# Adult PCP Quality Improvement Collaborative Session #3: 2/17/26

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Arizona State University

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

# 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
- Norah Ylang

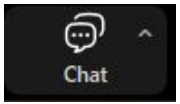
# Agenda

| Time | Topic | Presenter |
|---|---|---|
| 12:00 PM to 12:03 PM | Opening & Y4 Performance Measure Updates | William Riley, PhD |
| 12:03 PM to 12:15 PM | Measure Overview & Network Performance | Kailey Love, MBA, MS<br>Roshini Moodley Naidoo, MBChB, MBA, MPH |
| 12:15 PM to 12:35 PM | Measure Details: Definition, Coding, Targets, Attribution | George Runger, PhD<br>Taylor Vaughan, MPH |
| 12:35 PM to 12:45 PM | Common Barriers & Best Practices | William Riley, PhD<br>Roshini Moodley Naidoo, MBChB, MBA, MPH |
| 12:45 PM to 12:57 PM | Discussion | William Riley, PhD<br>Roshini Moodley Naidoo, MBChB, MBA, MPH |
| 12:57 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

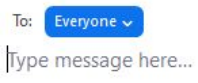



**Do not enter** your name or organization in the Chat. Zoom will automatically record your attendance. Please only use the chat for questions and comments.


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.




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.*

# Y4 Performance Measure Updates

- ASU is upgrading from the MY 2023 HEDIS specifications to the MY 2025 HEDIS specifications for TI 2.0 Year 4 performance measures.
- AHCCCS has approved the following codes for use in the TI 2.0 Adult PCP AOC Year 4 performance measure calculations:
  - **87626** (already part of MY HEDIS 2025 measure specifications) for CCS

ASU TIPQIC will retrospectively calculate performance with the updated measure specifications, using the above codes as numerator-qualifying criteria for the CCS measure. Updated performance will be reflected in the April/May dashboard. Please direct any data-related questions to tipqic@asu.edu.

# Measure Overview & Network Performance

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| Table 1<br>Targeted Investments (TI) 2.0<br>Year 4 Milestones and Incentive Percentages | | | |
|---|---|---|---|
| **MILESTONES** | **ADULT PCP** | | |
| | **INCENTIVE % OF ANNUAL PAYMENT** | | |
| **M1. Performance Measures** | **50** | | |
| | **CCS** | **PPC** | **AAP** |
| | **20** | **15** | **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** | | |

# Adult PCP QIC Curriculum Overview

| Adult PCP AOC Measures | TI Year 4: 10/1/2025 - 9/30/2026 | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | O | N | D | J | F | M | A | M | J | J | A | S |
| CCS | QIC | | | | | | QIC | | | | | |
| PPC-Pre | | | QIC | | | | | | QIC | | | |
| AAP | | | | | 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

# ADULT PCP

| Performance Measure | Measure Description | TI AOC Performance * | All AHCCCS Performance * | 2023 CMS AZ 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 | | | | | |
| Cervical Cancer Screening (CCS) ✷ ✾ ✱ ✪ ❋ | The percentage of women 21–64 years of age who were screened for cervical cancer. | 43.5% | 42.8% | 52.5% | 55.4% |
| Prenatal and Postpartum Care - Timeliness of Prenatal Care (PPC-Pre) ✷ ✾ ✪ ❋ | The percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization. | 61.6% | 59.5% | 83.1% | 83.1% |
| **Adults' Access to Preventive/Ambulatory Health Services (AAP)** | **The percentage of members 20 years of age and older who had an ambulatory or preventive care visit.** | **75.3%** | **75.4%** | **N/A** | **74.2%** |

*Report period ending August 31, 2025

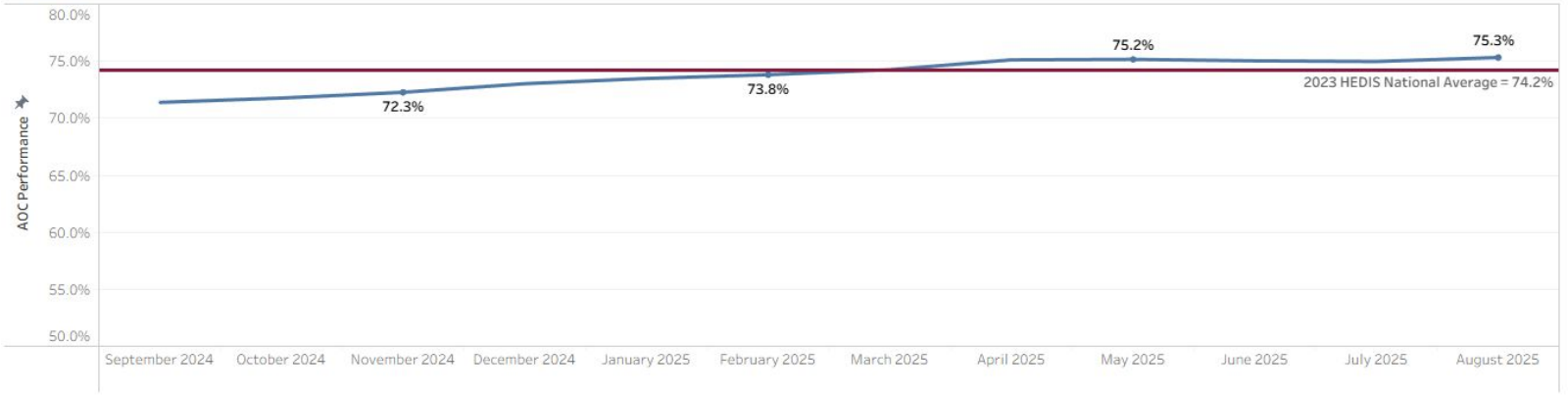
1. https://www.medicaid.gov/medicaid/quality-of-care/core-set-data-dashboard/main?focusStates=%5B%22AZ%22%5D
2. https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/

Note: The HEDIS national average refers to performance under 'Medicaid HMO.'

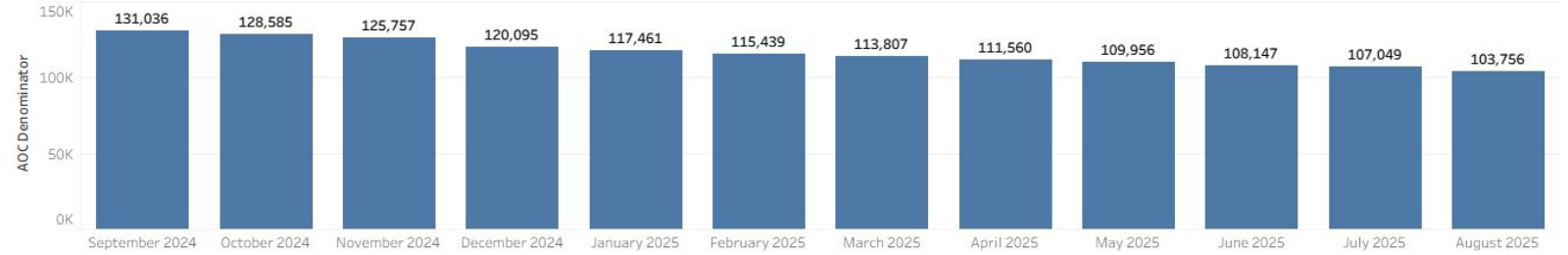
# AAP Network Performance

**Measure Performance** (each month is a 12-month report period)

ADULT PCP




**Measure Denominator**



# Measure Details

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# Adults Access to Preventive/Ambulatory Health Services (AAP)

*AAP*: The percentage of patients 20 years of age and older who had an ambulatory or preventive care visit.

# AAP Importance

- Ensures timely preventive and routine care
- Supports early detection of chronic conditions
- Promotes management of ongoing health risks
- Improves patient engagement with primary care
- Enhances continuity of care
- Tracks provider and health system performance
- Reduces avoidable hospitalizations and complications

# AAP

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

| TI Area of Concentration | Measure | Denominator Definition | Numerator Definition |
|---|---|---|---|
| Adult PCP | AAP | Members aged 20 years old and older as of the report period end date. | Members in the denominator who had a preventive or ambulatory care visit during the last 12 months of the report period. |

The AAP measure requires members to be continuously enrolled in medical benefits without a break greater than 45 days.

# 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 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
- Members with SMI enrolled in an ACC Regional Behavioral Health Agreement (RBHA) health plan are included

**Member Population Exclusions**

- ACC and ACC-RBHA members who utilized hospice services or died

# What Services Qualify for the Numerator?

**Billing Codes**

- TI 2.0 Year 4 will now use HEDIS® Measurement Year 2025 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 2025 Reference Guide
    - Mercy Care - HEDIS® MY 2025 Reference 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 MY 2025 measure calculations are available at no cost. Download the 2025 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 are used.
- These assignments are provided monthly by health plans and AHCCCS. Milestone performance is calculated based on memberlevel 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


- Two tiers were set for the AAP 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 Adult 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

# AAP Non-Medical Drivers and Closed Loop Referral Systems

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# Advantages of Providers Screening for Non-Medical Drivers of Health for AAP

- Identifies social barriers to accessing care (transportation, housing, food, financial stress)
- Detects psychosocial or behavioral factors affecting care engagement
- Allows targeted interventions to reduce missed visits
- Improves patient engagement and trust
- Supports care coordination and reduces preventable gaps
- Directly improves AAP performance by removing obstacles to preventive care

# 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.
  - AAP performance among TI patients with a documented G code was 22.8% 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.

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

# Closed Loop Referral Systems and AAP

- Ensures referrals to social or specialty services are received
- Confirms patients complete recommended care
- Tracks outcomes and resolves gaps in real time
- Reduces missed care due to unresolved barriers
- Strengthens accountability and care coordination
- Improves AAP performance by supporting access to preventive and follow-up care

# Case Study: AAP

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# AAP

- Most adults have some contact with the healthcare system each year
- AAP gaps often occur because:
  - Care is delivered in higher-level care settings (ED, inpatient)
  - Patients are attributed to a PCP they rarely see
- Result: Patients engage in care—but AAP remains unmet

Key message:

AAP is an attribution and visit-type challenge that impacts access

# Case Study

Patient D (Age 46)

- Adult patient attributed to a primary care provider (PCP) within the health plan
- Has multiple chronic or recurring conditions requiring episodic care
- Actively engaged with the healthcare system, but primarily through higher-level care settings

Healthcare Utilization Over the Measurement Year

- Member had an inpatient admission for acute back pain
  - Care was centered on acute stabilization and evaluation
  - Does not meet criteria for a qualifying preventive or ambulatory visit for AAP → PCP held accountable for patients they do not truly manage

# Case Study cont.

- Emergency department visit for migraine
  - Treated and discharged the same day
  - ED visit does not count toward AAP
- AAP Result
  - No qualifying preventive or ambulatory visit during the measurement year

# Discussion

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# Peer Volunteers

- Partners in Recovery
  - Derrick Baker
- CODAC
  - Nicole Huggett

# Discussion Questions

- Are there barriers to access that can be mitigated without significant changes to existing workflows?
- Which visits should count for AAP but often don’t?
- How do teams identify patients who use care elsewhere?
- What keeps problem-focused visits from being AAP-eligible?
- What’s one workflow that could convert existing visits into AAP credit?

# 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 Optional QIC session(s)

# Questions?

**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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