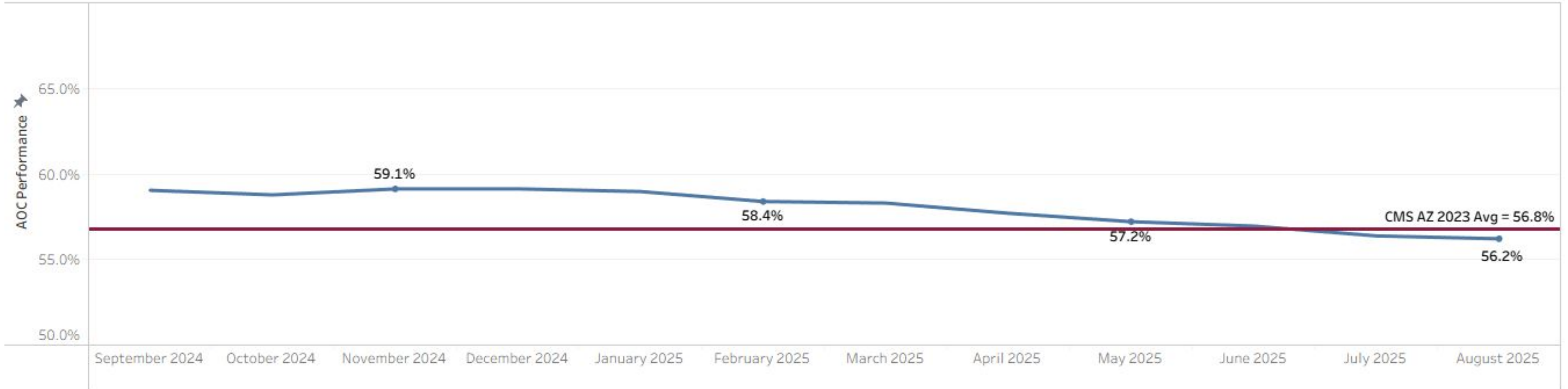
# Peds PCP

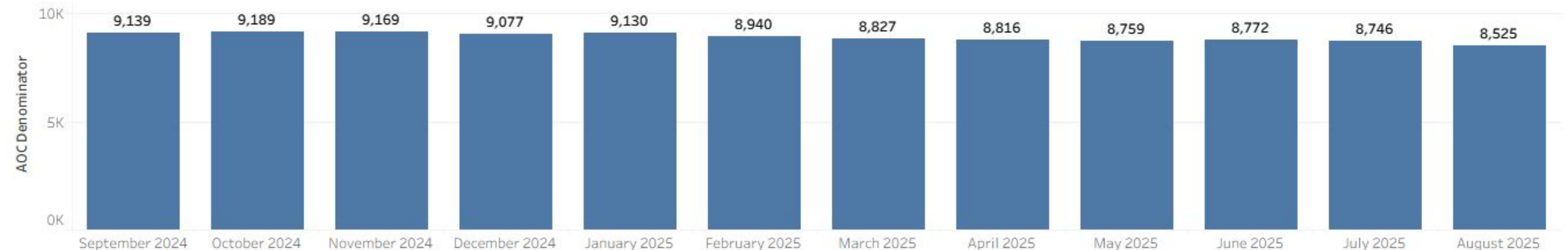
| Performance Measure | Measure Description | TI AOC Performance * | All AHCCCS Performance * | 2023 AZ Medicaid Average[1] | 2023 HEDIS National Average[2] |
|---|---|---|---|---|---|
| ✷ = Proposed 2026 ACOM306 Measure; ✻ = MAC 2024 Scorecard Measure; ✾ = 2025 CMS Core Set Measure; ✱ = 2024 UDS Quality of Care Measure; + = 2024 SAMHSA CCBHC Quality Measure; ✪ = NCQA HEDIS Stratified Measure; ❃ = MAC QRS Measure | | | | | |
| Well Child Visits (W30) - Part 2 ✷ ✻ ✾ ✪ ❃ | Percentage of child beneficiaries that had two well-child visits with a PCP between ages 15 months and 30 months | 65.2% | 64.9% | 59.2% | 69.2% |
| Child and Adolescent Well Care Visits (WCV) ✷ ✻ ✪ ❃ | Patient(s) 3 - 21 years that had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner in the last 12 reported months | 52.2% | 48.8% | 45% | 52.1% |
| **Well Child Visits (W30) - Part 1** ✻ ✾ ✪ ❃ | **The percentage of child beneficiaries who had 6 or more well-child visits with PCP in the first 15 months of age.** | **56.2%** | **57.9%** | **56.8%** | **59%** |

*Report period ending August 31, 2025
1. https://www.medicaid.gov/medicaid/quality-of-care/core-set-data-dashboard/main?focusStates=%5B%22AZ%22%5D
2. https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/

Note: The HEDIS national average refers to performance under 'Medicaid HMO.' Performance data highlighted in blue (IET, FUH, FUM, FUI, FUA) do not have age-stratified values, so the reported figures represent aggregate performance across all ages.

# W30 Part 1 - Network Performance



# Measure Details

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# Child and Adolescent Well Care Visits Definition

*W30 Part 1:* The percentage of child beneficiaries who had 6 or more well-child visits with PCP in the first 15 months of age.

# Quality Alignment

| Peds PCP | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Performance Measure | Measure Description | TI AOC Performance * | Quality Alignment | | | | | | | |
| | | | 2026 ACOM 306 Measure | MAC 2024 Scorecard Measure | 2025 CMS Core Set Measure | 2024 UDS Quality of Care Measure | 2024 SAMHSA CCBHC Quality Measure | NCQA HEDIS Stratified Measure | MAC QRS Measure |
| Well Child Visits (W30) - Part 1 ✻ ✾ ✪ ❃ | The percentage of child beneficiaries who had 6 or more well-child visits with PCP in the first 15 months of age. | 56.2% | | ✻ | ✾ | | | ✪ | ❃ |

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1. https://www.medicaid.gov/medicaid/quality-of-care/core-set-data-dashboard/main?focusStates=%5B%22AZ%22%5D
2. https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/

Note: The HEDIS national average refers to performance under 'Medicaid HMO.' Performance data highlighted in blue (IET, FUH, FUM, FUI, FUA) do not have age-stratified values, so the reported figures represent aggregate performance across all ages.

# W30 Part 1 Importance

Measures early preventive care access

Supports healthy growth and development

Identifies issues early

Reinforces evidence-based pediatric care

Encourages continuity with primary care

Improves long-term child outcomes

# Well Child Visits

Your performance is reported as a percentage calculated as the = numerator / denominator

| TI Area of Concentration | Measure | Denominator Definition | Numerator Definition |
|---|---|---|---|
| Peds PCP | Well Child Visits (W30) - Part 1 | Members aged 15 months as of the report period end date. | Members in the denominator who had six or more well-child visits with a PCP in the first 15 months of life. |

Note: Visits must be 14 days apart.

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# What is the Reporting Period?

- A HEDIS® measure's reporting period is a continuous 12-month window.
- TIP Provider Dashboards show your organization's performance on the selected measure for 12 consecutive, overlapping report periods, where each report period is a 12-month period ending in the month and year shown on the X-axis.
- Your performance levels for 12 report periods are provided so you can track how your performance changes across time. TI incentive payments are based on your performance for the Federal Fiscal Years (October 1st to September 30th).

# Which Members Are in My Denominator?

To understand the members that you are accountable for and who are attributed to you (i.e., in your denominator) for this measure, you need to know the denominator definition (previous slide), as well as the AHCCCS member population assessed, and the attribution method used.

**Member Population Assessed**

- Members enrolled in one of the six AHCCCS Complete Care (ACC) health plans

**Member Population Exclusions**

- ACC members who utilized hospice services or died

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# What Services Qualify for the Numerator?

**Billing Codes**

- TI 2.0 Year 4 use HEDIS® Measurement Year 2023 measure definitions.
- Due to licensing agreements, we are not able to publish a list of all qualifying services codes. However, we can direct you to resources containing the billing codes.
    - Please see these Arizona Health Plan Measure Guides. You do not have to be contracted with the plan to access these resources.
        - United Healthcare - HEDIS® MY 2023 Reference Guide
        - Definitions Only - Banner University Family Care - HEDIS® Guide
    - For more information on HEDIS measures or to get your own license, see the NCQA HEDIS® site.
    - Value sets and codes used in HEDIS 2024 (Measurement Year 2023) measure calculations are available at no cost. Download the 2023 Quality Rating System (QRS) HEDIS Value Set Directory from the NCQA store.

# Attribution

- PCP attribution is based on claims and PCP-member assignments.
- Members are attributed to the PCP with whom they have the strongest relationship, as documented by claims, considering the frequency of visits, MCO PCP assignment, and the member's most recent PCP visit if multiple relationships exist. If no established relationship is documented, members are attributed to their MCO-assigned PCP. The most recent member assignments at the report period end.
- These assignments are provided monthly by health plans and AHCCCS. Milestone performance is calculated based on member-level attribution aggregated to the Organizational (Tax ID) level for participating sites.
- Interested providers can work with the ASU TIPQIC team to examine AHCCCS members who are eligible for each measure and attributed to their organization through a member list comparison (Data Harmonization).

# Target Setting

+ t a b | e a u

Username

Enter your username

Password

Sign In

Forgot your password?

- Two tiers were set for the W30 - Part 1 measure
  - AHCCCS emailed each provider organization with individual target setting information
- For your organization's specific target, please see your dashboard or the email received from the AHCCCS TI team.
- TI Peds PCP providers need to exceed their target to achieve the incentives associated with this performance measure.

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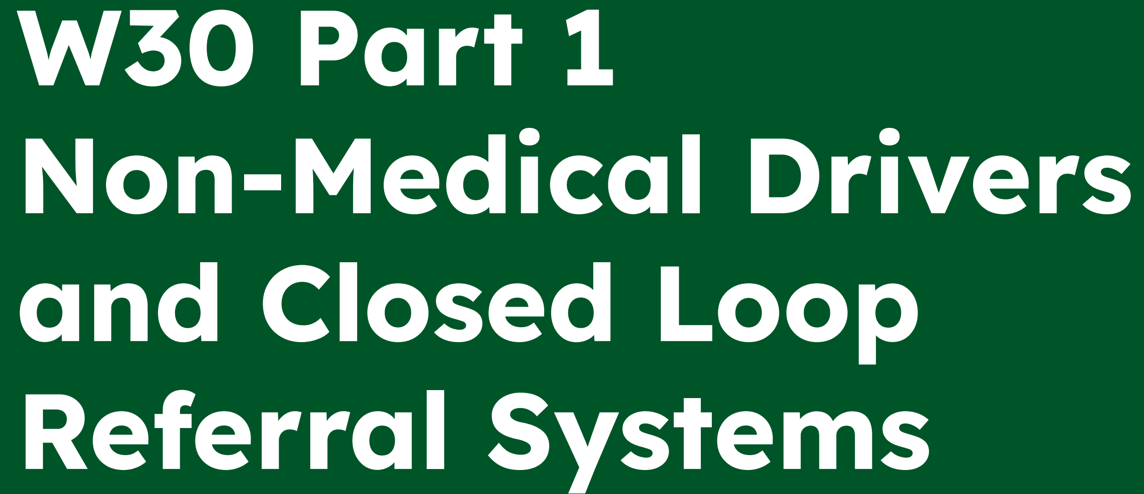
To log in to your dashboards, please visit data.tipqic.org.

If you would like to make any changes to your log-in or password, please email support@tipqic.org

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# Advantages of Providers Screening for Non-Medical Drivers of Health for W30 Part 1

**Why It Matters for W30 – Part 1**

- Identifies barriers early in infancy
- Addresses transportation, housing, food needs
- Reduces missed and delayed visits
- Supports caregiver engagement and trust
- Enables targeted care coordination
- Improves continuity with primary care
- Increases timely well-child visit completion

**Impact on W30 Performance**

Early NMDOH screening allows providers to proactively remove access barriers, increasing the likelihood that infants complete the required well-child visits within the first 15 months of life.

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# Non-Medical Drivers of Health (NMDOH) G/Z Codes

- Between May 2024 and August 2025, TI providers screened 35,721 unique patients for non-medical drivers of health, submitting 41,167 G codes via claims.
  - The most commonly identified needs were housing, employment, and larger economic conditions, with over 5,959 NMDOH referrals given to help patients meet these needs.
- NMDOH screening can be associated with higher performance across several HEDIS® quality measures.
  - W30 - Part 1 performance among TI patients with a documented G code was 4.3% higher than among TI patients without a G code.
- Year 4 Milestone 2B: **ATTEST** to documenting NMDOH screening and referral results via consistent submission of claims using G procedure codes (G9919 and G9920), V4 modifier, and Z diagnosis codes as appropriate.

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https://www.azahcccs.gov/PlansProviders/Downloads/TI/Milestone/Year4MilestoneRequirements.pdf

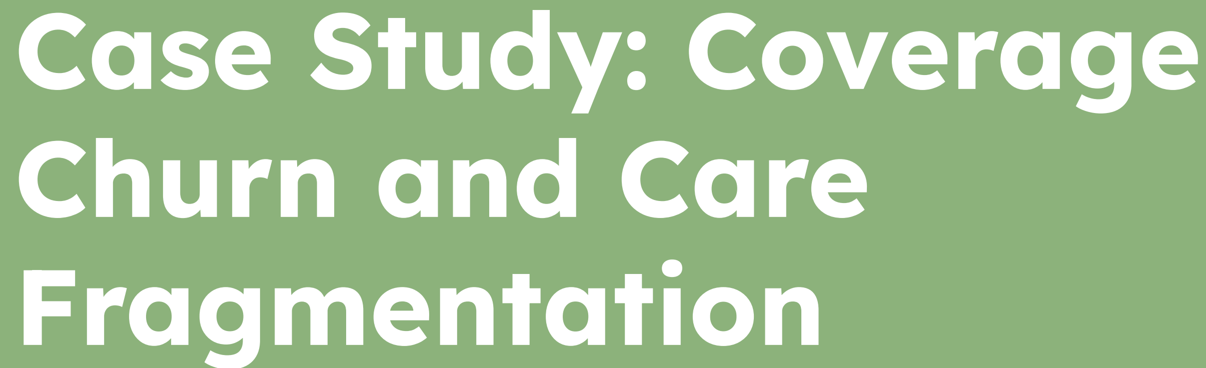
# Closed Loop Referral Systems and W30 Part 1

**Improving Access and Visit Completion**

- Ensures referrals reach community resources
- Confirms services are received
- Tracks referral outcomes in real time
- Reduces unmet social needs
- Strengthens care team accountability
- Improves follow-up and retention

**Impact on W30 Performance**

Closed-loop referral systems help ensure identified NMDOH needs (e.g., transportation, childcare, food support) are resolved, reducing appointment no-shows and supporting timely completion of well-child visits.


Case Study: Coverage
Churn and Care
Fragmentation

# Coverage Churn & Care Fragmentation (W30)

Infants often experience coverage gaps, plan changes, and care transitions in the first 15 months. Well-child visits may:

- Occur outside active Medicaid coverage
- Be completed with a non-attributed provider
- Be mis-timed or mis-documented

Result: Visits happen—but don't count. W30 can be a continuity and attribution challenge, not just an access challenge.

# Case Study

Infant born at 34 weeks and discharged from the NICU at 3 weeks of age. Family completes:

- Newborn visit with hospital-affiliated clinic
- 2-, 4-, and 6-month well-child visits with a community pediatric practice
- 9-month visit delayed due to caregiver job change and temporary Medicaid lapse
- 12-month visit completed after re-enrollment, but with a different PCP due to plan change

At measurement:

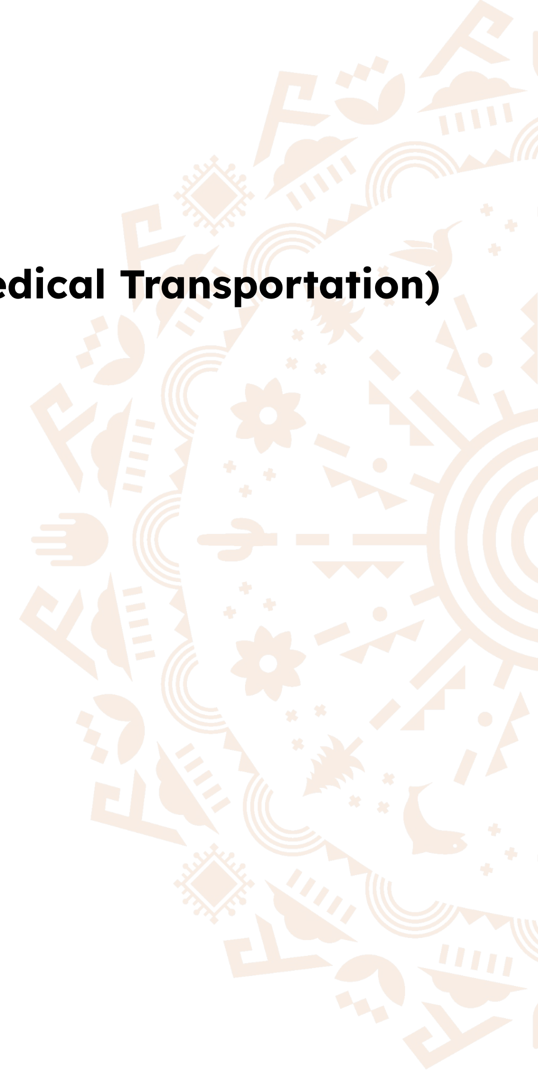
- Two visits occurred during a coverage gap
- One visit occurred with a non-attributed provider

W30 result: 4 counted visits; Clinical reality: 7 well-child visits completed

Question: Where was continuity lost?

# W30 Part 1 Common Barriers

- Transportation insecurity, despite **NEMT (Non-Emergency Medical Transportation)** availability
- Socioeconomic instability (housing, food, financial stress)
- Caregiver work constraints and limited paid leave
- Limited pediatric providers accepting Medicaid
- Coverage churn disrupting continuity of care
- Low health literacy and limited awareness of visit schedules
- Language, cultural, and trust barriers
- Care fragmentation and documentation gaps



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# W30 Part 1 Best Practices

- Schedule all visits in advance
- Use reminder and recall systems
- Promote NEMT (Non-Emergency Medical Transportation) awareness and assistance
- Offer extended hours and same-day access
- Assign care coordination or outreach staff
- Educate caregivers on visit schedules
- Address language and cultural needs
- Monitor performance and close gaps

# Discussion

# Peer Volunteers

- Arizona Community Physicians
  - Holli Wyman
- Children's Clinics for Rehab
  - Melissa Ritchey

# Discussion Questions

- How can teams identify infants experiencing coverage churn in real time?
- Which W30 “gaps” are truly missed visits versus attribution or documentation issues?
- What happens to care continuity when families switch plans, providers, or care settings?
- How to capture visits completed outside a clinic (NICU follow-ups, urgent care, other PCPs)?
- Can EHR templates be optimized for W30-eligible well-child visits?
- Where do timing, coding, or visit-type errors most commonly occur?
- What is one workflow change that could help us protect W30 performance during coverage churn?

# Peds PCP Discussion

# Discussion Questions

### Understanding Current Performance

- What are your clinic's current W30 Part 1 rates, and where are the biggest gaps?
- At which infant age intervals do you see the most missed well-child visits?
- Which patient populations are least likely to complete all required visits?

### Workflow and Scheduling

- How are well-child visits scheduled during the newborn or first post-discharge visit?
- What processes are in place to ensure visits are scheduled in advance through 15 months?
- Where do scheduling or follow-up breakdowns most commonly occur?

### Engagement and Communication

- How do you educate caregivers about the importance and timing of multiple well-child visits?
- What reminder or recall methods have been most effective in your practice?
- How do you address missed or canceled visits to prevent future gaps?

### Non-Medical Drivers of Health (NMDOH)

- How and when do you screen for non-medical drivers of health in infancy?
- Which social needs most often interfere with well-child visit completion?
- How are NMDOH findings documented and acted upon by the care team?

# Discussion Questions

### Transportation and Access

- How do you identify families who may need NEMT support?
- What challenges do families report when using NEMT, and how are they addressed?
- How do you confirm transportation before scheduled visits?

### Care Coordination and Referrals

- How are referrals to community resources initiated and tracked?
- Are closed-loop referral systems used to confirm services were received?
- What gaps exist between identifying a need and resolving it?

### Documentation and Data Capture

- How do you ensure well-child visits are accurately coded and captured in claims?
- Where have you seen documentation gaps affect W30 reporting?
- How do clinical and billing teams coordinate around HEDIS requirements?

### Peer Learning and Improvement

- What strategies have worked well in your practice to improve W30 performance?
- What barriers feel hardest to address, and where could peer support help?
- What one change could you test in the next 30–60 days to improve outcomes?

# Closing

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# Closing & Next Steps

- For those interested in CME, an evaluation survey will be distributed following this event and CME certificates will be distributed to those who complete this survey at the end of the month.
- Register for the upcoming Optional QIC session(s)

**AHCCCS Questions:** targetedinvestments@azahcccs.gov
**ASU TIPQIC General Inquiries:** TIPQIC@asu.edu
**Support Tickets:** support@TIPQIC.org

**Relevant Websites:**

- AHCCCS TI: https://www.azahcccs.gov/PlansProviders/TargetedInvestments/
- ASU TIPQIC: tipqic.org
- Dashboards: data.tipqic.org

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