ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

Arizona Section 1115 Demonstration Waiver Evaluation

Interim Evaluation Report

This demonstration is operated under a Section 1115 Research and Demonstration Waiver initially approved by the Centers for Medicare & Medicaid Services (CMS) on October 14, 2022.

October 2025

Revised January 2026

TIP QIC Targeted Investments Program Quality Improvement Collaborative

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Executive Summary

Medicaid, established by the Social Security Act of 1965, is a collaborative program between federal and state governments that offers free or low-cost health care coverage to approximately 77 million eligible low-income Americans.[1] Medicaid coverage is offered to pregnant women, families with children, the elderly, individuals with disabilities, and in certain states, low-income adults without children. The Centers for Medicare and Medicaid (CMS) and federal law set the minimum standards of care that states must provide to Medicaid beneficiaries, while also allowing states to develop and implement their own methods for delivering and financing health care services to meet these standards. Section 1115 of the Social Security Act allows states to experiment with innovative demonstration projects and assess state-specific policy changes aimed at enhancing efficiency and reducing costs without increasing Medicaid spending.

In line with the Special Terms and Conditions (STCs) of Arizona's Section 1115 waiver demonstration, the Arizona Health Care Cost Containment System (AHCCCS) retained the team at Arizona State University (ASU) as independent evaluators to conduct a thorough assessment of the Targeted Investments (TI) 2.0 Program, one of Arizona's Section 1115 waiver demonstration programs. The objective of this evaluation is to provide CMS and AHCCCS with an independent evaluation that ensures adherence to Section 1115 waiver requirements, supports state and federal decision-making regarding the demonstration's effectiveness, and aids AHCCCS in further development of clinically appropriate, fiscally responsible, and effective Medicaid demonstration programs. Of the 55 measures evaluated with an appropriate comparison group for statistical testing, 51 were consistent with evaluation expectations. In the first year after implementation, statistical analyses showed that 93 percent of measures were consistent with the tested hypotheses. Overall, most measures demonstrated favorable changes, indicating positive trends for the TI population. These results highlight a strong foundation for continued quality improvement and sustained positive outcomes as the program progresses. This report represents the Interim Evaluation Report of the TI 2.0 Program.

Demonstration Overview

On January 18, 2017, CMS approved AHCCCS' request to amend Arizona's 1115 Demonstration Waiver, implementing TI 1.0.[2] This program supported providers in

[1] Centers for Medicare & Medicaid Services. August 2024 Medicaid & CHIP Enrollment Data Highlights. Medicaid.gov. Published 2024. https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html
[2] Centers for Medicare & Medicaid Services. AHCCCS Targeted Investments Program Approval. Available at: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-

Arizona moving toward integrated and coordinated care. It aimed to reduce fragmentation between acute care and behavioral health (BH) care, increase efficiencies in service delivery for Arizona Medicaid beneficiaries with BH needs, and improve health outcomes for affected populations under the AHCCCS Complete Care (ACC) and ACC-Regional Behavioral Health Agreement (RBHA) lines of business, excluding Arizona Long Term Care System (ALTCS) members and Arizona's Department of Child Safety (DCS) for members enrolled in the Comprehensive Health Plan (CHP). TI 1.0, which utilized $350 million across the original demonstration period, successfully funded limited-time, outcome-based projects to build infrastructure to create and sustain integrated care delivery systems that improve care coordination and drive better health and financial outcomes for adults with BH needs; children with BH needs, including children with or at risk for autism spectrum disorder (ASD); children in the welfare system; and individuals transitioning from incarceration.

On October 14, 2022, CMS approved the renewal of the TI program through TI 2.0 for $250 million over a five year period from October 1, 2022, through September 30, 2027.[3] The TI 2.0 program builds upon the success of TI 1.0 by further integrating point-of-care systems, providing guidance and incentives to providers for initiating new and meaningful system transformations, and enhancing requirements to comprehensively address quality health care and ensuring fair health care access through the provision of whole-person care.

TI 2.0 supports Arizona's goal to fully transform the Medicaid delivery system to an integrated whole-person care structure by encouraging providers to thoughtfully develop infrastructure and protocols to optimize the coordination of services designed to meet the member's acute, behavioral, and health-related social needs (HRSNs)/non-medical drivers of health (NMDOH)[4] and address identified health disparities amongst their patient population. AHCCCS will achieve this goal by supporting providers throughout the state to develop and enhance care coordination processes with healthcare and community-based organizations and provide guidance, tools, and technical assistance for internal population health analyses.

Targeted Investments 2.0 Annual Requirements

Providers participating in the TI 2.0 program may apply to participate in up to five clinical areas of concentration (AOCs) based on the populations they serve: Adult Behavioral

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Topics/Waivers/1115/downloads/az/Health-Care-Cost-Containment-System/az-hccc-trgtd-invstmnts-prgrm-appvl-01182017.pdf. Accessed on: Aug 3, 2023.

[3] Centers for Medicare & Medicaid Services. AHCCCS Section 1115 Waiver. Published 2022. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/az-hccc-ca-10142022.pdf
[4] AHCCCS began using NMDOH in Year 4; references throughout may use either HRSN or NMDOH.

Health (BH), Adult Primary Care (PCP), Pediatric BH, Pediatric PCP, and Justice. In addition to AHCCCS provider eligibility and service volume requirements, participating providers in the TI 2.0 program must complete the requirements outlined below to achieve the incentives associated with that program year.

- **Year 1 (October 2022 – September 2023)** - Onboarding/Application: Eligible providers will earn Year 1 incentive payments for successfully completing the application and process requirements.
- **Year 2 (October 2023 – September 2024)** - Develop and Implement Process/Procedures: Participants will earn Year 2 incentives by developing processes and procedures related to TI 2.0 initiatives. AHCCCS will validate minimum elements required to meet the processes and procedures requirement. TI organizations can expect to participate in Quality Improvement Collaborative sessions (QICs) led by the ASU Targeted Investments Program Quality Improvement Collaborative (TIPQIC) team. Each session will bring AHCCCS, ASU, MCOs, CBOs, and other stakeholders together to discuss challenges and share best practices for TI 2.0 policies and procedures.
- **Year 3 (October 2024 – September 2025)** - Demonstrate Process/Procedures: Participants will demonstrate that the procedures and processes developed in TI 2.0 Year 2 have been successfully implemented. Each participant's incentive payments are determined by the processes and procedures associated with each passed milestone.
- **Year 4 (October 2025 – September 2026) & Year 5 (October 2026 – September 2027)** - Performance Measurement: Eligible provider organizations will earn Year 4 and Year 5 incentive payments by meeting or exceeding performance measure targets, which will be communicated at the beginning of each respective program year, as well as other milestone requirements. Year 4 and Year 5 performance measures will be selected to adopt the newest and most aligned measures with steward-backed criteria related to TI 2.0 initiatives.

Research Hypothesis

Five hypotheses were tested in total to assess the TI 2.0 program (Table 1). Each hypothesis directly supported one or more of the program goals and was associated with several research questions, each of which could be evaluated using multiple measures.

Hypothesis 1 explored how the program leveraged system-wide collaboration to improve health care for underserved populations from the perspective of various stakeholders. Hypotheses 2 to 4 assessed the program's impact on population health and other member outcomes for each of the three distinct beneficiary populations within

TI 2.0: pediatric, adult, and justice-involved beneficiaries. Hypothesis 5 evaluated the costs associated with the program.

A comprehensive list of evaluation hypotheses and research questions can be found in the 'Evaluation Questions and Hypotheses' section. Appendix A offers further details on the methods, data sources, and associated measures for each of the research questions mentioned below.

Table 1

	TI 2.0 Hypotheses
1	The TI 2.0 program will increase collaboration and coordination amongst the managed care organizations (MCOs), accountable care organizations (ACOs), subcontracted networks, and provider organizations.
2	The TI 2.0 program will improve the delivery of care that addresses inequitable health outcomes for children.
3	The TI 2.0 program will improve the delivery of care that addresses inequitable health outcomes for adults.
4	The TI 2.0 program will improve the delivery of care for AHCCCS enrolled adults released from criminal justice facilities and who are referred to a TI Justice clinic.
5	The care costs for the TI 2.0 program participants will be lower than the care costs of the non-TI participants.

Results

The Interim Evaluation Report presents findings from key informant interviews, beneficiary survey results, and all performance measures with available data. For each performance measure, outcomes among TI providers were compared with those of non-TI providers, and differences between the baseline (FFY 2022; October 1, 2021 – September 30, 2022) and ramp-up (FFY 2023; October 1, 2022 – September 30, 2023) periods were assessed. This report addresses all five hypotheses. One hypothesis relates to descriptive reporting and synthesis from qualitative data collection. Three involve statistical testing of performance measure rates and beneficiary survey results when an appropriate comparison group is available. The final hypothesis assesses the cost of care between TI-attributed beneficiaries and non-TI attributed beneficiaries.

A total of 70 measures were calculated for this report, and 55 had an appropriate comparison group that allowed for statistical testing. Tables 2a and 2b summarize the results for these measures across all hypotheses, stratified by quantitative performance/claims data and beneficiary survey data, respectively. Most measures have a defined desired direction, where a rate increase or decrease may indicate a favorable change. However, some measures depend on context and do not have a clear favorable direction. For a measure to be considered improved, it must show a statistically significant change in the desired direction between the baseline and ramp-up period. Conversely, for a measure to be considered worsened, it must show a statistically significant change opposite to the desired direction between the baseline and ramp-up period.[5]

The results in Table 2a and 2b indicate that of 55 measures with a defined desired direction, 10 showed statistically significant improvements, 4 showed a statistically significant decline, and nearly 41 did not change significantly.

[5] Statistical significance was determined based on the traditional confidence level of 95 percent.

Table 2a: Summary of Measure Rate Changes Between Baseline and Ramp-Up Periods for TI 2.0 - Performance Data

Hypothesis	Evaluation Year	Significant Improvement	No Significant Difference	Significant Decline	No Desired Direction[1]
Hypothesis 2: The TI 2.0 program will improve the delivery of care that addresses inequitable health outcomes for children.	2023	4	9	1	0
Hypothesis 3: The TI 2.0 program will improve the delivery of care that addresses inequitable health outcomes for adults.	2023	5	9	2	1
Hypothesis 4: The TI 2.0 program will improve the delivery of care for AHCCCS-enrolled adults released from criminal justice facilities and who are referred to a TI Justice clinic.	2023	0	6	0	3
Hypothesis 5: The care costs for the TI 2.0 program participants will be lower than the care costs of the non-TI participants.	2023	0	1	0	0
TOTAL	**2023**	**9**	**25**	**3**	**4**

[1] Determination of improvement is not applicable or is dependent on context

Table 2b: Summary of Measure Rate Changes Between Baseline and Ramp-Up Periods for TI 2.0 - Survey Results

Hypothesis	Evaluation Year	Significant Improvement	No Significant Difference	Significant Decline	No Desired Direction[1]
Hypothesis 2: The TI 2.0 program will improve the delivery of care that addresses inequitable health outcomes for children.	2023	1	8	0	0
Hypothesis 3: The TI 2.0 program will improve the delivery of care that addresses inequitable health outcomes for adults.	2023	0	8	1	0
Hypothesis 4: The TI 2.0 program will improve the delivery of care for AHCCCS-enrolled adults released from criminal justice facilities and who are referred to a TI Justice clinic.	2023	0	0	0	11
TOTAL	**2023**	**1**	**16**	**1**	**11**

[1] Determination of improvement is not applicable or is dependent on context

A difference-in-difference (DiD) analysis was performed to evaluate the TI 2.0 program, examining the change between the baseline period and the first year of the ramp-up period (FFY 2023). Results demonstrate that after the first year of the program in FFY 2023, the TI 2.0 program led to a significant decrease in the number of preventable

emergency department (ED) visits among all population groups; improved dental care utilization among adolescents; increased access to preventive/ambulatory health services among adults; and higher rates of initiation of substance use treatment, particularly opioid-related, among beneficiaries transitioning from the criminal justice system. While some findings suggested a marked improvement, such as child receiving topical fluoride varnish and timely post-discharge follow-up with healthcare providers among adults and justice-involved beneficiaries, many did not reach statistical significance. Providers across all five AOCs have demonstrated a strong commitment to addressing disparate health outcomes through various program activities. They have actively engaged in their patients' care by improving internal processes to conduct standardized, multi-domain HRSN/NMDOH assessments, pursuing National Committee for Quality Assurance (NCQA) Health Outcomes Accreditation (formerly Health Equity Accreditation), and implementing targeted projects aimed at better addressing the unique needs of the populations they serve.

Conclusions

Quantitative Findings

Statistical analysis of performance measure rate changes between the baseline and ramp-up showed mixed results, though there was an overall tendency toward improvement. Of the 55 measures with a defined desired direction of change, 10 showed improvement while 4 worsened during the ramp-up period. Two of these were performance measures for which TI providers maintained their performance between the baseline period (FFY 2022) to the ramp-up period (FFY 2023), while non-TI providers showed significant gains. These two service-based measures were also likely influenced by the COVID-19 public health emergency (PHE) that began in Federal Fiscal Year (FFY) 2020, which disrupted the delivery and utilization of healthcare services.

Another measure was the number of ED visits among adult beneficiaries. Although TI adult beneficiaries experienced a higher rate of ED visits compared to their non-TI counterparts, this was accompanied by a significant decrease in preventable ED visits, indicating improved care coordination and more appropriate use of emergency services. The final measure was part of the adult beneficiary survey. TI adult beneficiaries reported lower levels of self-reported overall health compared to non-TI adult beneficiaries, likely reflecting the program's engagement with higher-need populations. Yet, the overall positive performance outcomes indicate that TI providers were able to deliver higher-quality care, ultimately benefiting the patients and addressing their more complex health needs.

Most hypotheses tested anticipated that the TI 2.0 program would maintain or improve care and outcomes for beneficiaries. Measures showing no significant change combined with those that improved showed that 51 of 55 measures were consistent with evaluation expectations. Statistical analyses of the TI 2.0 program found results aligned with the tested hypotheses for 93 percent of measures evaluated in the first year after implementation. Although only four measures declined for the TI population, the majority showed favorable trends, highlighting areas of strength and opportunities for continued quality improvement. Building on the foundation laid by TI 1.0, these trends reflect strengthened organizational capacity and the potential for meaningful, long-term improvements across the healthcare delivery system.

Qualitative Findings

Qualitative analysis of transcripts from key informant interviews and focus group data provide critical contextual information about the implementation of the TI 2.0 program demonstration, aiding in the interpretation of the results. During the first year of the demonstration (FFY 2023), ten focus groups were conducted with a representative group of providers, MCOs, and AHCCCS staff to collect insights and experiences related to the TI 1.0 program and expectations for TI 2.0. These findings contributed to the interim report, however they do not encompass every research question included in the evaluation.

Several themes emerged from the qualitative research findings. First, respondents indicated that the TI 1.0 program was a foundational initiative that significantly enhanced healthcare delivery by promoting consistency, integration, and collaboration across organizations. Through a structured approach, it enabled clinics to standardize processes, clarify expectations, and strengthen staff training, which built confidence in service delivery. Leadership and community buy-in were key to successfully implementing program goals, aligning organizational efforts, and fostering effective policies. The program's alignment with population health initiatives: 1) supported improved performance in value-based care by enabling data-driven strategies, 2) addressed previous gaps in standardization, and 3) re-enforced AHCCCS priorities to promote cross-sector collaboration to develop communication protocols and expand care networks.

Second, support from AHCCCS and ASU was instrumental, offering technical assistance, data analysis tools, and peer learning opportunities that demystified program requirements and facilitated shared problem-solving. Access to ASU dashboards and internal data systems improved performance tracking and care coordination. The program also strengthened staff education and laid a foundation for sustainability, with organizations committed to building on the progress made.

Third, challenges, such as data inaccuracies, system limitations, and staff capacity limitations persisted. Despite these issues, TI 1.0 had a profound impact, including enhancing patient attribution, expanding integrated BH services, and improving care for high-risk populations.

Fourth, providers are looking forward to the opportunities that TI 2.0 presents, emphasizing the potential for improved external partnerships while also reinforcing internal strengths. Many express a desire for additional support and information, particularly regarding initiatives addressing disparate health outcomes. There is a shared optimism that as organizations progress, improvements will become evident across all participating entities. Notable advancements have already been observed, especially in the enhancement of electronic medical record (EMR) systems, which has positively impacted communication, alert systems, and internal processes. With the extension of the TI program through TI 2.0 for an additional five years, providers anticipate even greater integration and development within their healthcare organizations.

A fifth theme emerging from discussions is the importance of creating a partnership framework that incorporates primary care, BH, and social service agencies. Providers envision that TI 2.0 will establish a structured environment that facilitates a comprehensive approach to healthcare, addressing quality measures and social determinants of health effectively. The integration of platforms, such as CommunityCares, has proven beneficial in facilitating HRSNs/NMDOHs referrals, although many still express the need for a fully closed-loop system. Although designed to track referrals through completion, practical constraints make it difficult to verify that all services are delivered. CommunityCare's ultimate goal is a seamless referral process that reduces manual handoffs and enhances patient experience and outcomes.

Sixth, there are anticipated challenges with the implementation of TI 2.0. Providers recognize the complexity of addressing HRSNs/NMDOHs and the resources needed to navigate these issues effectively. The heavy workload associated with the closed-loop referral process can be burdensome for staff, increasing the likelihood that referrals are made without follow-up on necessary actions. Furthermore, the commitment required from clinicians, including significant training time, poses a challenge. Many organizations are already struggling to balance their current responsibilities with the additional demands of training and integrating new systems, raising concerns about the sustainability of these efforts.

In summary, while providers are optimistic about the potential of TI 2.0 to enhance partnerships and healthcare delivery, they acknowledge the significant challenges that lie ahead. By addressing issues related to staff capacity, data accuracy, and community resource availability, organizations can better position themselves for success in

implementing this transformative initiative. The commitment to improving health outcomes and fostering collaborative networks will be crucial in realizing the full benefits of TI 2.0 for both providers and patients.

The results presented in this Interim Evaluation Report are not the final results for the AHCCCS Medicaid 1115 TI 2.0 waiver demonstration program. The Summative Evaluation Report will include four additional years of quantitative data, as well as additional qualitative data. If data for appropriate comparison groups are identified, the Summative Evaluation Report may also present results from more robust analyses for measures beyond the TI program.

Background

This section details the history, guidelines, and implementation of the CMS Medicaid Section 1115 waiver demonstrations. It begins with an overview of the historical context of waiver demonstrations, followed by CMS guidelines for states to develop and implement their own demonstration programs. The application by Arizona's Medicaid agency, AHCCCS, is then presented, including an outline of waiver evaluation deliverables and timelines, the milestones for the Interim Evaluation Report, and the historical background of Arizona's Section 1115 waiver demonstrations. A detailed overview of the TI 2.0 program is then discussed.

Historical Background of Medicaid Section 1115 Waiver Demonstrations

Medicaid, established by the Social Security Act of 1965, is a collaborative federal-state program that offers free or low-cost health care coverage to approximately 72 million eligible low-income Americans. This includes pregnant women, families with children, the elderly, individuals with disabilities, and in many states, low-income adults without children. CMS and Federal law establish the minimum care standards that states must provide to Medicaid-eligible populations, while also giving states the opportunity to design and test their own strategies for delivering and funding health care services to meet these standards.

The Social Security Act provides several waiver and demonstration authorities that enable states to operate their Medicaid programs with flexibility outside certain federal regulations. These include Section 1115, Section 1915(b), Section 1915(c), and more. Section 1115 allows states to conduct innovative demonstration projects and assess state-specific policy changes, aiming to enhance efficiency and improve health outcomes without increasing Medicaid expenditures. States utilize this waiver authority in various ways, such as modifying eligibility criteria to extend coverage to new demographics, offering services not typically covered, providing different service

packages, and introducing innovative service delivery systems. As of July 2024, Arizona is among 47 states that have received approval for a Section 1115 Demonstration waiver program, allowing them to explore innovative approaches in delivering or providing care to their Medicaid populations.[6]

Section 1115 Demonstration waivers are generally approved for a five-year initial period and can be extended for up to an additional three to five years, depending on the population served.[7] States must assess whether their demonstrations meet their intended goals and objectives by conducting an evaluation of the program. Once a demonstration is approved, states must submit an evaluation design plan to CMS for review and approval. This plan must outline the hypotheses to be tested, the data sources to be utilized, and other elements specified in the associated waiver STCs. If a state seeks to extend its demonstration, its extension application must include, among other requirements, an Interim Evaluation Report summarizing the findings up to that point. Additionally, states are mandated to submit a Summative Evaluation Report within 18 months after the conclusion of the demonstration period.

CMS Evaluation Guidance

On November 6, 2017, CMS issued an informational bulletin detailing enhancement for the monitoring and evaluation of Section 1115 demonstrations.[8] These enhancements aim to allocate evaluation resources more cost-effectively, standardize measurement sets, provide better formative feedback, and strengthen evaluation designs for robust analysis to inform future Medicaid policies. In January 2018, the Government Accountability Office (GAO) highlighted several shortcomings in the existing Section 1115 demonstration evaluations, including gaps in important measures and limited policy utility.[9] While the November 2017 bulletin addressed many of these issues, CMS, with its subcontractor Mathematica Policy Research, further elaborated on these

[6] Kaiser Family Foundation. Medicaid Waiver Tracker: Approved and Pending Section 1115 Waivers by State. June 18, 2024. Available at: https://www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state/. Accessed on: July 3, 2024.
[7] Centers for Medicare & Medicaid Services. About Section 1115 Demonstrations | Medicaid. www.medicaid.gov. https://www.medicaid.gov/medicaid/section-1115-demonstrations/about-section-1115-demonstrations/index.html
[8] Centers for Medicare & Medicaid Services. November 6, 2017, CMCS Informational Bulletin: Section 1115 Demonstration Process Improvements. Available at: https://www.medicaid.gov/federal-policy-guidance/downloads/cib110617.pdf. Accessed on: Nov. 5, 202
[9] Government Accountability Office. Report to Congressional Requesters, January 2018. Medicaid Demonstrations: Evaluations Yielded Limited Results, Underscoring Need for Changes to Federal Policies and Procedures. Available at: https://www.gao.gov/assets/690/689506.pdf. Accessed on: Jul 3, 2024.

improvements through guidance documents and white papers to standardize evaluations nationwide.[10]

CMS has provided guidance for states and evaluators on developing evaluation designs and preparing evaluation reports, emphasizing the importance of planning to identify key measures and outcomes and ensuring data collection beyond routine administrative data.[11] Collaborating with CMS to approve Evaluation Design Plans helps standardize evaluations across states, enhancing their utility in shaping Medicaid policy nationwide and focusing resources on cost-effective evaluations. Additionally, CMS offers detailed recommendations to strengthen research designs, identify analytic approaches, and consider comparison groups, thereby improving the ability to draw causal inferences and evaluate specific Section 1115 waiver demonstrations.[12,13]

On January 7, 2021, CMS released a state health official letter that describes opportunities, including Section 1115 demonstrations, to address members' HRSNs/NMDOHs in Medicaid and CHIP.[14] Addressing health inequities involves addressing enrollees' HRSNs/NMDOHs through improved care delivery, consistent quality measurement, and coverage of clinically appropriate interventions. Some states, like Arizona, have leveraged 1115 demonstration flexibilities to cover evidence-based services that address HRSNs/NMDOHs, allowing for a more tailored approach to defining target populations. To cover HRSNs/NMDOHs services, states must adhere to additional requirements and budget neutrality calculations. CMS supports states in

[10] Centers for Medicare & Medicaid Services. 1115 Demonstration State Monitoring & Evaluation Resources. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/1115-demonstration-monitoring-evaluation/1115-demonstration-state-monitoring-evaluation-resources/index.html. Accessed on July 3, 2024.
[11] Centers for Medicare & Medicaid Services. CMS Strengthens Monitoring and Evaluation Expectations for Medicaid 1115 Demonstrations. Published March 14, 2019. Available at: https://www.cms.gov/newsroom/press-releases/cms-strengthens-monitoring-and-evaluation-expectations-medicaid-1115-demonstrations
[12] See, e.g., Contreary, K., Bradley, K., & Chao, S. June 2018. Best practices for causal inference for evaluations of Section 1115 Eligibility and Coverage Demonstrations. White paper: Mathematica Policy Research; Reschovsky, J. D., Heeringa, J., & Colby, M. June 2018. Selecting the best comparison group and evaluation design: A guidance document for state section 1115 demonstration evaluations. White paper: Mathematica Policy Research; Pohl, R. V, and Bradley, K. October 2020. Selection of Out-of-State Comparison Groups and the Synthetic Control Method. White paper: Mathematica Policy Research; Felland, L., and Bradley, K. October 2020. Conducting Robust Implementation Research for Section 1115 Demonstration Evaluations. White paper: Mathematica Policy Research.
[13] Centers for Medicare & Medicaid Services. Implications of COVID-19 for Section 1115 Demonstration Evaluations: Considerations for Sates and Evaluators. August 2020. Available at: https://www.medicaid.gov/medicaid/section-1115-demo/downloads/evaluation-reports/1115-covid19-implications.pdf. Accessed on: Nov. 5, 2024.
[14] Centers for Medicare & Medicaid Services. Opportunities in Medicaid and CHIP to Address Social Determinants of Health (SDOH). Published January 7, 2021. Available at: https://www.medicaid.gov/federal-policy-guidance/downloads/sho21001.pdf

addressing HRSNs/NMDOHs by providing a framework to evaluate proposals for these services through 1115 demonstrations.

Along with general guidance for strengthening evaluations, CMS provided specific guidance for various types of Section 1115 waiver demonstrations. These include community engagement, retroactive eligibility, substance use disorder, and serious mental illness/serious emotional disturbance waivers. The guidance documents were used to shape the hypotheses, research questions, analytic approaches, and data sources for this evaluation.

Arizona's Waiver Evaluation Deliverables

In accordance with the STCs of Arizona's Section 1115 waiver, AHCCCS contracted with ASU as an independent evaluator to comprehensively assess Arizona's Section 1115 waiver TI demonstration program. This evaluation aims to provide CMS and AHCCCS with an independent assessment to ensure compliance with Section 1115 waiver requirements, support state and federal decision-making on the demonstration's efficacy, and assist AHCCCS in developing a clinically appropriate, fiscally responsible, and effective Medicaid demonstration program.

Evaluation Design Plan

The Evaluation Design Plan outlines the State's strategy for conducting the evaluation as required by CMS. CMS sets expectations for the plan's content, requiring the State to detail how its plan aims to achieve the waiver's objectives, specify its hypotheses, evaluation questions, and related measures and analytic methods. The State must describe how these elements will collectively demonstrate that its approach is effective. Once CMS approves the plan, it is posted on the State's website for public comment. The TI 2.0 Program Evaluation Design Plan covers the TI 2.0 demonstration program outlined in the executive summary.

Interim Evaluation Report

As stated in STCs 121, an Interim Evaluation Report must be submitted "for the completed years of the demonstration and for each subsequent extension of the demonstration."[15] This report will cover the evaluation's progress and findings up to the present. The results presented are based on the mixed-methods approach detailed in the CMS-approved evaluation design plan. Quantitative analyses were performed across the six programs using administrative claims/encounter data and beneficiary

[15] Centers for Medicare & Medicaid Services. Special Terms and Conditions Arizona Health Care Cost Containment System (AHCCCS) Medicaid Section 1115 Demonstration. AHCCCS. 2025; 11-W00275/9, 21-W-00074/9. Available at: https://www.azahcccs.gov/Resources/Downloads/WaiverAnd%20ExpenditureAuthoritiesAnd%20STCs.pdf. Accessed on: Dec 1, 2025.

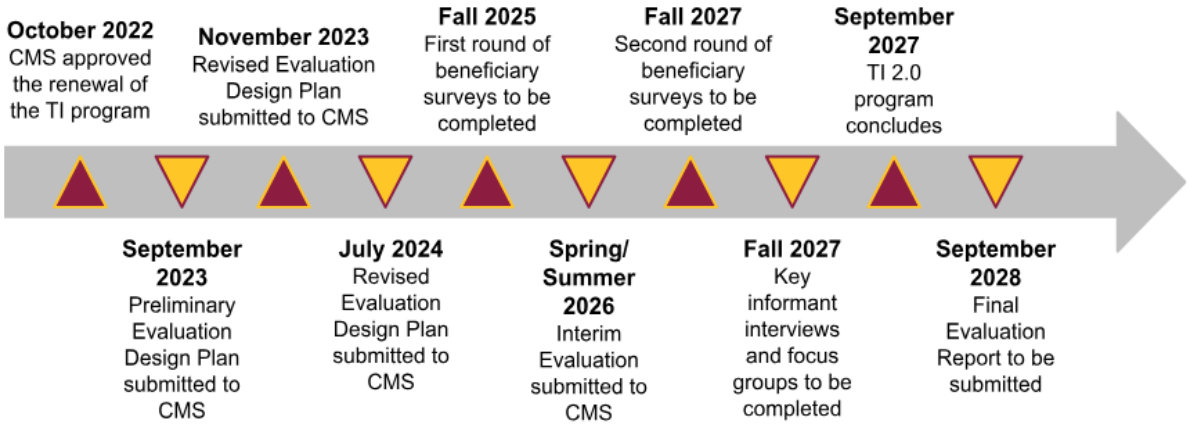
survey data. Additionally, qualitative insights from key informant interviews and provider focus groups, which assess barriers and facilitators to implementation, are included to complement the quantitative findings.[16]

Summative Evaluation Report

The Summative Evaluation Report is required to be prepared and submitted within 18 months following the conclusion of the demonstration period, incorporating the details approved in the Evaluation Design Plan and the Interim Evaluation. It will encompass additional years of data and may also include results from more comprehensive analyses for measures beyond the TI program if appropriate comparison group data are available.

Figure 1 provides an overview of the evaluation activities for Arizona's Section 1115 TI waiver demonstration.

Figure 1: Timeline of Evaluation Activities



Historical Background of Arizona's Section 1115 Waiver

Arizona's Medicaid program was established with the belief that collaborations between the government and private sector offer the most efficient way to provide quality health care to the state's most vulnerable residents. Although Arizona was the last state to initiate its Medicaid (Title XIX) program, it was the first to develop a healthcare delivery system where most members were served by MCOs. Since its launch in 1982, AHCCCS has operated a statewide managed care model under its Section 1115

[16] Felland, L., and Bradley, K. October 2020. Conducting Robust Implementation Research for Section 1115 Demonstration Evaluations. White paper: Mathematica Policy Research.

waiver.[17] Over the years, Arizona's demonstration has been expanded to include other population groups, such as those covered by the Children's Health Insurance Program (CHIP) (Title XXI) and additional Medicaid-covered services, including long-term care and BH services. Despite these expansions, the AHCCCS core service delivery model has remained consistent in using a managed care model to provide high-quality health care across the state.

In 1988, significant changes to the original waiver demonstration led to the creation of ALTCS, a capitated long-term care program for individuals aged 65 or older or those with disabilities requiring nursing facility-level care. By 1989, ALTCS began providing acute care, long-term care, and behavioral health services, along with a broad range of home- and community-based services, to Medicaid-eligible individuals at risk of institutionalization. In October 1990, AHCCCS further expanded coverage to include comprehensive behavioral health services for all remaining members.

The initial AHCCCS Acute Care program waiver demonstration enabled AHCCCS to run a statewide managed care system that included only acute care services and 90 days of post-hospital skilled nursing facility care. All Medicaid-eligible individuals and children in the CHIP population were required to enroll, except for members who identify as American Indian or Alaska Native, who may choose to enroll in Managed Care or the AHCCCS Fee For Service (FFS) program. The AHCCCS Acute Care program also established two initiatives to support children with special needs: DCS CHP[18] and the Children's Rehabilitation Services (CRS) program.[19] [20] By December 2011, the Acute Care Program delivered a wide range of healthcare services to around 1.1 million enrolled members under Title XIX and Title XXI.[21] The program primarily served children and pregnant women from households with incomes at or below 100% of the federal poverty limit. Most eligible Acute Care members received their healthcare through contracted AHCCCS health plans.

[17] American Indians/Alaska Natives and individuals enrolled in the Federal Emergency Services program are not subject to mandatory managed care
[18] DCS CHP replaced the Comprehensive Medical and Dental Plan (CMDP) in April 2021.
[19] Arizona Department of Child Safety. Care DCS CHP. Accessed July 5, 2024. Available at: https://dcs.az.gov/services/chp
[20] AHCCCS. Children's Rehabilitative Services (CRS) Designation. Accessed July 5, 2024. Available at: https://www.azahcccs.gov/AHCCCS/Initiatives/CareCoordination/CRS.html
[21] AHCCCS. Acute Care RFP Fact Sheet. Available at: https://www.azahcccs.gov/PlansProviders/HealthPlans/YH14publicmeeting.html

In July 2013, Arizona further expanded Medicaid under the Affordable Care Act (ACA) through the AHCCCS Restoration Plan[22,23] This expansion led to a 42 percent increase in AHCCCS enrollment, adding 487,021 individuals.[24]

AHCCCS has taken several steps to integrate medical and BH care coverage. In 2013, most AHCCCS beneficiaries received physical health services through an acute care health plan, while BH services were provided through a BH care plan, known in Arizona as a RBHA. On October 1, 2018, ACC plans became the integrated health plans for the majority of AHCCCS members, streamlining the service delivery system and simplifying payment streams for members who previously had to coordinate physical and BH benefits through separate health plans.[25]

These initiatives were further supported by the TI 1.0 program, which was approved by CMS on January 18, 2017. This program allocated $300 million over five years to Arizona providers who collaborate with the state to enhance the integration of physical and BH care, improve care delivery efficiency, and enhance health outcomes.[26] In 2021, CMS approved an additional $50 million for a Year 6 extension to the original program and updated Waiver and Expenditure Authorities and STCs.

On March 13, 2020, the President of the United States declared SARS-CoV-2, also known as the COVID-19 virus, a nationwide emergency under Section 501(b) of the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. 5121-5207 (the "Stafford Act"). This declaration gave the Secretary of the U.S. Department of Health and Human Services the authority to enhance states' response capabilities to the COVID-19 outbreak, including the authority to temporarily waive or modify Medicaid and CHIP requirements through Section 1135 of the Social Security Act.

Throughout the national COVID-19 public health emergency, the U.S. Department of Health and Human Services extended state Medicaid agencies the authority to expand services to address healthcare needs stemming from the pandemic. Accordingly, AHCCCS was granted permission to waive specific Medicaid and CHIP requirements as necessary to combat the ongoing spread of COVID-19 and mitigate any disruptions in care for AHCCCS members during the emergency declaration period. These temporary

[22] AHCCCS. A Brief History of AHCCCS Highlights. Accessed December 1, 2025. Available at: https://www.azahcccs.gov/AHCCCS/Downloads/ABriefHistoryOfAHCCCS.pdf
[23] AHCCCS. Difficult Choice: Expanding Adult Medicaid Coverage. Available at: https://www.azahcccs.gov/Resources/Downloads/BackgroundInformation.pdf
[24] Health Insurance & Health Reform Authority. Arizona and the ACA's Medicaid expansion. Available at: https://www.healthinsurance.org/arizona-medicaid. Accessed on: July 5, 2024.
[25] AHCCCS. AHCCCS Complete Care. Available at: https://www.azahcccs.gov/AHCCCS/Initiatives/AHCCCSCompleteCare/
[26] AHCCCS. Targeted Investments 1.0 Program. Available at: https://www.azahcccs.gov/PlansProviders/TargetedInvestments/TI1.0/ProgramOverview.html

"flexibilities" were implemented through policy adjustments or various legal mechanisms, including a Section 1135 waiver (designed for public health emergencies), the Section 1115 waiver, an Appendix K contract specific to Home and Community-Based Services (HCBS), and State Plan Amendments.

During the COVID-19 pandemic, AHCCCS responded by simplifying provider enrollment and nursing facility screening, adjusting premiums and copays for waiver members, reimbursing COVID-19 testing, and expanding respite care services. Additionally, AHCCCS did not disenroll most members since the pandemic began in 2020, in accordance with federal continuous coverage requirements.[27] However, the Consolidated Appropriations Act (CAA) passed in December 2022 mandated AHCCCS to resume standard renewal processes for all Medicaid members. As of April 1, 2023, AHCCCS began disenrolling members who no longer met eligibility requirements.

The Waiver renewal, which was approved on October 14, 2022, authorized the renewal of the TI program through TI 2.0. TI 2.0 will build upon the success of TI 1.0 by further integrating point-of-care systems, providing guidance and incentives to providers for initiating new and meaningful system transformations, and enhancing requirements to comprehensively address quality health care and ensuring fair health care access through the provision of whole-person care.

AHCCCS' Quality Strategy

According to the Code of Federal Regulations (CFR) 42 CFR 438.340 et. seq., AHCCCS first established its Quality Strategy in 2003.[28] Since then, it has been regularly updated to incorporate new approaches to member care and ongoing efforts in quality improvement. AHCCCS' Quality Strategy is a proactive and integrated approach aimed at enhancing health outcomes through innovative initiatives, continuous assessment, monitoring, and performance improvement based on results. The strategy supports meeting or exceeding established standards for access, quality, and delivery of care for services provided to members, with a focus on identifying and addressing issues related to these standards.

AHCCCS places significant emphasis on a comprehensive Quality Strategy to support efforts to improve or sustain the health status of members, particularly those with chronic conditions, promoting increased resilience and functional health.

AHCCCS' Strategic Plan

[27] AHCCCS. How AHCCCS is Planning for the End of the Public Health Emergency. Published March 22, 2022. Available at: https://www.azahcccs.gov/Renewals
[28] AHCCCS. Quality Strategy. Published July 1, 2024. https://www.azahcccs.gov/PlansProviders/Downloads/QualityStrategyJuly2024Final.pdf

AHCCCS' Strategic Plan guides the agency in addressing current and future challenges while promoting the health and economic well-being of Arizona residents. AHCCCS' 5-Year Strategic Plan for State Fiscal Years 2025 – 2029 outlines six key goal areas: (1) advance whole-person care, (2) lower the uninsured rate, (3) maintain a strong provider network, (4) support preventive care, (5) maintain high member satisfaction, and (6) strengthen program integrity. By following this plan, AHCCCS aims to address current challenges while positioning the agency to meet future needs effectively.[29]

AHCCCS Whole Person Care Initiative

In 2019, AHCCCS introduced the AHCCCS Whole Person Care Initiative to focus on addressing the critical HRSNs/NMDOHs of enrolled members, which significantly impact their physical and mental health outcomes.[30] These needs include addressing issues such as homelessness, housing instability, food insecurity, and the need for transportation assistance. AHCCCS aims to enhance access to resources across the Medicaid delivery system to address members' HRSNs/NMDOHs through initiatives such as the closed-loop referral system (CLRS) and TI 2.0, thereby advancing equitable health care access across Arizona.

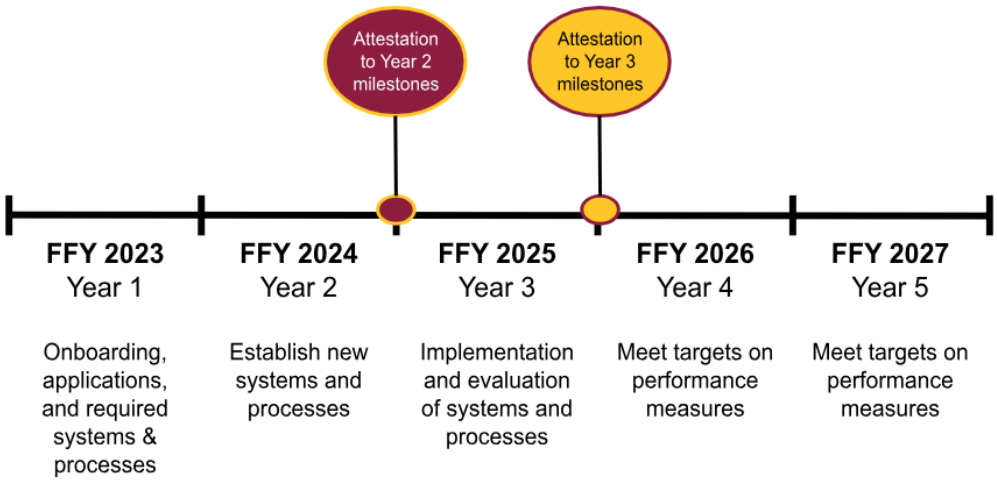
Demonstration Overview

On October 14, 2022, TI 2.0 was approved by CMS for $250 million as part of Arizona's Section 1115 Waiver.[31] The TI 2.0 program is active for five years from October 1, 2022, through September 30, 2027. The TI 2.0 program aims to expand AHCCCS' integrated care and coordination goal beyond clinical interventions, addressing social inequities and disparities that significantly impact health outcomes.

Figure 2 displays a timeline of key events for the program.

[29] AHCCCS. AHCCCS 5-Year Strategic Plan, State Fiscal Years 2025-2029. Available at: https://www.azahcccs.gov/AHCCCS/Downloads/Plans/AHCCCS5YearStrategicPlanStateFiscalYears2025 2029.pdf
[30] AHCCCS. AHCCCS Whole Person Care Initiative. Available at: https://www.azahcccs.gov/AHCCCS/Initiatives/AHCCCSWPCI/
[31] AHCCCS. AHCCCS 1115 Waiver Approval. Published October 14, 2022. Available at: https://www.azahcccs.gov/Resources/Downloads/Federal/AHCCCS_ExtensionApprovalLetterFinal10142 022.pdf

Figure 2: TI 2.0 Timeline of Key Events



This Section 1115 waiver evaluation will determine whether AHCCCS has been able to meet the research hypotheses and goals for the TI 2.0 demonstration.

Demonstration Goals

This demonstration program seeks to improve quality and promote equitable access to health care for the targeted patient population. The main goals of the program are:

- **Reduce Health Disparities**: Enhance the reliability of data and leverage stratified dashboards and multivariate analyses to identify health disparities at the AHCCCS, MCO network and provider-practice level, and implement evidence-based approaches to improve care delivery and health outcomes for pediatric, adult, and justice-involved beneficiaries.
- **Improve Member Outcomes**: Identify and address each member's acute, behavioral health, and HRSNs/NMDOHs to improve overall health outcomes and reduce health disparities.
- **Reduce Total Cost of Care:** Strengthen partnerships and address inefficiencies in care coordination among MCOs, ACOs, subcontracted networks, and medical, behavioral, and community service provider organizations to develop an efficient, integrated care delivery system with minimal duplication of effort.

As a State-Directed Payment program, TI 2.0 will achieve these goals by directing MCOs to use funding to make specific incentive payments to providers. Participants must satisfy metrics in the form of process measures and quantitative performance measures to earn payment. Each required performance target will have an incentive

amount associated with it, and providers will receive an incentive payment for each requirement that is met. Providers also received an incentive payment for completing the Year 1 application process to become approved for participation in TI 2.0. The application included attestations, new process requirements, procedures, and protocol deliverables.[32]

Provider Eligibility Requirements

To participate and receive a TI 2.0 payment, providers must:

- Maintain good financial standing with AHCCCS;
- Meet eligible provider type requirements (group payment, BH outpatient, and integrated clinics (IC));
- Maintain National Plan and Provider Enumeration System; and
- Meet Electronic Health Record (EHR) requirements. Providers must maintain a commitment to adopt the Health Information Exchange, Contexture, and bidirectional sharing with the platform.[33]

Process Milestones

Over the demonstration period, providers will earn incentives to implement certain processes and meet outcomes-based metrics. Providers will participate in the following activities to meet these metrics:

- Program Year 1 (FFY 2023): [34]
    - All organizations must demonstrate intent to have an EHR system capable of bi-directional data exchange with the HIE.
    - For the Pediatric (BH and PCP) and Adult (BH and PCP) process requirements, the organization is expected to identify coordination staff who will advance whole-person care and population health initiatives, and to define and implement protocols and procedures related to HRSN/NMDOH screening, care coordination, and trauma-informed care. Additional process requirements for the Adult Primary Care and Pediatric Primary Care clinical areas of concentration (AOCs) include developing protocols that address high-risk member identification and tracking procedures to efficiently and effectively coordinate care, as well as

[32] AHCCCS. TI 2.0 Application Requirements and Example Documents. Available at: Acchttps://azahcccs.gov/PlansProviders/TargetedInvestments/TI2.0/ExampleDocs.html
[33] AHCCCS. TI 2.0 Program Eligibility & Payment. Available at: https://www.azahcccs.gov/PlansProviders/TargetedInvestments/Payment.html
[34] AHCCCS. TI 2.0 Application Requirements and Example Documents. Available at: https://www.azahcccs.gov/PlansProviders/TargetedInvestments/TI2.0/ExampleDocs.html

processes that ensure access to psychiatric consultation and support coordinated care activities.
    - For the Justice process requirements, the organization must establish contracts with all ACC MCOs serving the Justice clinic's GSA and secure these contracts by March 2024. The organization must also provide a commitment letter that includes Justice clinic information and an implementation plan outlining future supervision settings, co-location strategies, data-sharing methods, collaboration expectations, partner directory procedures, partnership metrics, care coordination, and evidence-based services for justice-involved individuals, contingent on TI 2.0 Justice approval.
- Program Years 2 (FFY 2024) and 3 (FFY 2025): [35]
    - Participate in the Targeted Investment Program Quality Improvement Collaboratives (QICs) and online projects, where providers will learn and implement quality improvement techniques and engage in peer learning.
        - For the Adult PCP, Pediatric PCP, and Pediatric BH AOCs:
            - In Program Year 2, 20% of the annual payment will be tied to QIC attendance and 10% to the online projects; in Program Year 3, QIC attendance will account for 5% and online projects 10% of the payment.
        - For the Adult BH and Justice AOCs:
            - In Program Year 2, 15% of the annual payment will be tied to QIC attendance and 10% to the online projects; in Program Year 3, QIC attendance will account for 5% and online projects 10% of the payment.
    - Implement language access protocols to promote respectful, easy to understand, and responsive services for all individuals regardless of their preferred language, age, or cultural background. Prioritize providing translated materials and interpreter support services before appointments, ensuring clear communication and equitable access for all individuals. In Program Year 2, there will be no incentive payment associated with this milestone. In Program Year 3, it will represent 10% of the annual payment for Adult BH and Justice AOCs, and 15% for the Adult PCP, Pediatric PCP, and Pediatric BH AOCs.
    - Implement a process for screening for health-related social needs (HRSN)/non-medical drivers of health (NMDOH) and connecting members seen to CBOs to address individual social needs. In Program Year 2, it will

[35] AHCCCS. TI 2.0 Milestone Resources. Available at: https://www.azahcccs.gov/PlansProviders/TargetedInvestments/TI2.0/Milestones.html

represent 15% of the annual payment for Pediatric PCP and Justice AOCs, 20% for the Adult PCP and Adult BH AOCs, and 25% for the Pediatric BH AOC. In Program Year 3, it will represent 20% of the annual payment for the Pediatric PCP and Justice AOCs, 25% for the Adult PCP and Adult BH AOCs, and 35% for the Pediatric BH AOC.

- Implement procedures to use a closed-loop referral system to standardize referrals and coordination with community-based organizations. In Program Year 2, it will represent 15% of the annual payment for the Adult PCP, Adult BH, Pediatric PCP, and Justice AOCs, and 20% for the Pediatric BH AOC. In Program Year 3, it will represent 10% of the annual payment for all AOCs.
- Evaluate differences in health outcomes and HRSNs/NMDOHs among the population attributed to the practice and implement strategies to address the various health outcomes. In both Program Years 2 and 3, it will represent 15% of the annual payment for the Adult PCP, Pediatric PCP, and Justice AOCs, 20% for the Adult BH AOC, and 25% for the Pediatric BH AOC.
- Implement specialty-specific programs and processes, such as:
  - Postpartum depression screening in the Pediatric PCP AOC, representing 15% of the annual payment in both Program Years 2 and 3;
  - Dental varnish efforts in the Pediatric PCP AOC, representing 10% of the annual payment in both Program Years 2 and 3;
  - Engaging caregivers of newborns to screen for anxiety and depression in the Adult PCP AOC, representing 20% of the annual payment in both Program Years 2 and 3;
  - Perinatal Mental Health certification in the Adult BH AOC, representing 10% of the annual payment in Year 2 and 20% in Year 3;
  - Tobacco cessation programs for patients transitioning from the criminal justice system. This requirement will represent 10% of the annual payment in both Program Years 2 and 3 for the Justice AOC; and
  - Engaging with patients transitioning from the criminal justice system prior to MCO reach-in activities, which will represent 20% of the annual payment in both Program Years 2 and 3 for the Justice AOC.

- Program Year 4
  - Meet or exceed performance targets for selected health care quality measures by AOC for 50% of the annual payment;

  - Screen members annually with a standardized NMDOH screening tool and consistently submit NMDOH results via claims for 25% of the Program Year 4 payment;
  - Participate in AHCCCS' closed loop referral system, CommunityCares, or another NMDOH referral system for 15% of the annual payment; and
  - Attend the Targeted Investment Program QICs for 10% of the Program Year 4 payment.

- Process milestone requirements for Program Year 5 are being developed as of the submission of this report.

The activities required of participating providers are expected to be continued and sustained systemwide after completion of the program so that providers can better serve their patient population.

Performance Milestones

Table 3 outlines the selected Program Year 4 performance measures applicable to each provider, organized by AOC. The results presented in this report and future evaluation reports for measures in this table will not be used to assess whether providers are meeting performance measure targets for purposes of incentive payments. Performance measure targets for these measures have been established for each participating provider organization based on baseline performance, as calculated by ASU TIPQIC.

Table 3: Performance Measures by Area of Concentration

Milestone Measures	Pediatric		Adult		Justice
	BH	PCP	BH	PCP	
Access to preventive/ambulatory health services				✓	
Adherence to antipsychotic medications for individuals with schizophrenia			✓		
Cervical cancer screening				✓	
Child and adolescent well-care visits		✓			
Follow-up after ED visit for mental illness (7 day)			✓		✓
Follow-up after ED visit for substance use (7 day)					✓
Follow-up after hospitalization for mental illness (7 day)[1]	✓		✓		

Follow-up after hospitalization for mental illness (30 day)	✓				
Initiation and engagement of substance use disorder treatment					✓
Metabolic monitoring for children and adolescents on antipsychotics	✓				
Timeliness of prenatal care				✓	
Well-child visits in the first 15 months of life		✓			
Well-child visits in the first 30 months of life		✓			

[1] Ages 6-17 for pediatric providers. Ages 18 and older for adult providers.

The TI program directs its MCOs to provide financial incentives to eligible Medicaid providers who meet these performance measure targets and benchmarks to improve their ability to address members' acute, behavioral, and HRSNs/NMDOHs. This demonstration is funded by up to $250 million from CMS.

To participate in the TI program and receive incentive payments, eligible Medicaid provider organizations are required to meet specific programmatic milestones and performance benchmarks. A key step in reducing health disparities and improving member outcomes for participating TI providers is participating in AHCCCS' closed loop referral system, CommunityCares. Providers who participate in CommunityCares must develop referral and communication processes with each CBO to refer members for community resources and/or interventions. This participation is beneficial because it ensures seamless communication between providers, improves care coordination and patient outcomes, and reduces delays by tracking referrals from initiation to completion.

Participating providers are also expected to establish other protocols, policies, and systems of care that support the provision of whole person care through the integration of physical and BH, including the implementation of CLAS Standards, documenting the member's Electronic Health Record (EHR) and claims (i.e. a TI 2.0 milestone requirement that uses specific procedure and diagnosis codes to indicate the results of a HRSN/NMDOH screening), and collecting member-reported demographic data to better identify disparities and HRSNs/NMDOHs prevalent within the attributed population. The activities required of participating providers are expected to be continued and sustained systemwide after completion of the program so that providers can better serve their patient population.

Table 4 shows the number of providers (who were identified by tax identification numbers (TINs)) by area of concentration who were participating in TI 2.0 as of December 2025.

Table 4: Number of Participating Organizations by Area of Concentration

Area of Organizations	Number of Organizations
Pediatric Behavioral Health	40
Pediatric Primary Care	43
Adult Behavioral Health	54
Adult Primary Care	50
Justice	17
119 unique tax identification numbers (TINs) Note: Many provider organizations are participating in more than one area of concentration; therefore, the total count of organizations by area of concentration will not equal 119.	

As part of their participation in the TI program, providers are encouraged to engage in Quality Improvement Collaboratives (QICs). These meetings, hosted by ASU, offer a platform for providers to learn how to implement evidence-based strategies to improve population health and to participate in peer learning. Engaging in these activities helps providers continuously enhance care quality, share best practices, and apply lessons learned from peers to improve patient outcomes. In Year 2 of the program, providers were required to attend all three QIC meetings. All 119 providers attended all required Year 2 QIC meetings. It is important to note that this milestone component's requirements and expectations will increase in Year 3 and beyond, reflecting continued program growth and higher performance standards as provider organizations seek to enhance care quality and improve patient outcomes.

NCQA Health Outcomes Accreditation

Provider organizations seeking NCQA Health Outcomes Accreditation[36] demonstrate to the members or patients they serve, and to state regulators, payers and business partners, that evaluating and reducing health disparities is an organizational priority. This Accreditation is intended to help organizations cultivate an understanding of their population through standardized data collection, provide appropriate, responsive services and identify opportunities to address health disparities and improve services.

Provider organizations that pursue Health Outcomes Accreditation benefit from the program's:

- 15+ years as the industry gold standard for continuously improving quality of and access to care.
- Data-driven methods for identifying and addressing gaps in care, improving member/patient experience and tracking intervention effectiveness.
- Broad, nationwide adoption helps state partners, contracting partners and business units or markets align around common goals and priorities.
- External accountability for improving health outcomes and sustaining long-term investments for public health, population health, and addressing health disparities.
- Balance of standardized methods and ability to tailor measures and interventions for a population or setting's unique needs.

To be eligible for Health Outcomes Accreditation, providers must:

- Be operational for at least 6 months.
- Perform functions relevant to their organization type, as outlined in the program's standards and guidelines.
- Comply with applicable federal, state and local laws and registrations, including licensure requirements.
- Operate without discrimination based on gender, sexual orientation, race, creed or national origin.
- Have a quality improvement process in place.

The Health Outcomes Accreditation program comprises core standard activities, organized into categories, that are scored during an organization's survey.

[36] On January 15, 2026, NCQA Health Equity Accreditation will become Health Outcomes Accreditation. While all TI 2.0 providers will be assessed under the 2024 Health Equity Accreditation standards, they will receive statuses that reflect the program's new title.

HE 1: Organizational Readiness: Build and train a workforce with relevant experience, knowledge or expertise to support provision of care and services that help members or patients achieve their best possible health.

HE 2: Race/Ethnicity, Language, Gender Identity and Sexual Orientation Data. Collect, evaluate, and analyze standardized demographic data to identify health disparities and set measurable goals to reduce them, and tailor care, education, resources, and services to meet the diverse needs of populations served.

HE 3: Access and Availability of Language Services. Collect standardized data on languages used by the member or patient population, and on the language profile of the broader community, to be able to communicate about care, benefits, or services.

HE 4: Practitioner Network Cultural Responsiveness. Build and maintain a network of licensed and certified practitioners who can meet cultural and linguistic needs and provide culturally and linguistically responsive care and services.

HE 5: Culturally and Linguistically Appropriate Services Programs. Build an infrastructure for actionable, measurable goals, and ongoing performance monitoring for long-term, sustained commitment to reducing health disparities and improving the cultural and linguistic appropriateness of services.

HE6: Reducing Health Disparities. Stratify clinical performance and experience measures to identify health disparities, prioritize opportunities for targeted interventions, and track the effectiveness of interventions.

HE7: Delegation of Health Outcomes Activities. Oversee relationships where a provider seeking NCQA accreditation gives another entity the authority to perform an activity to meet an NCQA requirement.

Note:

- The following standards are now scored as “NA” on surveys:
  - **HE 1A:** Building a Diverse Staff
  - **HE 1B:** Promoting Diversity, Equity and Inclusion Among Staff
  - **HE 2A:** Systems for Individual-Level Data
    - **Factor 3:** gender identity
  - **HE 2D:** Collection of Data on Gender Identity
  - **HE 6B:** Use of Data to Address Disparities
    - **Factor 3:** gender identity
- The following standards are scored without evidence of gender identity:
  - **HE 2F:** Privacy Protections for Data

    - **HE 2G:** Notifications of Privacy Protections
- The following standards are scored without evidence of minimum requirement:
    - **HE 5A:** Program Description
        - **Factor 2:** Involving members of culturally diverse community (5% of population by characteristic)

Understanding the NCQA Health Outcomes Accreditation Journey

Accreditation is a transformative process that begins well before a provider organization's formal application and continues through a thoughtful, evidence-based review.

The Accreditation journey typically begins 12-18 months before a provider submits materials for review. During this phase, the provider consults with NCQA to confirm eligibility and gain an understanding of expectations by purchasing NCQA's official standards and guidelines, and accessing a web-based survey tool, the Interactive Review Tool (IRT).

One critical early step is a gap analysis: an internal review that helps an organization compare its current practices with the evidence NCQA requires. Analysis often reveals areas that require attention and potential updates – such as system configuration, policies and procedures, member-facing notices, or data collection processes. Because some changes can take months (or years) to implement, the gap analysis helps organizations choose a realistic survey submission date.

When the organization is on track to prepare for the survey, it submits a preapplication form to NCQA. The full application must be submitted at least 12 months before the provider organization's desired survey date.

The NCQA Accreditation Survey Coordinator (ASC) is the organization's guide through the Accreditation Process and can answer last-minute questions. The ASC contacts the provider about three months before it submits materials.

Unlike traditional audits, NCQA's Health Outcomes Accreditation survey is asynchronous and conducted entirely online: there are no onsite visits. The organization uploads evidence (e.g. documented processes, reports, member-facing notices) into the IRT platform on the submission date, and the NCQA's surveyors review how well the provider organization demonstrates compliance with the standards. NCQA awards a full, partial, or zero-point value for each distinct activity.

Surveys include the following steps:

1. *Evidence Upload:* The provider submits all documentation by the survey date (this can happen earlier than the survey date).
2. *Initial Review:* An NCQA surveyor reviews the evidence and identifies gaps or areas needing clarification.
3. *Live Discussion:* The provider meets with the surveyor, via conference call, to discuss initial findings, outstanding questions, and opportunities for improvement.
4. *Additional Submission:* The provider organization uploads evidence to address gaps discovered during the surveyor's review (new evidence may not be created at this stage).
5. *Final Review:* The surveyor recommends scores, and NCQA staff conduct a secondary review to ensure consistency.

About 90 days after submission, NCQA's Review Oversight Committee determines the provider's score and overall status.

- Scores of 80% or more points results in a 30-year status of Accredited in Health Outcomes.
- Scores of 55%-79% of points result in Provisional-Accredited status. Providers that earn this status must be re-surveyed on all activities scored at less than full credit within one year.
- Scores of 54% or less of available points are denied Accredited status.

Support for TI 2.0 Providers

Fifteen TI 2.0 providers, each with a varying number of sites totaling 93 sites, are scheduled to be surveyed in 2026 under the 2024 Accreditation standards. Throughout the first part of this initiative, NCQA provided targeted support to TI 2.0 provider organizations, as noted in Table 5 below.

Table 5: NCQA Activities to Date

Activity	Activity Details	Occurrence
Orientation Webinars	Kickoff Meeting: IRT orientation, NCQA Timeline, and Discuss Project Contacts	6/20/2024
	Technical Training	7/15/2024
	Survey End-to-End process	8/27/2025
	IRT Demonstration	9/24/2025
Office Hours	Topics included: Accreditation Standards and Factors, IRT Process and Timeline, Survey End-to-End Processes, IRT Demo, Types of	Beginning with a monthly cadence – held on the last

Activity	Activity Details	Occurrence
	Evidence and NCQA Expectations, Policy Updates, Q&A	Wednesday of the month at 3-4pm ET
Reporting (Monthly Progress Reports and Quarterly Data Extracts)	Reports included updates on the current project status and each provider's status	Monthly and quarterly
Deep Dive Webinar	An asynchronous self-paced course with four modules focusing on various aspects of the accreditation	Access link sent to providers on 1/8/2025
FAQ Document	A living document maintained by NCQA that captures general questions, process questions, IRT questions, general standards, evidence questions and resources	Developed 11/8/2024; updated as needed

Evaluation Questions and Hypotheses

The primary purpose of the interim evaluation is to determine whether the AHCCCS TI waiver demonstration is achieving the goals outlined in the Background section. This section provides the TI 2.0 logic model, hypotheses, and research questions, which focus on evaluating the impact of these goals.

Logic Model

Figure 3 illustrates how providing financial investments to participating TI 2.0 providers will ultimately lead to improved health outcomes, increased coordination of care, and generate cost savings. By providing milestones that must be met at specific time frames to earn financial incentives, AHCCCS expects to encourage increased levels of integration and coordination of care among participating providers. In the short term, AHCCCS expects increased identification of needs and communication between a PCP, BH provider, and CBOs. This should lead to increased levels of care management, which will lead to long-term improved health outcomes and a reduction in health disparities among identified beneficiaries. Hypotheses associated with these outcomes are denoted in parentheses in the logic model (hypotheses descriptions can be found in Table 1).

Figure 3: Logic Model

			Expected Outcomes		
Resources/ Input What are the resources and funding streams necessary to implement the demonstration renewal?	**Activities** What will AHCCCS do to continue implementation of the demonstration renewal?	**Output** What is the expected direct result of the demonstration renewal?	**Short Term** Expected initial outcomes	**Intermediate** Expected intermediate-term outcomes	**Long term** Expected long-term outcomes of the demonstration
Approximately $150 million in DHSP total computable expenditures to allow the state to claim approximately $75 million in FFP for these programs $12.5 million in original state funds Additional federal funds claims made using the above as the sources of the state match TI 2.0 AHCCCS staff to administer TI 2.0 program, payments, and application portal AHCCCS staff to conduct TI 2.0 - related training Input (time and knowledge) from the ASU team, other contracted vendors (e.g.	AHCCCS to provide key milestones, including application and onboarding, development of processes and procedures to support TI 2.0 initiatives and meet performance measure targets AHCCCS and ASU will provide relevant TI 2.0 training to participating providers AHCCCS will provide incentive payments to participating providers who meet milestones and eligibility requirements AHCCCS and ASU will foster peer learning through QICs AHCCCS will work in conjunction with ASU and other contracted vendors (e.g. NCQA) to provide timely and standardized	Proficiency in quality improvement methods and techniques Participating providers will develop and implement screening protocols and practices to identify HRSN/NMDOH Participating providers will screen children and adults for BH disorders and children for developmental disorders Participating providers will develop outreach plans and communication protocols to increase integration between MCOs, PCPs, and BH providers Participating providers will create support plans to educate members and their families on diagnoses and support for members upon release from the criminal justice facilities	Increased screening for HRSN/NMDOH, BH, and developmental disorders Increased communication between patients' PCP and their specialty and BH providers Health-related social risk factors and health disparities are identified, and a plan is developed to address the disparities Increased referrals for members to CBOs via the closed-loop referral system Increased number of clinics partnering with probation and/or parole	Timely follow-up after hospitalizations for BH disorders Increased levels of care management Enhanced collaboration and communication among healthcare providers to address and mitigate health disparities due to enhanced EHR system requirements, bi-directional data sharing with the state's HIE platform, and participation in a CLRS Increased member satisfaction Increase in culturally and linguistically	Improved health outcomes (Hypotheses 1-4) Generated cost savings to offset the DSHP (Hypothesis 5) Health disparities are reduced and progress towards improving fair health care access is achieved

			Expected Outcomes		
Resources/ Input What are the resources and funding streams necessary to implement the demonstration renewal?	**Activities** What will AHCCCS do to continue implementation of the demonstration renewal?	**Output** What is the expected direct result of the demonstration renewal?	**Short Term** Expected initial outcomes	**Intermediate** Expected intermediate-term outcomes	**Long term** Expected long-term outcomes of the demonstration
NCQA), key stakeholders, and SMEs within AHCCCS Program activities informed by the QIC Best practice guides Technical assistance provided by the ASU, NCQA, andTI 2.0 AHCCCS staff	feedback to participants AHCCCS will collaborate with ASU to offer resources related to population health management and the science of improvement AHCCCS will support ASU in conducting population health outcomes analyses, identify health inequities, and develop plans to address them Some participants will earn NCQA Health Outcomes Accreditation (formerly Health Equity Accreditation)	Participating providers will identify health disparities and create plans to address them Some participants will earn NCQA Health Outcomes Accreditation (formerly Health Equity Accreditation) Participating providers will implement language access standards and their patients will be informed about the availability of culturally and linguistically appropriate services		appropriate care and services Reduced fragmentation between acute care and BH care	

Confounding Factors

Members not in TI 2.0 who seek care with TI 2.0 participating providers; member churn and/or attrition in TI 2.0; members not in TI 2.0 who seek care with TI 2.0 participating providers; members who seek care from both TI 2.0 and non-TI 2.0 participating providers; previous medical history; other AHCCCS programs could result in the confounding of program impacts; integration of care from non-TI 2.0 participating providers may vary; differential enrollment across waivers may mitigate the extent of confounding program effects; providers may vary in the degree in which they provide care coordination management.

Note: AHCCCS: Arizona Health Care Cost Containment System; ASU: Arizona State University, BH: behavioral health; CBO: community based organization; DSHP: Designated State Health Program; HIE: Health Information Exchange; HRSN: health related social needs; MCO: managed care organization; NCQA: National Committee for Quality Assurance; NMDOH: non-medical drivers of health; PCP: primary care provider; QIC: quality improvement collaborative; TI: Targeted Investments

Hypotheses and Research Question

To thoroughly assess the TI 2.0 program, five hypotheses (H) will be tested using 31 research questions (RQs) (Table 6).

Table 6: TI Hypotheses and Research Questions

Hypotheses	Research Questions
H1: The TI 2.0 program will increase collaboration and coordination amongst the MCOs, ACOs, subcontracted networks, and provider organizations.	• RQ 1.1: What was the experience of AHCCCS in implementing and/or maintaining TI 2.0 and its care coordination and health related social needs (HRSN) initiatives? • RQ 1.2: What was the experience of MCOs, ACOs, and subcontracted networks implementing and/or maintaining TI 2.0 and its care coordination and HRSN initiatives? • RQ 1.3: What was the experience of providers implementing and/or maintaining TI 2.0 and its care coordination and HRSN initiatives? • RQ 1.4: What is the rate of participating providers in TI 2.0? • RQ 1.5: What is the percentage of TI 2.0 providers with the National Committee for Quality Assurance (NCQA) Health Equity Accreditation? • RQ 1.6: Has the percentage of providers with executed agreements with Contexture for addressing HRSN and/or admit-discharge-transfer (ADT) alerts increased compared to prior to the demonstration? • RQ 1.7: What is the percentage of TI 2.0 beneficiaries who were screened using health-related social need (HRSN) assessments that received a referral to a community-based organization (CBO)? • RQ 1.8: What is the percentage of TI 2.0 providers that completed the TI 2.0 health equity projects?
H2: The TI 2.0 program will improve the delivery of care that addresses inequitable health outcomes for children.	• RQ 2.1: Have health disparities related to care coordination been reduced among children attributed to TIP 2.0 providers compared to prior to the demonstration? • RQ 2.2: Have general and mental health outcomes maintained or improved among children attributed to

Hypotheses	Research Questions
	TI 2.0 providers compared to prior to the demonstration? • RQ 2.3: Have health disparities related to access to care been reduced among children attributed to TI 2.0 providers compared to prior to the demonstration? • RQ 2.4: Have health disparities related to experience of care been reduced among children attributed to TI 2.0 providers compared to prior to the demonstration? • RQ 2.5: Have health disparities related to dental care utilization been reduced among children attributed to TI 2.0 providers compared to prior to the demonstration? • RQ 2.6: Have health disparities related to ED utilization been reduced among children attributed to TI 2.0 providers compared to prior to the demonstration? • RQ 2.7: Have health disparities related to treatment or management of behavioral health concerns been reduced among children attributed to TI 2.0 providers compared to prior to the demonstration?
H3: The TI 2.0 program will improve the delivery of care that addresses inequitable health outcomes for adults.	• RQ 3.1: Have health disparities related to care coordination been reduced among adults attributed to TI 2.0 providers compared to prior to the demonstration? • RQ 3.2: Have general and mental health outcomes maintained or improved among adults attributed to TI 2.0 providers compared to prior to the demonstration? • RQ 3.3: Have health disparities related to access to care been reduced among adults attributed to TI 2.0 providers compared to prior to the demonstration? • RQ 3.4: Have health disparities related to the experience of care been reduced among adults attributed to TI 2.0 providers compared to prior to the demonstration? • RQ 3.5: Have health disparities related to maternal health been reduced among adults attributed to TI 2.0 providers compared to prior to the demonstration? • RQ 3.6: Have health disparities related to ED and IP utilization been reduced among adults attributed to TI 2.0 providers compared to prior to the demonstration? • RQ 3.7: Have health disparities related to treatment or management of behavioral health concerns been reduced among adults attributed to TI 2.0 providers compared to prior to the demonstration?

Hypotheses	Research Questions
H4: The TI 2.0 program will improve the delivery of care for AHCCCS enrolled adults released from criminal justice facilities and who are referred to a TI Justice clinic.	• RQ 4.1: Do adult beneficiaries who are recently released from a criminal justice facility and who are referred to a TI Justice clinic have better care coordination than those who were not subject to the demonstration? • RQ 4.2: Do adult beneficiaries who are recently released from a criminal justice facility and who are referred to a TI Justice clinic have better general and mental health outcomes than those who were not subject to the demonstration? • RQ 4.3: Do adult beneficiaries who are recently released from a criminal justice facility and who are referred to a TI Justice clinic have higher rates of access to care than those who were not subject to the demonstration? • RQ 4.4: Do adult beneficiaries who are recently released from a criminal justice facility and who are referred to a TI Justice clinic have better experiences of care than those who were not subject to the demonstration? • RQ 4.5: Do adult beneficiaries who are recently released from a criminal justice facility and who are referred to a TI Justice clinic have higher rates of SUD treatment and adherence than those who were not subject to the demonstration? • RQ 4.6: Do adult beneficiaries recently released from a criminal justice facility and who are referred to a TI Justice clinic have lower rates of ED utilization than those who were not subject to the demonstration? • RQ 4.7: Do adult beneficiaries recently released from a criminal justice facility and who are referred to a TI Justice clinic have better management of alcohol and other drugs than those who were not subject to the demonstration? • RQ 4.8: Do adult beneficiaries recently released from a criminal justice facility and who are referred to a TI Justice clinic have better success with tobacco cessation than those who were not subject to the demonstration?
H5: The care costs for TI 2.0 participants will be lower than the care costs of non-TI participants.	RQ 5.1: Are the care costs for TI participants lower than the care costs for non-TI participants in TI 2.0?

Methodology

The main objective of an impact assessment in policy and program evaluation is to determine a causal link between the implementation of a policy or program and its associated outcomes. Achieving this requires comparing outcomes between the group receiving the intervention and a valid counterfactual—representing what would have happened had the intervention not been introduced. The most rigorous experimental approach is a randomized controlled trial (RCT), in which an intervention population is identified, and participants are randomly assigned either to the intervention group or to a control group, which serves as the counterfactual. However, in practice, particularly in the context of healthcare policies, random assignments are often impractical.

To address this challenge, various quasi-experimental and observational methods have been developed to assess policy effects on outcomes. The research questions outlined in the previous section will be examined using at least one of these methods. The choice of methodology largely depends on data availability, specifically regarding (1) data needed to measure outcomes, (2) data necessary for constructing a valid comparison group, and (3) data collected over relevant time periods, typically spanning one to two years before implementation and continuing annually thereafter. Table 7 provides an overview of the analytic approaches included in the evaluation, indicating whether each method requires baseline (pre-implementation) data, a comparison group, or the ability to infer causality. Additionally, it highlights key requirements unique to each approach.

Table 7: Ramp-Up Period

Analytic Approach	Baseline Data	Comparison Group	Causal Inference	Notes
Difference-in-Difference	✓	✓	✓	Trends in outcomes should be similar between comparison and intervention groups at baseline.
Interrupted Time Series	✓		✓	Requires sufficient data points prior to and following implementation.
Trend Analysis	✓			Requires multiple baseline data points.

Analytic Approach	Baseline Data	Comparison Group	Causal Inference	Notes
Pre-Test/Post-Test	✓			

Evaluation Design Summary

This interim evaluation report provides an initial comparison of outcomes between the baseline period (FFY 2022) and the ramp up period (FFY 2023) of the TI 2.0 evaluation across the intervention (TI providers) and comparison (non-TI providers) groups.

A mixed-methods approach was used to evaluate TI 2.0, with qualitative data collection centered on program experience and care coordination and/or HRSNs/NMDOHs. Table 8 outlines the main quantitative and qualitative methods used in this report for the TI 2.0 program. Appendix A provides additional details on the methods, data sources, and associated measures for the program.

Table 8: Quantitative and Qualitative Methods

Quantitative Analytic Approaches	Qualitative Approaches
• Difference-in-differences • Health outcomes analysis	• Interviews/focus groups • Beneficiary surveys

Analytic Approaches

Difference-in-Differences

A difference-in-differences (DiD) analysis was performed for all measures using claims/encounter data for evaluating the TI program as data was available for both the TI-attributed population (intervention group) and the non-TI attributed population (comparison group). While evaluating the measures outlined in Hypothesis 4, TI justice members were compared to a synthetic justice control that was consistent with CMS' guidance on selecting a synthetic control. This approach compared the changes in outcome rates between the baseline period (FFY 2022) and the ramp up period (FFY 2023), across the intervention (TI providers) and comparison groups (non-TI providers).

The DiD approach was used where possible, as it controls for any factors external to the TI program that are applied equally to both groups, such as the coronavirus disease 2019 (COVID-19) pandemic or Housing and Health Opportunities (H2O) participation[37]. However, the method is still susceptible to external factors that may have differentially impacted one group and not the other.

For the DiD analysis to be valid, the comparison group must accurately represent the change in outcomes that would have been experienced by the intervention group in the absence of the program. The DiD analysis was conducted with group-level rates, using an adjusted logistic regression model.

The general form of the DiD model was:

$$\text{logit}(P(Yit = 1)) = \beta 0 + \beta 1\ T + \beta 2\ \text{post} + \beta 3\ (\text{post} \times T) + \varepsilon$$

where Y is the binary outcome for group i in year t, T is a binary indicator of the intervention group, post is a binary indicator for the ramp-up period, and ε is an error term. The intercept β0 represents the outcome on the log-odds scale for the comparison group at the baseline. The coefficient β1 identifies the average difference between the groups during the baseline period prior to the implementation of TI 2.0 on the log-odds scale. The time period dummy coefficient β2 captures the log-odds change in the average outcome between the baseline and evaluation time periods for the non-intervention group. The coefficient on the interaction term β3 represents the DiD estimate of interest in this evaluation. In other words, it is the log-odds difference in the average outcome between the baseline and evaluation time periods for the intervention group, compared to the difference in average outcome between the baseline and ramp-up time period for the non-intervention group.

The time periods covered in this report are shown in Table 9.

Table 9: Interim Report Time Periods

Baseline Period	Ramp-Up Period
October 1, 2021–September 30, 2022	October 1, 2022–September 30, 2023

A Poisson regression model with a log link was used to estimate the DiD effect for continuous outcomes such as ED visits. This model was chosen because it appropriately handles count data by modeling event rates and allows adjustment for

[37] AHCCCS. AHCCCS Housing and Health Opportunities (H2O) Demonstration. Available at: https://azahcccs.gov/Resources/Federal/HousingWaiverRequest.html

differing population sizes through an offset, providing interpretable rate ratios for changes over time between groups.

The general form of this DiD model was:

$$\log(E(Yit))=\beta0+\beta1T+\beta2post+\beta3(T\times post)+\varepsilon$$

where Yit is the count outcome for group i in year t, T is a binary indicator of the intervention group, post is a binary indicator for the ramp-up period, and ε is an error term. The intercept β0 represents the expected log count of the outcome for the comparison group at baseline. The coefficient β1 identifies the average difference in log counts between the groups during the baseline period prior to the implementation of TI 2.0. The time period dummy coefficient β2 captures the change in the expected log count of the outcome between the baseline and ramp-up period for the non-intervention group. The coefficient on the interaction term β3 represents the DiD estimate of interest in this evaluation. In other words, it is the difference in the change of the expected log count of the outcome between the intervention group and the non-intervention group from baseline to evaluation.

A linear mixed-effects model was used to estimate the DiD effect for the cost analysis. This model was chosen because it can account for correlations within repeated measures over time (e.g., repeated observations for the same provider) by including random effects, while simultaneously estimating fixed effects for group, time, and their interaction. The mixed model provides interpretable estimates of mean differences over time between groups, accounting for within-group variability.

The general form of this DiD model was:

$$Yit =\beta0 +\beta1\ T+\beta2\ post+\beta3\ (T\times post)+ui +\epsilon it$$

where Yit is the Per Member Per Month (PMPM) for provider i at time t, T is a binary indicator of the intervention group, post is a binary indicator for the ramp-up period, ui is the provider random intercept accounting for within-unit correlation, and ϵit is the residual error term. The intercept β0 represents the expected PMPM for the comparison group at baseline. The coefficient β1 represents the average PMPM difference between the intervention and comparison groups at baseline. The coefficient β2 captures the PMPM change over time for the comparison group. The coefficient on the interaction term β3 is the DiD estimate of interest. It represents the difference in the PMPM change from baseline to evaluation between the intervention and comparison groups. By including random intercepts ui, the model accounts for repeated measurements and potential clustering within units, improving the precision of fixed-effect estimates.

Health Outcomes Analysis

In alignment with TI 2.0 program goals of enhancing comprehensive whole person care systems that effectively address health related social risk factors and unmet social needs, the TI 2.0 evaluation incorporated a multi-pronged analysis of health outcomes. The primary approach for this analysis entailed a detailed assessment of changes in health disparities during the baseline (FFY 2022) and ramp up period (FFY 2023), across patients attributed to TI and non-TI providers

For each measurement year during the interim report period, ASU TIPQIC calculated outcome measures for relevant demographic stratifications in which sufficient data are available; such as beneficiary age, beneficiary sex, beneficiary race, beneficiary ethnicity, beneficiary geography, beneficiary disability status, and language spoken by beneficiary. Additional subgroup analyses were conducted based on HRSNs/NMDOHs and the Social Vulnerability Index (SVI) at the census tract level among beneficiaries to identify existing disparities and assess whether TI 2.0 results in reduced health disparities. Measure rates from each demographic stratification were compared to the non-TI- attributed population. These comparisons were examined for both (1) statistically significant differences, using a series of independent sample t-tests (or ANOVA) and G-squared tests, and (2) clinically meaningful differences in standardized relative percentages and effect sizes. These differences were plotted over time to illustrate any widening or narrowing of specific health disparities.

The secondary approach provided a summary metric of health outcomes for each measure in each evaluation year through a G-squared test to account for unequal denominators in equity measures. [38] The G-squared test assesses the statistical significance of the difference between observed and expected frequencies in categorical data. This will be calculated for each measure for each year to provide a broad measure of health outcomes and may be used to supplement the primary approach described above.

Population Identification

TI 2.0 participating providers were identified as those currently participating in the program during demonstration year 1 (FFY 2023) and who also attested to the year 1 milestones/process requirements. The comparison group was limited to providers who were not participating in TI 2.0 and who had the same provider types as the TI 2.0 eligible provider types: group payment, BH outpatient, and integrated clinics.

[38] McDonald, John H. (2014). "Small numbers in chi-square and G–tests". Handbook of Biological Statistics (3rd ed.). Baltimore, MD: Sparky House Publishing. pp. 86–89. Accessed on: Nov 28, 2023

Arizona Medicaid beneficiaries were attributed to TI 2.0 providers by utilizing multiple resources including (1) monthly PCP assignment lists from each ACC and ACC-RBHA health plan, (2) measure-specific attribution reports that identify beneficiaries and attributed providers for receiving incentives based on meeting performance measure targets developed by ASU, as well as (3) claims/encounter data identifying beneficiaries' utilization of care. Likewise, a beneficiary was included in the non-TI (comparison) group if, for a particular measure, they were attributed to a provider who is not participating in TI 2.0 or had never had an encounter with a TI provider during the study period (2021–2023). Subsequent analyses were performed at the provider-aggregate level; therefore, for each measure, members attributed to a non-TI provider were included even if they received services from a TI provider, and vice versa. Attribution for the justice population relied on monthly justice referral lists provided by each participating justice clinic and the ACC/ACC-RBHA health plans. The justice population identified for each year included individuals referred during that year and the preceding year. A synthetic control group was calculated for the TI Justice population to support comparative analyses.[39]

Data Sources

Multiple data sources are used to evaluate the five hypotheses for the TI 2.0 evaluation. Data collected includes administrative claims/encounter data, TI-administrative program data, state beneficiary survey data, aggregate data, race and ethnicity data, provider focus groups, and key informant interviews. Administrative data sources include information extracted from the Prepaid Medical Management Information System (PMMIS). PMMIS was utilized to collect, manage, and maintain Medicaid recipient files (e.g., eligibility, enrollment, demographics) and managed care encounter data. Qualitative data were gathered through key informant interviews and provider focus groups to capture insights on program implementation, care coordination strategies, and barriers and drivers of success. Supplemental data was utilized to support evaluation efforts related to HRSN/NMDOH referrals and participation in the H2O Demonstration program.

Administrative Program Data

Administrative program data extracted from the AHCCCS PMMIS was used to calculate most measures proposed in this interim evaluation report. These data include administrative claims/encounter data, beneficiary eligibility, enrollment, and demographic data. Provider data from the PMMIS and the ACC/ACC-RBHA health

[39] Centers for Medicare & Medicaid Services (2020). Selection of Out-of-State Comparison Groups and the Synthetic Control Method. Available at: https://www.medicaid.gov/sites/default/files/2021-05/outofstate-comp.pdf. Accessed on: Nov 29, 2023.

plans were also utilized as necessary to identify provider type and beneficiary attribution.

ASU TIPQIC used all fee-for-service (FFS) claims and managed care encounters for this evaluation, regardless of adjudication status. Interim transactions were excluded from the evaluation because these types of records introduce a level of uncertainty (from matching adjustments and third-party liabilities to the index claims) that can impact reported rates and cost calculations.

Beneficiary Surveys

Beneficiary surveys were administered to approximately 1.3 million ACC and ACC-RBHA members in Fall 2025. These surveys consisted of the Healthcare Effectiveness Data and Information Set (HEDIS®[40]) Consumer Assessment of Healthcare Providers and Systems (CAHPS®[41]) child and adult surveys, with additional questions for the TI Justice population. Survey results can be found in Hypotheses 2 through 4. Beneficiary survey data prior to the demonstration period were not available at the time of the interim evaluation report; as a result, only the Fall 2025 survey results will be presented in this report.

The beneficiary list was provided by AHCCCS in July 2025, and eligibility and enrollment criteria were applied to determine the final list of survey recipients. The beneficiary surveys opened in late August 2025 and closed in early October 2025. To improve response rates from previous interim reports, surveys were distributed through Qualtrics via e-mail, text, or both methods. The surveys were sent in both English and Spanish, according to each beneficiary's preferred language on file. ASU TIPQIC also implemented a responsive survey design that allowed the team to monitor non-response in subpopulations and adapt outreach strategies (e.g., additional reminders or alternative modalities) as needed.

The survey followed a population-based, census-style approach. Each eligible adult and justice-involved member received a survey unique to them. To minimize survey burden in households with multiple children, only one pediatric survey was sent per eligible household, addressed to the primary applicant. An additional question in the pediatric survey allowed ASU TIPQIC to apply the results to other children in the household if the respondent indicated that their healthcare experiences did not differ from the child for whom the survey was completed. Surveys were distributed through multiple modalities, including text and email, and each eligible beneficiary was contacted a minimum of two

[40] HEDIS® is a registered trademark of the National Committee of Quality Assurance (NCQA).
[41] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

times with the available contact information, with the option to opt out at any time via Qualtrics or email.

The overall survey response rate was 1%. A total of 95 (1.1% response rate) justice-involved beneficiaries responded to the survey (5 in Spanish; 90 in English). Responses were higher among adult beneficiaries, with 8,167 adults (1.1%) completing the survey (1,789 in Spanish; 6,378 in English). Before results were extended to other children in the household when indicated by the respondent, a total of 3,789 (1.2%) primary applicants completed a survey on behalf of their oldest child. After results were extended, 5,773 (1%) pediatric surveys were analyzed.

Contexture

Data provided from Arizona's health information exchange (HIE), Contexture, was used in the TI 2.0 interim evaluation report to determine the number of providers that have an executed agreement with the platform and are actively receiving admit-discharge-transfer (ADT) alerts.

Key Informant Interviews and Focus Groups

It is important to acknowledge that administrative data and beneficiary surveys do not offer a comprehensive view of the implementation of the demonstration programs as experienced by key TI 2.0 stakeholders. To address this gap, key informant interviews were conducted with AHCCCS, MCO, and ACO staff. Additionally, provider focus groups and interviews were held to capture the experiences of providers with the program and their reported activities to support care coordination and/or HSRN/NMDOH before and after the implementation of the TI 2.0 program. Data from ten key informant interviews and focus groups were collected in the Fall of 2023. Topics of conversation included care coordination, HRSN/NMDOH initiatives, alignment of programs with other value-based payment (VBP) contracts, and TI 2.0 expectations and goals.

All interviews and focus groups were recorded to ensure accuracy in notetaking and transcription. Notes and transcriptions were analyzed using open coding techniques to identify key themes and concepts raised by interviewees and focus group participants. Subsequently, axial coding techniques were used to identify relationships between the concepts identified during open coding. The results of the analysis do not provide a statistically representative sample of experiences with the demonstration implementation. Instead, the responses obtained through key informant interviews and focus groups are intended to provide context for the breadth and variety of experiences among key stakeholders. Particularly with respect to provider responses, the experiences of other providers may differ from those described in this report.

Supplemental Data

ASU TIPQIC received supplemental data from a variety of organizations to improve the evaluation of the TI 2.0 program. Member and provider data from the Housing and Health Opportunities (H2O) program was used to help mitigate the potentially confounding effects of the H2O program on the TI 2.0 program outcomes. Actuarial capitation certification documents were downloaded from AHCCCS's website to inform the preliminary PMPM calculations for the cost analysis. The wording in the NCQA Health Outcomes Accreditation section and the count of providers with a scheduled Health Outcomes Accreditation Survey were provided by NCQA. 2010 Rural-Urban Commuting Area (RUCA) Codes were downloaded from the U.S. Department of Agriculture (USDA) Economic Research Service and used to link ACC and ACC-RBHA beneficiaries' ZIP codes to classify their geography as urban or rural.[42]

Methodology Limitations

Strengths

In this interim evaluation report, AHCCCS and ASU TIPQIC presents baseline and ramp-up period rates for performance measures selected to reflect key processes and outcomes anticipated to be influenced by the TI 2.0 program. AHCCCS and ASU TIPQIC chose the data sources and performance measures due to their specific strengths, contributing to a comprehensive and multi-faceted program evaluation. The quantitative analyses in this interim evaluation report aim to evaluate changes in performance measure rates and beneficiary survey responses associated with the TI program. The performance metrics included in the evaluation were selected because of their relevance to the processes and outcomes intended to be impacted by the TI 2.0 program. Additionally, the measures selected are based on standardized, well-validated metrics from recognized measure stewards, including the NCQA Healthcare Effectiveness Data and Information Set (HEDIS®) metrics and the CMS Core Sets. The interim report is, therefore, based on data and analyses that provide a strong foundation for the final Summative Evaluation report. However, it is important to acknowledge the limitations of the data, measures, and methods to properly interpret the results within the broader context of the TI 2.0 program.

Weaknesses

One limitation of the TI 2.0 evaluation relates to the health outcomes analysis. ASU TIPQIC recognizes that health outcomes are a complex subject and that there have been many significant discussions around the topic of measuring health outcomes

[42] USDA. Rural-Urban Commuting Area Codes. Available at: https://www.ers.usda.gov/data-products/rural-urban-commuting-area-codes

among the broader scientific community. There is no single approach to evaluating health outcomes that is without limitations, and thus, this evaluation utilizes multiple methods to address health outcomes related research questions. The health outcomes analysis is designed to provide an overview of how health disparities have changed during the TI 2.0 study period but acknowledges the primary limitation that any changes in disparities identified cannot be causally attributed to the program, as co-occurring external factors may impact the measured outcomes.

Potential sources of bias and confounding should be considered when interpreting the findings. Members who are not enrolled in TI 2.0 may still receive services from TI 2.0 participating providers, and some may seek care from both TI 2.0 and non-TI 2.0 providers, making it difficult to isolate program effects. Member churn and attrition can further introduce instability in the enrolled population over time. Differences in previous medical history or participation in other AHCCCS programs may also confound estimated impacts, as these factors may independently influence outcomes. Additionally, integration of care from non-TI 2.0 participating providers may vary, and differential enrollment across waiver programs may mitigate or amplify the extent of confounding. Variation across providers in the level and quality of care coordination and management may also contribute to heterogeneous program effects, complicating interpretation of overall findings.

Another limitation to consider pertains to the potential biases that may have arisen from the data captured during the COVID-19 Public Health Emergency (PHE). Understanding and acknowledging these biases is essential for maintaining the credibility and reliability of any analyses or conclusions drawn from the data. The circumstances surrounding the PHE, such as resource constraints experienced by providers and differential access to healthcare services, can contribute to skewed health-related data. To address potential biases in the analysis, ASU TIPQIC adopted a comprehensive approach, as detailed earlier, to ensure a more precise and nuanced interpretation of the data gathered during the PHE.

Working primarily with administrative data presents challenges. Healthcare Common Procedure Coding System (HCPCS) codes (G8431, G8510, and G8511) used to identify postpartum depression screening and follow-up care are no-pay codes and may be underreported, resulting in artificially low rates. While the HRSN/NMDOH G codes (G9919, G9920, and G9921) are also no-pay codes, their use is tied to incentive payments, which encourages their use throughout the duration of the TI 2.0 program. It is important to note that the American Medical Association terminated G9921 effective December 31, 2024, which will necessitate a methodology change in the final evaluation report. Additionally, attribution in administrative data relies on unique combinations of AHCCCS billing and servicing provider identification numbers, which can represent

either individual providers or care locations. This ambiguity complicates accurate attribution of services and limits the ability to assess factors such as the presence of a culturally sensitive workforce. Together, these issues constrain the completeness and precision of performance measurement for postpartum depression screening, follow-up care, and workforce cultural competency.

Another limitation of this report is the use of electronic survey distribution via Qualtrics, which may have introduced selection bias and limited generalizability of the findings. Compared to traditional methods such as mail or telephone surveys, electronic distribution may disproportionately exclude individuals without reliable internet access, those with limited digital literacy, or those who are less inclined to engage with email or online platforms. This mode of dissemination may result in underrepresentation of older adults, non-English/non-Spanish speakers, and rural populations, who may have distinct healthcare experiences and needs. Additionally, response bias may have occurred if those with particularly positive or negative experiences with their healthcare coverage were more motivated to respond. These potential sources of bias should be considered when interpreting the study results and their applicability to the broader ACC and ACC-RBHA beneficiary population.

The final limitation applies to the DiD analytic approach and stems from the mismatch in the level of program implementation and the level of analysis of outcomes. The TI 2.0 program provides incentive payments to support care coordination that advances health outcomes and whole person care. However, outcome metrics for this program are evaluated at the individual beneficiary level. As such, the design of the program leads to challenges with isolating program effects. Given the proposed methodology for attributing beneficiaries to providers based on PCP assignment lists, performance metric attribution reports, and beneficiaries' utilization of care from claims and encounter data, the potential for spillover effects and contamination of the TI data is possible. Providers may drop in and out of TI 2.0 participation by year, leading to groups of providers who participated in all years, and others who participated for only some of the years. It is also possible that beneficiaries' attribution to a TI participating provider may vary throughout the study period, as beneficiaries may seek care from both TI participating providers and non-TI participating providers. ASU TIPQIC considered a hierarchical model to account for the fluidity of providers and beneficiaries moving between "treated" and "untreated" states, although there are still complex considerations with a hierarchical model. G-computation was used in this report because it performs well for effect estimation, particularly with large sample sizes and many variables. However, the presence of nesting introduces additional complexity and can complicate significance testing within these models

Results

The following section presents measure results by research question and the related hypotheses for the TI 2.0 program. The program is split into three groups: adult members, pediatric members, and ACC and ACC-RBHA members transitioning from the criminal justice system ("justice"). A DiD approach was utilized to assess the effect of the demonstration from baseline (FFY 2022, prior to the demonstration period) to the first year of the ramp up period (FFY 2023), across TI and non-TI providers. For details on the measure definitions and specifications, reference Appendix A. Full measure results with denominator data are presented in Appendix B.

The evaluation of the TI 2.0 program employs a mixed-methods strategy that encompasses assessments of both provider experiences and their effectiveness in achieving the program's overall objectives, alongside evaluations of beneficiary experiences and quantitative health outcomes.

Beneficiaries of the TI 2.0 program were identified as those assigned to a provider participating in TI 2.0 during each measurement year or the year preceding the baseline period.[43] They are classified into the three distinct groups mentioned above. Correspondingly, the hypotheses and findings discussed in this section are tailored to meet the specific needs of these groups and are structured by hypothesis and research questions within each hypothesis. Most hypotheses encompass multiple research questions, and each research question typically employs several measures. The measures detailed in this section are derived from administrative claims and encounter data, as well as information related to TI program participation.

Results Summary

Results for claims-based measures are separated into three components: (1) a descriptive component that reports annual rates for the baseline and first ramp-up period, (2) results from the DiD analysis, and (3) results from the health outcomes analysis. For both the DiD analysis and the health outcomes analysis, a model was run to compare the baseline period with the first year of the ramp-up phase (FFY 2023).

In total, 70 measures were calculated between the baseline and ramp-up period. 41 of these measures were performance rates and 29 measures were calculated from beneficiary surveys. 55 of these measures had an appropriate comparison group to allow for statistical testing. The results of the DiD analyses, however, allow for a comparison between the TI-participating providers and their non-TI counterparts to

[43] TI providers were any BH or PCPs who indicated participation in the TI program during demonstration year 3 (FFY 2025). Justice beneficiaries were identified as having been attributed to a participating TI provider, including providers specifically working with the justice transition project.

estimate whether the TI program was able to demonstrate better changes in outcomes than non-TI providers. While the results are based on an assumption that the PHE and the H2O program had the same impact on both sets of providers, it is important to note that AHCCCS' response to the PHE through the TI program represents an indirect difference of the PHE and H2O program between the TI and non-TI providers.

Table 10 presents the research questions and the number of measures with an appropriate comparison group for statistical testing that moved in the desired direction (improved) or in the opposite direction (declined). Parentheses show the counts of measures that improved or declined and were statistically significant. Note that the research questions for Hypothesis One involve descriptive reporting and the synthesis of qualitative data; therefore, they will not be listed in the table below. Refer to the descriptive summaries that follow.

Table 10: Measures and Desired Direction

Research Question	Year	Total Measure Count	Improving (Statistically Significant)	Declining (Statistically Significant)
2.1: Have health disparities related to care coordination been reduced among children attributed to TI 2.0 providers compared to prior to the demonstration?	2023	1	1 (0)	0
2.2: Have general and mental health outcomes maintained or improved among children attributed to TI 2.0 providers compared to prior to the demonstration?	2023	2	1 (0)	1 (0)
2.3: Have health disparities related to access to care been reduced among children attributed to TI 2.0 providers compared to prior to the demonstration?	2023	6	3 (1)	3 (1)
2.4: Have health disparities related to experience of care been reduced among children attributed	2023	3	2 (0)	1 (0)

Research Question	Year	Total Measure Count	Improving (Statistically Significant)	Declining (Statistically Significant)
to TI 2.0 providers compared to prior to the demonstration?				
2.5: Have health disparities related to dental care utilization been reduced among children attributed to TI 2.0 providers compared to prior to the demonstration?	2023	2	2 (1)	0
2.6: Have health disparities related to ED utilization been reduced among children attributed to TI 2.0 providers compared to prior to the demonstration?	2023	2	1 (1)	1 (0)
2.7: Have health disparities related to treatment or management of behavioral health concerns been reduced among children attributed to TI 2.0 providers compared to prior to the demonstration?	2023	7	6 (2)	1 (0)
3.1: Have health disparities related to care coordination been reduced among adults attributed to TI 2.0 providers compared to prior to the demonstration?	2023	3	2 (1)	1 (0)
3.2: Have general and mental health outcomes maintained or improved among adults attributed to TI 2.0 providers compared to prior to the demonstration?	2023	2	0	2 (1)
3.3: Have health disparities related to access to care been reduced among adults attributed to TI 2.0 providers compared to prior to the demonstration?	2023	4	1 (1)	3 (0)

Research Question	Year	Total Measure Count	Improving (Statistically Significant)	Declining (Statistically Significant)
3.4: Have health disparities related to the experience of care been reduced among adults attributed to TI 2.0 providers compared to prior to the demonstration?	2023	3	3 (0)	0
3.5: Have health disparities related to maternal health been reduced among adults attributed to TI 2.0 providers compared to prior to the demonstration?	2023	2	2 (0)	0
3.6: Have health disparities related to ED and IP utilization been reduced among adults attributed to TI 2.0 providers compared to prior to the demonstration?	2023	2	1 (1)	1 (1)
3.7: Have health disparities related to treatment or management of behavioral health concerns been reduced among adults attributed to TI 2.0 providers compared to prior to the demonstration?	2023	9	4 (2)	5 (1)
4.1: Do adult beneficiaries who are recently released from a criminal justice facility and who are referred to a TI Justice clinic have better care coordination than those who were not subject to the demonstration?	2023	1	1 (0)	0
4.2: Do adult beneficiaries who are recently released from a criminal justice facility and who are referred to a TI Justice clinic have better general and mental health outcomes than those who were not subject to the demonstration?	2023	0	0	0

Research Question	Year	Total Measure Count	Improving (Statistically Significant)	Declining (Statistically Significant)
4.3: Do adult beneficiaries who are recently released from a criminal justice facility and who are referred to a TI Justice clinic have higher rates of access to care than those who were not subject to the demonstration?	2023	0	0	0
4.4: Do adult beneficiaries who are recently released from a criminal justice facility and who are referred to a TI Justice clinic have better experiences of care than those who were not subject to the demonstration?	2023	0	0	0
4.5: Do adult beneficiaries who are recently released from a criminal justice facility and who are referred to a TI Justice clinic have higher rates of SUD treatment and adherence than those who were not subject to the demonstration?	2023	0	1 (0)	1 (0)
4.6: Do adult beneficiaries recently released from a criminal justice facility and who are referred to a TI Justice clinic have lower rates of ED utilization than those who were not subject to the demonstration?	2023	0	0	0
4.7: Do adult beneficiaries recently released from a criminal justice facility and who are referred to a TI Justice clinic have better management of alcohol and other drugs than those who were not subject to the demonstration?	2023	3	2 (0)	1 (0)
	2023	0	0	0

Research Question	Year	Total Measure Count	Improving (Statistically Significant)	Declining (Statistically Significant)
4.8: Do adult beneficiaries recently released from a criminal justice facility and who are referred to a TI Justice clinic have better success with tobacco cessation than those who were not subject to the demonstration?				
5.1: Are the care costs for TI participants lower than the care costs for non-TI participants in TI 2.0?	2023	1	0	1 (0)

Hypothesis 1: The TI 2.0 program will increase collaboration and coordination amongst the MCOs, ACOs, subcontracted networks, and provider organizations.

Hypothesis 1 used administrative program data and focus group data to test whether the TI 2.0 program's efforts to increase collaboration and coordination among MCOs, ACOs, subcontracted networks, and provider organizations reduced population health disparities and improved member health outcomes. Eight research questions were used to assess Hypothesis 1.

During the second year of the demonstration, focus groups were conducted with a representative group of providers, MCOs, and AHCCCS staff to collect insights and experiences related to the TI 1.0 program and expectations for TI 2.0. This existing data contributed to this interim evaluation report, although it is important to acknowledge that it may not directly address all specific research questions outlined in the evaluation.

Research Question 1.1: What was the experience of AHCCCS in implementing and/or maintaining TI 2.0 and its care coordination and health related social needs (HRSN) initiatives?

Key Findings

- AHCCCS has focused on standardizing data, supporting provider accreditation, improving health care access through analyses, clarifying HRSN/NMDOH processes, and fostering collaboration with providers and CBOs to address social needs and improve care coordination.

AHCCCS has made significant strides in supporting TI 2.0 and its care coordination efforts, with a particular focus on reducing disparate health outcomes and improving collaboration. To support practices, AHCCCS has developed milestone requirements, provided documentation criteria, and included NCQA support for providers to obtain accreditation.

AHCCCS and ASU are collaborating to provide support to providers, including multivariate and AHCCCS Root Cause at Scale (ARCS) analyses to assess inequities, with a recognition that many variables contribute to health disparities. AHCCCS and ASU are also focusing on NCQA Health Outcomes Accreditation (formerly Health Equity Accreditation) by better communicating the value of earning NCQA Health Outcomes Accreditation and encouraging measure alignment with other programs like the AHCCCS Contractors Operations (ACOM) Policy - 306, Alternative Payment Model Initiative, and the Differential Adjusted Payment (DAP) program.

AHCCCS prioritized the implementation of language access standards and HRSN/NMDOH processes and are fostering peer collaboration and engaging CBOs to address resource gaps in meeting social needs. They are working to clarify workflows, particularly for high-volume PCPs with numerous CBO partners. AHCCCS is also focused on ensuring that the eight required HRSN/NMDOH domains, including housing instability, food insecurity, utility assistance, transportation needs, interpersonal safety, social isolation/support, employment, and justice involvement, are met on screening tools so that providers can connect members to CBOs to meet these needs

AHCCCS also provided flexibility in tools for CommunityCares and incentivizing provider participation, particularly through DAP requirements, while continuously refining processes for better coordination and alignment across all involved stakeholders.

Research Question 1.2: What was the experience of MCOs, ACOs, and subcontracted networks implementing and/or maintaining TI 2.0 and its care coordination and HRSN initiatives?

Key Findings

- MCOs, ACOs, and subcontracted networks highlighted the need for alignment of performance measures with other state requirements, improved data quality, expanded community partnerships, and flexible implementation strategies to effectively enhance care coordination and address social needs through TI 2.0.

MCOs, ACOs, and provider networks expressed strong support for TI 2.0 while emphasizing the need for alignment of performance measures across contracts to reduce provider burden and improve engagement. High-priority areas included prenatal

care, cancer screenings, and well visits, with recommendations to co-locate services in primary care settings and use mobile units to improve access.

CommunityCares was seen as a promising system, though still developing. Key success factors include expanding the network of CBOs, improving EHR integration, and addressing data quality issues, particularly for demographics and contact information. HRSN/NMDOH screening requirements were viewed as critical for identifying and addressing social needs.

HRSN/NMDOH implementation is occurring at both the provider and health plan levels, with MCOs supporting providers through training, communication strategies, and initiatives focused on reducing health disparities. MCO participants welcomed cross-sector collaboration, while also stressing the importance of maintaining flexibility to tailor strategies to organizational needs.

TI 2.0 is seen as a valuable initiative to strengthen care coordination and address social needs, though success will depend on improved data systems, provider engagement, and community capacity.

Research Question 1.3: What was the experience of providers implementing and/or maintaining TI 2.0 and its care coordination and HRSN initiatives?

Key Findings

- Providers see strong potential in TI 2.0 to enhance collaboration and address health-related social needs, but face ongoing challenges with staff burden, data gaps, and limited community resources that could hinder full benefit to patients.

Providers expressed sincere optimism about the opportunities TI 2.0 brings, particularly for enhancing care coordination, internal systems, and cross-sector partnerships. Many highlighted early improvements, such as better EHR functionality and streamlined communication, and looked forward to further integration with the program's extension.

At the same time, providers encountered significant challenges. These included burdensome workflows associated with CommunityCares, limited community resources (especially for housing), and the time demands of staff training. Accurate demographic data collection and attribution for behavioral health entities also remain problematic, hindering efforts to reduce disparate health outcomes.

Despite these hurdles, providers emphasized the importance of leadership and staff buy-in, sustained engagement, and improved data systems. Overall, the experience

reflects a balance of cautious optimism and realistic concern, underscoring the need for support, clarity, and infrastructure to fully realize TI 2.0 goals.

Research Question 1.4: What is the rate of participating providers in TI 2.0?

Key Findings

- Less than 2.5% of eligible Arizona Medicaid providers (identified by tax identification numbers (TINs)) are participating in TI 2.0.
- Among the 119 unique provider organizations currently participating in the program, clinical focus areas varied, with the majority concentrating on adult behavioral health, adult primary care, and pediatric primary care, while fewer organizations specialized in pediatric behavioral health and justice-related services.

Five thousand fifty-eight unique tax identification numbers (TINs) with an appropriate AHCCCS billing provider type[44] submitted professional and/or UB claims between 2021 and 2023. Of these, 119 TINs are currently participating in the TI 2.0 program. Table 11 shows the number of provider organizations by AOC currently participating in TI 2.0 as of December 2025.

Table 11: Number of Participating Organizations by AOC

AOC	Number of Participating Provider Organizations
Pediatric Behavioral Health	40
Pediatric Primary Care	43
Adult Behavioral Health	54
Adult Primary Care	50
Justice	17

[44] The non-TI comparison group included the following provider types: group payment and integrated clinics (PCP and BH projects); BH outpatient clinics (BH project); and Federally Qualified Health Centers and Rural Health Clinics (justice project).

AOC	Number of Participating Provider Organizations
119 unique tax identification numbers (TINs)	

Note: Many provider organizations are participating in more than one area of concentration; therefore, the total count of organizations by area of concentration will not equal 119.

These 119 unique organizations represent more than 600 clinics statewide, delivering care across every county and serving all populations.

Research Question 1.5: What is the percentage of TI 2.0 providers with the National Committee for Quality Assurance (NCQA) Health Equity Accreditation?

Key Findings

- As of December 2025, 12.6% (N = 15) of TI 2.0 providers have scheduled their survey dates with NCQA to receive NCQA Health Outcomes Accreditation within the next year.

Forty-one TI 2.0 provider organizations, each with a varying number of sites, initially pursued Health Outcomes Accreditation. By the survey scheduling deadline (October 15, 2025), 15 providers had applied and scheduled surveys. Details on these provider organizations are listed in Table 12.

Table 12: TI 2.0 Providers Currently Seeking NCQA Health Outcomes Accreditation

Provider Organization	Survey Date	Geography of Sites	Provider's Participating TI 2.0 AOCs	Number of Sites
Provider #1	2/10/2026	Urban	Peds PCP	14
Provider #2	3/24/2026	Urban	Adult BH, Justice	6
Provider #3	4/14/2026	Urban	Adult BH, Peds BH	7
Provider #4	4/21/2026	Urban and Rural	Adult PCP, Peds PCP	1
Provider #5	4/21/2026	Urban and Rural	Adult BH, Adult PCP, Peds PCP, Peds BH, Justice	11
Provider #6	4/21/2026	Rural	Adult BH, Peds BH	2
Provider #7	4/28/2026	Urban	Justice	7

Provider Organization	Survey Date	Geography of Sites	Provider's Participating TI 2.0 AOCs	Number of Sites
Provider #8	4/28/2026	Urban	Peds PCP	1
Provider #9	4/28/2026	Urban and Rural	Adult BH, Adult PCP, Justice	7
Provider #10	4/28/2026	Urban	Adult BH, Adult PCP, Peds BH, Peds PCP	7
Provider #11	4/28/2026	Urban	Adult BH, Adult PCP, Peds PCP, Peds BH, Justice	22
Provider #12	4/28/2026	Urban	Adult BH, Adult PCP, Peds BH	1
Provider #13	4/28/2026	Urban	Peds BH	3
Provider #14	4/28/2026	Urban	Adult PCP, Peds PCP	3
Provider #15	5/19/2026	Urban	Adult PCP	1
			Total Number of Sites	93

To date, NCQA has successfully supported AHCCCS across Arizona through technical assistance to TI 2.0 providers pursuing Health Outcomes Accreditation and has scheduled 15 provider organizations for surveys.

One challenge during implementation was the need for realistic scheduling timelines and sustained engagement with the providers. The majority of TI 2.0 providers were not scheduled for surveys by the original deadline (August 30, 2025). NCQA extended the deadline to schedule a survey to October 15, 2025. Based on this experience, future efforts may benefit from deadlines that better reflect a provider's readiness and capacity. Closer and continuous engagement with provider organizations could also encourage timely scheduling.

Because TI 2.0 providers progressed at varying rates throughout the project, ongoing monitoring of readiness would provide visibility into survey preparedness. This approach would help ensure that provider organizations can meet deadlines and maintain momentum towards achieving Accreditation.

Research Question 1.6: Has the percentage of providers with executed agreements with Contexture for addressing HRSN and/or admit-discharge-transfer (ADT) alerts increased compared to prior to the demonstration?

Key Findings

- Among the 119 providers currently participating in the TI 2.0 program, 95.8% (N = 114) have executed agreements with Contexture, and 61.3% (N = 73) routinely receive ADT alerts.

Data for this measure prior to the demonstration was not available at the time of the interim evaluation report.

Pediatric Primary Care and BH Care

Executed Agreements with Contexture

Of the 73 unique Tax Identification Numbers (TINs) participating in the TI 2.0 pediatric primary care and BH areas of concentration, 70 provider organizations have an executed agreement with Contexture.

Admit-Discharge-Transfer (ADT) Alerts

Of the 73 unique TINs participating in the TI 2.0 pediatric primary care and BH areas of concentration, 51 provider organizations routinely receive ADT alerts.

Adult Primary Care and BH Care

Executed Agreements with Contexture

Of the 84 unique TINs participating in the TI 2.0 adult primary care and BH areas of concentration, 81 provider organizations have an executed agreement with Contexture.

ADT Alerts

Of the 84 unique TINs participating in the TI 2.0 pediatric primary care and BH areas of concentration, 50 provider organizations routinely receive ADT alerts.

Justice Practices

Executed Agreements with Contexture

Of the 17 unique TINs participating in the TI 2.0 justice program, 16 provider organizations have an executed agreement with Contexture.

ADT Alerts

Of the 17 unique TINs participating in the TI 2.0 justice program, 11 provider organizations routinely receive ADT alerts.

Research Question 1.7: What is the percentage of TI 2.0 beneficiaries who were screened using health-related social need (HRSN) assessments that received a referral to a community-based organization (CBO)?

Key Findings

- TI providers adopted the HRSN/NMDOH screening process quickly after receiving initial implementation guidance.
- Standardized, multi-domain social needs assessments among Medicaid beneficiaries revealed differences in the identification of health-related social needs and referral preferences across patient subgroups.

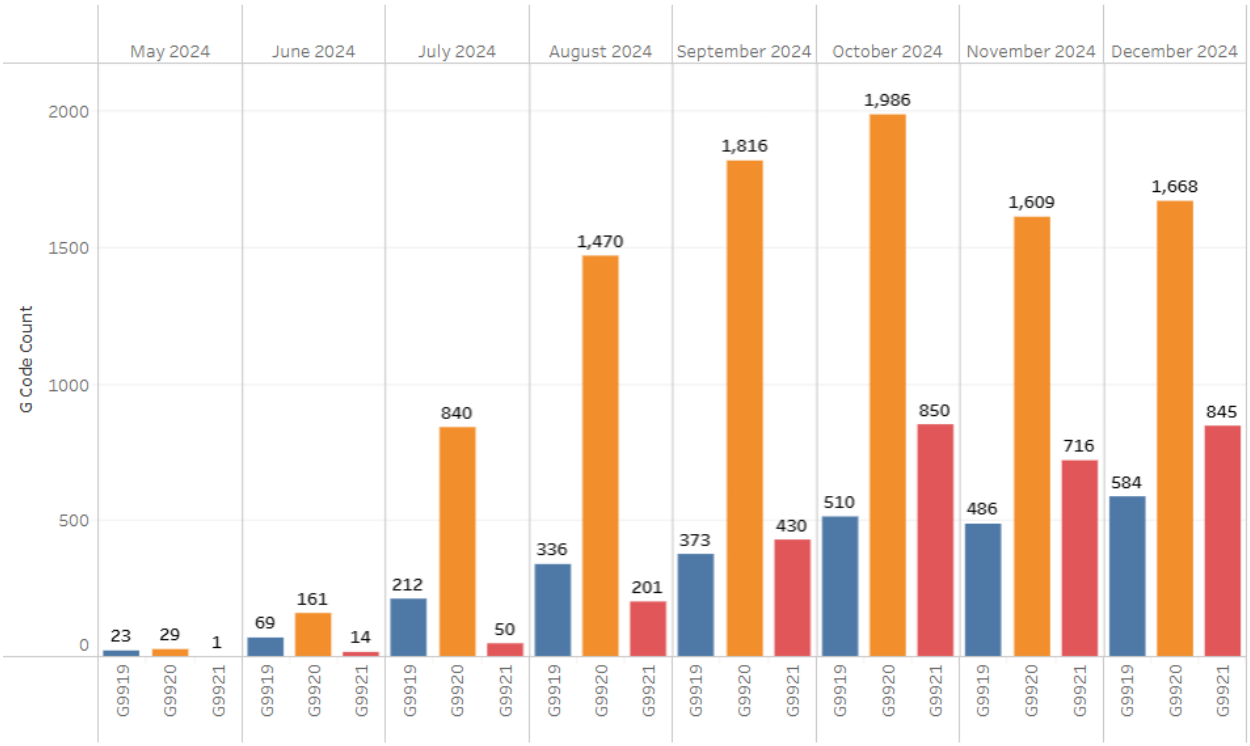
	NMDOH Assessments	May 1, 2024 - December 31, 2024
1-15	Number/percent of TI beneficiaries who received an HRSN screening assessment	14,277
1-16	Number/percent of TI beneficiaries who received a HRSN screening assessment and were referred to a CBO	16.6% (N = 2,373)
1-17	Number/percent of TI beneficiaries referred to a CBO that experienced a follow-up CBO appointment within 30 days	N/A The TI HRSN/NMDOH G and Z codes only reflect the HRSNs/NMDOH needs identified and the referrals that were either given or declined at the time of the appointment. Community Cares data was not received at the time of the interim evaluation report.

Initial guidance for the HRSN/NMDOH screening results was released in May 2024, with providers asked to develop the necessary processes to submit these new codes by September 30, 2025. Despite this extended timeline, early adoption has been strong. Between May and December 2024, 76 unique organizations submitted at least one

claim with a HRSN/NMDOH G code. During this period, 14,277 unique Medicaid beneficiaries received a comprehensive HRSN/NMDOH screening.[45] It is important to note that many beneficiaries were screened multiple times during this period; therefore, the number of submissions may differ from the figures presented in measures 1-15 and 1-16.

Figure 4 summarizes these early results by HRSN/NMDOH G code. Beneficiaries most often screened negative for a HRSN/NMDOH need (G9920; 9,579 total submissions), followed by screening positive with no referral (G9921; 3,107 submissions) and screening positive with a referral (G9919; 2,593 submissions). These results demonstrate meaningful progress in integrating HRSN/NMDOH needs, referrals, and case management into routine practice, reflecting growing provider engagement and momentum toward advancing care coordination, improving health outcomes, and supporting whole-person care initiatives.

Figure 4: TI NMDOH G Code Submissions Over Time



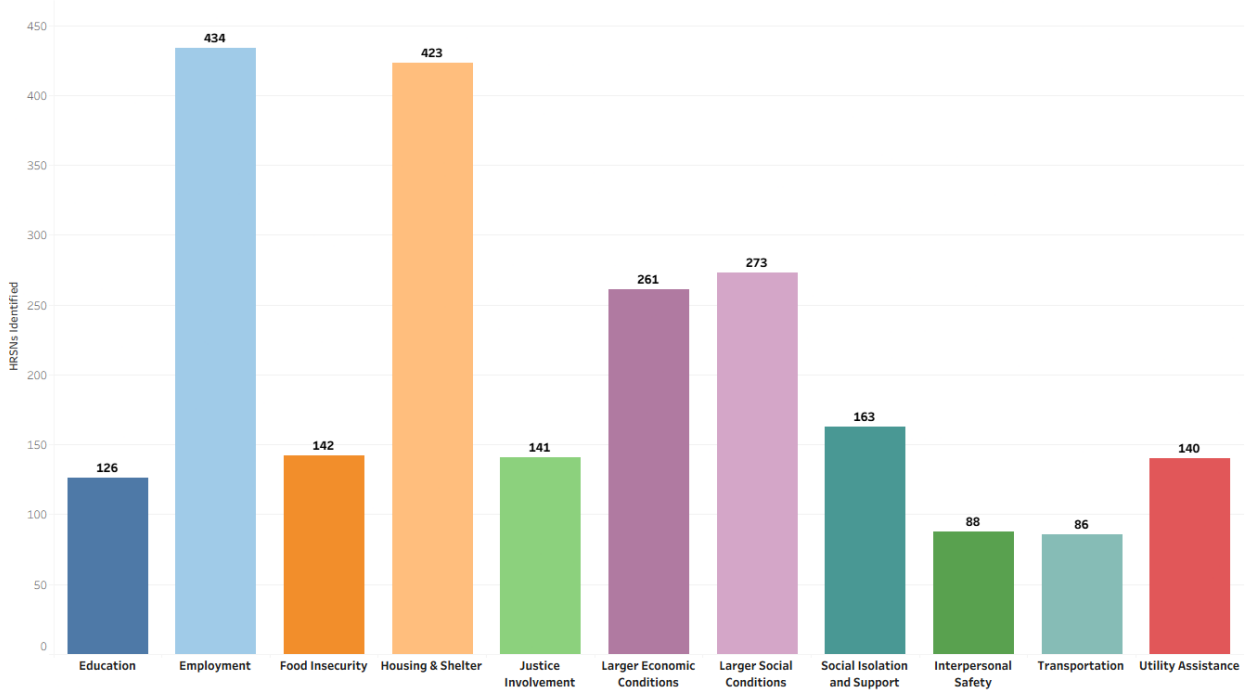
Note: Healthcare Common Procedure Coding System (HCPCS) codes G9919, G9920, and G9921 (prior to its termination on December 31, 2024) were used on claims to indicate the result of a patient's NMDOH screening. G9919 indicates that at least one NMDOH was identified during the NMDOH screening and

[45] A comprehensive HRSN/NMDOH screening refers to a standardized, multi-domain assessment of social needs (e.g., housing instability, utility assistance, food insecurity, transportation needs, interpersonal safety, social isolation/support, employment, and justice involvement) that may influence health and service utilization.

the patient accepted a referral to address that need. G9920 indicates that no NMDOHs were identified. G9921 indicates that at least one NMDOH was identified, but the patient declined a referral to address the need. Providers were required to include all relevant International Classification of Diseases, Tenth Revision (ICD-10) Z codes (Z55x–Z65x) associated with the identified NMDOH.

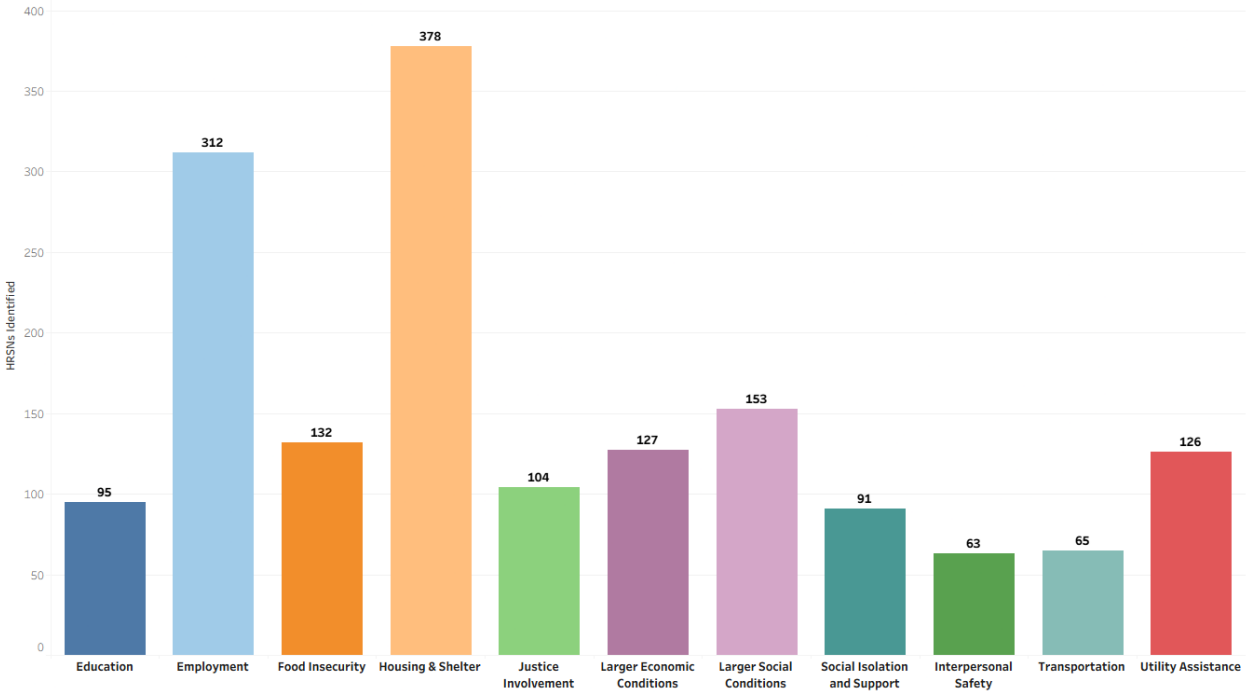
Between May 1 and December 31, 2024, 2,284 unique HRSN/NMDOH needs were identified via claims. The most commonly identified needs, regardless of referral status (Figure 5a), were employment (434), housing & shelter (423), and larger social conditions (273), such as stress and familial conflict.

Figure 5a: All HRSNs/NMDOH Needs Identified Between May - December 2024



Among patients referred to a CBO (Figure 5b), housing was the most frequently identified need (378), followed by employment (312) and larger social conditions (153).

Figure 5b: HRSNs/NMDOH Needs Identified Among Patients who were Referred to a CBO



Research Question 1.8: What is the percentage of TI 2.0 providers that completed the TI 2.0 health equity projects?

Key Findings

- Participating providers actively engaged in all assigned TI 2.0 health outcomes projects, demonstrating a strong commitment to advancing health outcomes and improving patient outcomes through quality improvement and implementation science.
- Nearly all TI 2.0 providers successfully completed the TI 2.0 health equity projects in Year 2, with 100% completion across all populations for Project A Part 1 and completion rates exceeding 97% for Project A Part 2.
- However, pass rates decreased over time across all populations, which may indicate changes in priorities due to provider availability, staff turnover, and competing operational demands.

All participating organizations were required to complete a series of health outcomes projects for Years 2 and 3 of the TI 2.0 program. These projects aim to build proficiency in process engineering techniques related to health outcomes, with providers applying them within their organizations to improve population health. Providers were asked to complete projects aligned with TI 2.0 milestones for each population served: Adults, Pediatrics, and Justice-involved individuals. Projects consisted of four elements divided into two parts: (1) a project charter outlining the project's objectives and scope and a process map providing a visual overview of the workflow; and (2) a root cause analysis to identify barriers to project success and a (Plan-Do-Study-Act) PDSA cycle detailing iterative steps for process improvement. Table 13 shows the pass rates for the TI 2.0 health outcomes projects among TI 2.0 providers, stratified by population served, for Year 2 of the program.

Table 13: TI 2.0 Health Outcomes Projects Pass/Fail Rate

Population Served	Year 2	
	Project A Part 1	Project A Part 2
Adults	100%	97.8%
Justice	100%	100%
Pediatrics	100%	98.5%

Hypothesis 2: The TI 2.0 program will improve the delivery of care that addresses inequitable health outcomes for children.

Hypothesis 2 uses administrative TI program data, claims/encounter data, and beneficiary surveys to test whether the demonstration improves the delivery of care that addresses inequitable health outcomes for children impacted by the TI program. Seven research questions are used to assess Hypothesis 2.

Research Question 2.1: Have health disparities related to care coordination been reduced among children attributed to TI 2.0 providers compared to prior to the demonstration?

Key Findings

- Among respondents, 83.5% of TI beneficiaries (N = 550) reported that their child's doctor seemed informed about the care their child received from specialists, compared to 80.8% of non-TI beneficiaries (N = 1,027).
  - Although this represents a 2.7 percentage point higher rate among TI participants, the difference was not statistically significant (p = 0.20). These findings suggest effective communication and coordination between primary and specialty care providers within TI participating organizations.

One measure from the pediatric beneficiary survey was used to assess research question 2.1. Beneficiary survey data prior to the demonstration period were not available at the time of the interim evaluation report; as a result, only the Fall 2025 survey results are presented.

Have disparities in care coordination been reduced among children attributed to TI?

		TI Beneficiaries		Non-TI Beneficiaries		Difference in Rate
		Number of Responses	Rate	Number of Responses	Rate	(p-value)
2-1	Beneficiaries' response to their child's doctor seeming informed about the care their child received from specialists	550	83.5%	1,027	80.8%	2.7% (0.20)

Research Question 2.2: Have general and mental health outcomes maintained or improved among children attributed to TI 2.0 providers compared to prior to the demonstration?

Key Findings

- Among respondents, 79.4% of TI beneficiaries (N = 1,696) and 78.9% of non-TI beneficiaries (N = 3,441) rated their child's overall health as very good or excellent (p = 0.72), indicating no significant difference between groups. This suggests that general health outcomes were similar for children served by TI and non-TI organizations.

- 70.4% of TI beneficiaries (N = 1,691) rated their child's emotional or mental health as very good or excellent, compared to 71.7% of non-TI beneficiaries (N = 3,442; this difference (–1.3 percentage points, p = 0.34) was not statistically significant, suggesting that mental health outcomes were maintained among children in TI and non-TI participating providers.

Two measures from the pediatric beneficiary survey were used to assess research question 2.2. Beneficiary survey data prior to the demonstration period were not available at the time of the interim evaluation report; as a result, only the Fall 2025 survey results are presented.

Have general and mental health outcomes improved among children attributed to TI?

		TI Beneficiaries		Non-TI Beneficiaries		Difference in Rate
		Number of Responses	Rate	Number of Responses	Rate	(p-value)
2-2	Percentage of beneficiaries who reported their child's rating of overall health as very good or excellent	1,696	79.4%	3,441	78.9%	0.5% (0.72)
2-3	Percentage of beneficiaries who reported their child's rating of emotional or mental health as very good or excellent	1,691	70.4%	3,442	71.7%	-1.3% (0.34)

Research Question 2.3: Have health disparities related to access to care been reduced among children attributed to TI 2.0 providers compared to prior to the demonstration?

Key Findings

- While the TI program did not show statistically significant improvements for children attributed to TI 2.0 providers compared to children attributed to non-TI providers, performance levels were sustained, indicating stability in care delivery.
- There were statistically significant differences in performance at both baseline and evaluation between various demographic subgroups across the TI and non-TI attributed populations. Spanish-speaking, TI-attributed children and adolescents outperformed their English-speaking counterparts across all three performance measures.
- Most beneficiaries reported positive experiences with their child's care, with similar perceptions of their child's provider spending enough time with them (TI: 89.4%, N = 1,480; non-TI: 89%, N = 2,692 ; p = 0.69) and access to necessary care (TI: 89.1%, N = 644; non-TI: 88.4%, N = 1,292); p = 0.63. TI beneficiaries were significantly more likely to secure routine care appointments promptly (85.7% (N = 1,424) vs. 81.5% (N = 2,835); p = 0.001), indicating better timely pediatric care access compared with non-TI beneficiaries.

Three performance measures and three beneficiary survey questions assessed access-to-care rates among child and adolescent beneficiaries. Beneficiary survey data prior to the demonstration period were not available at the time of the interim evaluation report; as a result, only the Fall 2025 survey results are presented.

	Pediatric Access to Care	FFY 2022	FFY 2023
2-4	Six or more well child visits on different dates of service on or before the 15-month birthday	57.9%	57.6%
2-4	Two or more well child visits on different dates of service between the child's 15-month birthday plus one day and the 30-month birthday.	62.9%	63.9%
2-5	Percentage of child and adolescent beneficiaries who had a well-care visit with a PCP or OB/GYN	54.7%	54.2%

Measure 2-4: Six or more well child visits on different dates of service on or before the 15-month birthday					
		Time Period			
Evaluation Year	Group	Baseline	Evaluation	DiD Log-Odds Estimate (p-value)	DiD Odds Ratio [95% CI]
2023	TI	57.9% *N = 11,397*	57.6% *N = 11,589*	-1.1 (0.17)	0.99 [0.97, 1]
	Non-TI	55.1% *N = 25,963*	55.9% *N = 23,959*		

Note: N represents the weighted denominator count.

Measure 2-4: Six or more well child visits on different dates of service on or before the 15-month birthday							
Demographic Variable	Subgroup	Group	Baseline	Denom.	Evaluation	Denom.	Change
Sex	Female	Non-TI	54.9%	12,794	55.5%	11,658	0.6%
		TI	58.6%	5,582	57.8%	5,651	-0.9%
	P-Value		<.0001		0.0056		
	Male	Non-TI	55.3%	13,169	56.2%	12,301	0.9%

Measure 2-4: Six or more well child visits on different dates of service on or before the 15-month birthday							
Demographic Variable	**Subgroup**	**Group**	**Baseline**	**Denom.**	**Evaluation**	**Denom.**	**Change**
		TI	57.1%	5,815	57.4%	5,938	0.2%
	P-Value		0.0176		0.1437		
Geography	Rural	Non-TI	50.1%	3,406	53.4%	3,088	3.3%
		TI	54.6%	474	52.0%	465	-2.6%
	P-Value		0.0615		0.5935		
	Urban	Non-TI	55.9%	22,470	56.3%	20,800	0.4%
		TI	58.0%	10,885	57.8%	11,080	-0.2%
	P-Value		0.0002		0.0081		
Language Spoken	English	Non-TI	54.1%	22,167	54.8%	20,081	0.7%
		TI	56.8%	9,887	56.4%	9,966	-0.5%
	P-Value		<.0001		0.0113		
	Spanish	Non-TI	61.0%	3,686	61.4%	3,765	0.5%
		TI	65.1%	1,443	65.2%	1,533	0.1%

Measure 2-4: Six or more well child visits on different dates of service on or before the 15-month birthday							
Demographic Variable	**Subgroup**	**Group**	**Baseline**	**Denom.**	**Evaluation**	**Denom.**	**Change**
	P-Value		0.0055		0.0096		
Race/ Ethnicity	Black	Non-TI	45.8%	2,342	47.7%	2,126	2.0%
		TI	49.7%	1,221	49.4%	1,281	-0.3%
	P-Value		0.0253		0.3441		
	Hispanic/ Latino	Non-TI	62.5%	2,622	62.1%	2,644	-0.4%
		TI	65.0%	1,244	64.6%	1,230	-0.5%
	P-Value		0.1228		0.1358		
	Multiracial and/or Multiethnic	Non-TI	59.6%	9,397	60.4%	8,724	0.9%
		TI	60.7%	4,251	60.2%	4,272	-0.5%
	P-Value		0.2028		0.776		
	White	Non-TI	55.9%	5,723	56.6%	4,818	0.7%
		TI	59.9%	2,244	57.4%	2,138	-2.5%
	P-Value		0.001		0.5157		

Measure 2-4: Two or more well child visits on different dates of service between the child's 15-month birthday plus one day and the 30-month birthday.					
		Time Period			
Evaluation Year	**Group**	**Baseline**	**Evaluation**	**DiD Log-Odds Estimate** (p-value)	**DiD Odds Ratio** [95% CI]
2023	TI	62.9% *N = 11,771*	63.9% *N = 11,108*	-0.005 (0.54)	1.0 [0.98, 1.01]
	Non-TI	54.7% *N = 30,007*	56.3% *N = 26,258*		

Note: N represents the weighted denominator count.

Measure 2-4: Two or more well child visits on different dates of service between the child's 15-month birthday plus one day and the 30-month birthday.							
Demographic Variable	**Subgroup**	**Group**	**Baseline**	**Denom.**	**Evaluation**	**Denom.**	**Change**
Sex	Female	Non-TI	57.3%	12,794	59.2%	11,658	1.93%
		TI	65.1%	5,582	64.8%	5,651	-0.24%
	P-Value		<.0001		0.0056		
	Male	Non-TI	57.7%	13,169	58.9%	12,301	1.18%
		TI	64.3%	5,815	65.7%	5,938	1.44%
	P-Value		0.0176		0.1437		

Measure 2-4: Two or more well child visits on different dates of service between the child's 15-month birthday plus one day and the 30-month birthday.							
Demographic Variable	**Subgroup**	**Group**	**Baseline**	**Denom.**	**Evaluation**	**Denom.**	**Change**
Geography	Rural	Non-TI	53.7%	3,406	56.6%	3,088	2.84%
		TI	63.8%	474	59.5%	465	-4.36%
	P-Value		0.0615		0.5935		
	Urban	Non-TI	58.1%	22,470	59.5%	20,800	1.39%
		TI	64.7%	10,885	65.5%	11,080	0.83%
	P-Value		0.0002		0.0081		
Language Spoken	English	Non-TI	53.7%	22,167	55.0%	20,081	1.34%
		TI	62.0%	9,887	62.3%	9,966	0.32%
	P-Value		<.0001		0.0113		
	Spanish	Non-TI	60.3%	3,686	64.6%	3,765	4.23%
		TI	68.6%	1,443	75.3%	1,533	6.71%
	P-Value		0.0055		0.0096		
Race/ Ethnicity	Black	Non-TI	46.7%	2,342	49.5%	2,126	2.84%

Measure 2-4: Two or more well child visits on different dates of service between the child's 15-month birthday plus one day and the 30-month birthday.							
Demographic Variable	**Subgroup**	**Group**	**Baseline**	**Denom.**	**Evaluation**	**Denom.**	**Change**
		TI	56.9%	1,221	59.0%	1,281	2.11%
	P-Value		0.0253		0.3441		
	Hispanic/ Latino	Non-TI	61.0%	2,622	64.3%	2,644	3.31%
		TI	68.3%	1,244	69.0%	1,230	0.65%
	P-Value		0.1228		0.1358		
	Multiracial and/or Multiethnic	Non-TI	59.9%	9,397	61.3%	8,724	1.44%
		TI	66.4%	4,251	66.3%	4,272	-0.13%
	P-Value		0.2028		0.776		
	White	Non-TI	56.4%	5,723	56.9%	4,818	0.51%
		TI	63.8%	2,244	64.9%	2,138	1.06%
	P-Value		0.001		0.5157		

Measure 2-5: Percentage of child and adolescent beneficiaries who had a well-care visit with a PCP or OB/GYN					
		Time Period			
Evaluation Year	Group	Baseline	Evaluation	DiD Log-Odds Estimate (p-value)	DiD Odds Ratio [95% CI]
2023	TI	54.7% *N = 17,101*	54.2% *N = 169,660*	-0.03 (<0.0001)	0.97 [0.97, 0.97]
	Non-TI	39.9% *N = 580,746*	42.3% *N = 519,295*		

Note: N represents the weighted denominator count.

Measure 2-5: Percentage of child and adolescent beneficiaries who had a well-care visit with a PCP or OB/GYN							
Demographic Variable	Subgroup	Group	Baseline	Denom.	Evaluation	Denom.	Change
Sex	Female	Non-TI	41.0%	290,629	43.4%	259,921	2.40%
		TI	55.6%	87,637	55.0%	83,653	-0.58%
	P-Value		<.0001		<.0001		
	Male	Non-TI	39.9%	290,117	42.4%	259,374	2.49%
		TI	54.6%	90,464	54.1%	86,007	-0.54%

Measure 2-5: Percentage of child and adolescent beneficiaries who had a well-care visit with a PCP or OB/GYN							
Demographic Variable	**Subgroup**	**Group**	**Baseline**	**Denom.**	**Evaluation**	**Denom.**	**Change**
	P-Value		<.0001		<.0001		
Geography	Rural	Non-TI	37.2%	73,755	40.0%	67,522	2.81%
		TI	46.2%	7,062	44.1%	6,480	-2.09%
	P-Value		<.0001		<.0001		
	Urban	Non-TI	40.9%	505,408	43.3%	450,173	2.41%
		TI	55.4%	170,461	54.9%	162,603	-0.51%
	P-Value		<.0001		<.0001		
Language Spoken	English	Non-TI	37.1%	474,188	39.3%	421,845	2.22%
		TI	52.2%	143,542	51.7%	136,783	-0.49%
	P-Value		<.0001		<.0001		
	Spanish	Non-TI	52.3%	102,987	55.4%	93,891	3.02%
		TI	65.8%	33,296	65.0%	31,499	-0.83%
	P-Value		<.0001		<.0001		

Measure 2-5: Percentage of child and adolescent beneficiaries who had a well-care visit with a PCP or OB/GYN							
Demographic Variable	**Subgroup**	**Group**	**Baseline**	**Denom.**	**Evaluation**	**Denom.**	**Change**
Race/ Ethnicity	Black	Non-TI	35.6%	55,920	37.2%	50,884	1.66%
		TI	50.3%	18,863	49.7%	17,805	-0.65%
	P-Value		<.0001		<.0001		
	Hispanic/ Latino	Non-TI	44.6%	70,017	46.9%	62,176	2.29%
		TI	59.1%	24,298	58.2%	23,030	-0.84%
	P-Value		<.0001		<.0001		
	Multiracial and/or Multiethnic	Non-TI	44.4%	233,668	47.1%	210,293	2.65%
		TI	58.2%	74,722	57.3%	71,225	-0.83%
	P-Value		<.0001		<.0001		
	White	Non-TI	34.6%	164,449	36.9%	142,307	2.30%
		TI	49.7%	43,770	49.7%	40,568	-0.04%
	P-Value		<.0001		<.0001		
Age Group	3 to 5	Non-TI	56.2%	89,018	58.2%	78,158	2.00%

Measure 2-5: Percentage of child and adolescent beneficiaries who had a well-care visit with a PCP or OB/GYN							
Demographic Variable	**Subgroup**	**Group**	**Baseline**	**Denom.**	**Evaluation**	**Denom.**	**Change**
		TI	65.8%	34,716	64.3%	32,158	-1.48%
	P-Value		<.0001		<.0001		
	6 to 12	Non-TI	44.8%	213,405	47.1%	193,492	2.34%
		TI	57.2%	74,314	57.2%	71,452	-0.04%
	P-Value		<.0001		<.0001		
	13 to 17	Non-TI	39.7%	160,292	42.0%	145,508	2.29%
		TI	54.0%	49,282	53.9%	46,719	-0.08%
	P-Value		<.0001		<.0001		

Have disparities in access to care been reduced among children attributed to TI?						
		TI Beneficiaries		Non-TI Beneficiaries		Difference in Rate
		Number of Responses	Rate	Number of Responses	Rate	(p-value)
2-6	Percentage of beneficiaries who reported that their child's doctor usually or always spent enough time with them	1,480	89.4%	2,692	89%	0.4% (0.69)
2-7	Percentage of beneficiaries who reported their child received needed care right away as soon as they needed	644	89.1%	1,292	88.4%	0.7% (0.63)
2-8	Percentage of beneficiaries who reported they got an appointment for routine care as soon as their child needed	1,424	85.7%	2,835	81.5%	4.2% (0.0005)

Research Question 2.4: Have health disparities related to experience of care been reduced among children attributed to TI 2.0 providers compared to prior to the demonstration?

Key Findings

- TI and non-TI beneficiaries reported similar positive experiences with provider communication and respect. Most beneficiaries said their child's doctor usually

or always explained things clearly (TI: 93.3%, N = 1,482; non-TI: 92.7%, N = 2,972; p = 0.45), listened carefully (TI: 93.5%, N = 1,483; non-TI: 93.9%, N = 2,972; p = 0.62), and showed respect for what they had to say (TI: 94.0%, N = 1,482; non-TI: 94.9%, N = 2,972; p = 0.27). These results suggest that children and their families generally experience high-quality, respectful communication from AHCCCS providers.

Three beneficiary survey questions and one administrative question assessed health disparities related to the experience of care among child and adolescent beneficiaries. Due to limitations in provider data availability, as described in the Methodology Limitations section, rates for a culturally sensitive workforce (Measure 2-12) could not be calculated and are therefore not reported. Beneficiary survey data prior to the demonstration period were not available at the time of the interim evaluation report; as a result, only the Fall 2025 survey results are presented.

Have disparities in care experience among children attributed to TI been reduced?

		TI Beneficiaries		Non-TI Beneficiaries		Difference in Rate
		Number of Responses	Rate	Number of Responses	Rate	(p-value)
2-9	Percentage of beneficiaries who reported their child's doctor usually or always explained things in a way that was easy to understand	1,482	93.3%	2,972	92.7%	0.6% (0.45)
2-10	Percentage of beneficiaries who reported their child's doctor usually or always listened carefully to them	1,483	93.5%	2,972	93.9%	-0.4% (0.62)

Have disparities in care experience among children attributed to TI been reduced?		TI Beneficiaries		Non-TI Beneficiaries		Difference in Rate
		Number of Responses	Rate	Number of Responses	Rate	(p-value)
2-11	Percentage of beneficiaries who reported their child's doctor usually or always showed respect for what they had to say	1,482	94%	2,972	94.9%	-0.9% (0.27)

Culturally Sensitive Workforce		FFY 2022	FFY 2023
2-12	Percentage of child and adolescent beneficiaries attributed/assigned to a TI provider with the same race/ethnicity and/or language	-	-

Note: Results for measure 2-12 are not presented due to insufficient data.

Due to limitations in provider data availability, as described in the Methodology Limitations section, rates for a culturally sensitive workforce (Measure 2-12) could not be calculated and are therefore not reported.

Research Question 2.5: Have health disparities related to dental care utilization been reduced among children attributed to TI 2.0 providers compared to prior to the demonstration?

Key Findings

- Dental care utilization increased among TI-attributed beneficiaries compared to the period before the demonstration.
- There were statistically significant differences in performance at both baseline and evaluation between various demographic subgroups across the TI and non-TI attributed populations.

- TI-attributed patients living in rural areas experienced significant performance improvements during the demonstration periods, with a 4.8% increase for the topical fluoride measure and 2.8% for the dental provider measure.

Two performance measures assessed dental care utilization among child and adolescent beneficiaries.

Dental Care Utilization		FFY 2022	FFY 2023
2-13	Percentage of child and adolescent beneficiaries receiving topical varnish	23.8%	26.7%
2-14	Percentage of child and adolescent beneficiaries who received a comprehensive or periodic evaluation with a dental provider during the measurement year	51.9%	53.2%

Measure 2-13: Percentage of child and adolescent beneficiaries receiving topical varnish

Evaluation Year	Group	Time Period: Baseline	Time Period: Evaluation	DiD Log-Odds Estimate (p-value)	DiD Odds Ratio [95% CI]
2023	TI	23.8% *N = 199,230*	26.7% *N = 190,943*	0.002 (0.40)	1.0 [0.99, 1.01]
	Non-TI	19.1% *N = 610,014*	21.5% *N = 552,835*		

Note: N represents the weighted denominator count.

Measure 2-13: Percentage of child and adolescent beneficiaries receiving topical varnish							
Demographic Variable	**Subgroup**	**Group**	**Baseline**	**Denom.**	**Evaluation**	**Denom.**	**Change**
Sex	Female	Non-TI	19.4%	303,442	21.8%	275,054	2.4%
		TI	24.2%	97,794	27.2%	93,947	3.0%
	P-Value		<.0001		<.0001		
	Male	Non-TI	18.8%	306,572	21.2%	277,781	2.3%
		TI	23.5%	101,436	26.3%	96,996	2.8%
	P-Value		<.0001		<.0001		
Geography	Rural	Non-TI	16.0%	78,305	18.0%	72,325	2.0%
		TI	19.4%	7,937	23.4%	7,284	4.0%
	P-Value		<.0001		<.0001		
	Urban	Non-TI	19.6%	529,991	22.0%	478,786	2.4%
		TI	24.0%	190,639	26.9%	182,974	2.9%
	P-Value		<.0001		<.0001		
Language Spoken	English	Non-TI	17.7%	499,961	20.0%	450,598	2.2%

Measure 2-13: Percentage of child and adolescent beneficiaries receiving topical varnish							
Demographic Variable	**Subgroup**	**Group**	**Baseline**	**Denom.**	**Evaluation**	**Denom.**	**Change**
		TI	21.9%	162,231	24.8%	155,293	2.9%
	P-Value		<.0001		<.0001		
	Spanish	Non-TI	25.4%	106,424	28.2%	98,479	2.8%
		TI	32.7%	35,611	35.6%	34,113	2.9%
	P-Value		<.0001		<.0001		
Race/ Ethnicity	Black	Non-TI	14.3%	58,639	16.1%	54,181	1.8%
		TI	17.9%	21,169	20.2%	20,342	2.2%
	P-Value		<.0001		<.0001		
	Hispanic/ Latino	Non-TI	21.8%	71,955	24.4%	65,116	2.6%
		TI	27.7%	26,346	30.8%	25,240	3.2%
	P-Value		<.0001		<.0001		
	Multiracial and/or Multiethnic	Non-TI	20.9%	243,964	23.1%	223,263	2.2%
		TI	25.7%	82,568	28.6%	79,429	2.9%

Measure 2-13: Percentage of child and adolescent beneficiaries receiving topical varnish							
Demographic Variable	**Subgroup**	**Group**	**Baseline**	**Denom.**	**Evaluation**	**Denom.**	**Change**
	P-Value		<.0001		<.0001		
	White	Non-TI	17.9%	168,704	20.3%	147,903	2.4%
		TI	22.4%	47,868	25.1%	44,645	2.7%
	P-Value		<.0001		<.0001		
Age Group	0 to 2	Non-TI	14.1%	56,223	16.4%	46,129	2.3%
		TI	16.1%	23,978	17.5%	21,640	1.4%
	P-Value		<.0001		<.0001		
	3 to 5	Non-TI	22.3%	89,260	25.2%	80,387	2.9%
		TI	25.6%	34,811	28.6%	32,798	3.0%
	P-Value		<.0001		<.0001		
	6 to 12	Non-TI	25.2%	213,939	28.0%	197,268	2.8%
		TI	29.2%	74,458	32.7%	72,536	3.4%
	P-Value		<.0001		<.0001		

Measure 2-13: Percentage of child and adolescent beneficiaries receiving topical varnish							
Demographic Variable	**Subgroup**	**Group**	**Baseline**	**Denom.**	**Evaluation**	**Denom.**	**Change**
	13 to 17	Non-TI	17.6%	160,683	19.6%	148,573	1.9%
		TI	22.7%	49,345	25.5%	47,491	2.8%
	P-Value		<.0001		<.0001		

Measure 2-14: Percentage of child and adolescent beneficiaries who received a comprehensive or periodic evaluation with a dental provider					
		Time Period			
Evaluation Year	**Group**	**Baseline**	**Evaluation**	**DiD Log-Odds Estimate** (p-value)	**DiD Odds Ratio** [95% CI]
2023	TI	51.9% *N = 214,009*	53.2% *N = 224,142*	0.02 (<0.0001)	1.02 [1.01, 1.02]
	Non-TI	43.2% *N = 656,678*	43% *N = 676,229*		

Note: N represents the weighted denominator count.

Measure 2-14: Percentage of child and adolescent beneficiaries who received a comprehensive or periodic evaluation with a dental provider							
Demographic Variable	**Subgroup**	**Group**	**Baseline**	**Denom.**	**Evaluation**	**Denom.**	**Change**
Sex	Female	Non-TI	44.0%	326,506	43.8%	335,889	-0.3%
		TI	52.7%	104,981	53.9%	110,300	1.2%
	P-Value		<.0001		<.0001		
	Male	Non-TI	42.5%	330,172	42.2%	340,340	-0.3%
		TI	51.1%	109,028	52.4%	113,842	1.4%
	P-Value		<.0001		<.0001		
Geography	Rural	Non-TI	38.3%	84,759	38.7%	87,829	0.4%
		TI	46.3%	8,597	49.1%	8,665	2.8%
	P-Value		<.0001		<.0001		
	Urban	Non-TI	44.0%	570,080	43.6%	586,325	-0.4%
		TI	52.1%	204,712	53.3%	214,694	1.3%
	P-Value		<.0001		<.0001		
Language Spoken	English	Non-TI	42.1%	540,538	42.0%	556,456	-0.1%

Measure 2-14: Percentage of child and adolescent beneficiaries who received a comprehensive or periodic evaluation with a dental provider							
Demographic Variable	**Subgroup**	**Group**	**Baseline**	**Denom.**	**Evaluation**	**Denom.**	**Change**
		TI	49.6%	175,122	51.2%	183,718	1.6%
	P-Value		<.0001		<.0001		
	Spanish	Non-TI	48.5%	111,998	47.5%	115,098	-1.0%
		TI	62.6%	37,255	62.6%	38,582	0.0%
	P-Value		<.0001		<.0001		
Race/ Ethnicity	Black	Non-TI	38.5%	64,281	38.4%	66,963	-0.1%
		TI	45.4%	23,170	46.8%	24,027	1.4%
	P-Value		<.0001		<.0001		
	Hispanic/ Latino	Non-TI	46.7%	76,319	46.2%	78,073	-0.5%
		TI	56.8%	27,717	58.2%	28,925	1.4%
	P-Value		<.0001		<.0001		
	Multiracial and/or Multiethnic	Non-TI	45.8%	257,987	45.6%	263,716	-0.2%
		TI	55.8%	87,125	57.0%	90,678	1.2%

Measure 2-14: Percentage of child and adolescent beneficiaries who received a comprehensive or periodic evaluation with a dental provider							
Demographic Variable	**Subgroup**	**Group**	**Baseline**	**Denom.**	**Evaluation**	**Denom.**	**Change**
	P-Value		<.0001		<.0001		
	White	Non-TI	43.1%	181,775	43.1%	182,888	-0.1%
		TI	50.0%	51,490	51.9%	52,748	1.9%
	P-Value		<.0001		<.0001		
Age Group	3 to 5	Non-TI	47.8%	94,782	46.8%	96,844	-1.0%
		TI	55.8%	36,542	56.9%	37,844	1.1%
	P-Value		<.0001		<.0001		
	6 to 12	Non-TI	44.5%	224,568	44.2%	231,024	-0.3%
		TI	54.4%	77,327	55.7%	80,914	1.4%
	P-Value		<.0001		<.0001		
	13 to 17	Non-TI	44.5%	167,868	44.2%	173,677	-0.3%
		TI	54.4%	50,890	55.7%	52,584	1.4%
	P-Value		<.0001		<.0001		

Research Question 2.6: Have health disparities related to ED utilization been reduced among children attributed to TI 2.0 providers compared to prior to the demonstration?

Key Findings

- While the total number of ED visits among TI-attributed child and adolescent patients increased, the percentage of potentially avoidable ED visits decreased.
- A statistically significant reduction in avoidable ED visits among TI patients relative to non-TI patients suggests that the program was associated with more appropriate use of emergency care.
- Among patients aged 3 to 5, those attributed to TI had a greater reduction in potentially avoidable ED visits (22.7%) compared to non-TI patients (19.7%).

Two claims-based measures assessed ED utilization among child and adolescent beneficiaries.

ED Utilization		FFY 2022	FFY 2023
2-15	Number of ED visits among children and adolescents	83,287	92,107
2-16	Number of potentially avoidable ED visits among children and adolescents	52,280 (62.8%)	39,236 (42.6%)

Measure 2-15: Number of ED visits among children and adolescents					
		Time Period			
Evaluation Year	Group	Baseline	Evaluation	Log DiD Estimate (P-Value)	DiD Rate Ratio [95% CI]
2023	TI	83,287 *N = 53,699*	92,107 *N = 58,922*	-0.0035 (0.36)	0.997 [0.985, 1.01]
	Non-TI	169,078 *N = 111,510*	174,859 *N = 114,019*		

Note: N represents the count of unique patients.

Measure 2-16: Number of potentially avoidable ED visits among children and adolescents					
		Time Period			
Evaluation Year	Group	Baseline	Evaluation	DiD Log-Odds Estimate (p-value)	DiD Odds Ratio [95% CI]
2023	TI	62.8% *N = 83,287*	42.6% *N = 92,107*	-0.015 (<0.0001)	0.985 [0.97, 0.99]
	Non-TI	60.9% *N = 169,078*	42.1% *N = 174,859*		

Note: N represents the weighted denominator count.

Measure 2-16: Number of potentially avoidable ED visits among children and adolescents							
Demographic Variable	Subgroup	Group	Baseline	Denom.	Evaluation	Denom.	Change
Sex	Female	Non-TI	59.9%	81,396	41.0%	84,242	-18.9%
		TI	61.6%	39,709	41.5%	44,151	-20.1%
	P-Value		<.0001		0.103		
	Male	Non-TI	61.8%	87,682	43.2%	90,617	-18.6%
		TI	63.8%	43,578	43.7%	47,956	-20.2%

Measure 2-16: Number of potentially avoidable ED visits among children and adolescents							
Demographic Variable	**Subgroup**	**Group**	**Baseline**	**Denom.**	**Evaluation**	**Denom.**	**Change**
	P-Value		<.0001		0.0981		
Geography	Rural	Non-TI	56.7%	25,692	44.5%	26,645	-12.2%
		TI	52.1%	3,817	38.2%	3,952	-13.9%
	P-Value		<.0001		<.0001		
	Urban	Non-TI	61.6%	142,864	41.7%	147,568	-19.9%
		TI	63.3%	79,146	42.9%	87,707	-20.4%
	P-Value		<.0001		<.0001		
Language Spoken	English	Non-TI	60.5%	143,444	41.7%	147,449	-18.8%
		TI	62.1%	70,171	41.7%	77,080	-20.5%
	P-Value		<.0001		0.7142		
	Spanish	Non-TI	62.7%	24,543	44.5%	26,170	-18.3%
		TI	66.3%	12,451	47.4%	14,210	-18.9%
	P-Value		<.0001		<.0001		

Measure 2-16: Number of potentially avoidable ED visits among children and adolescents							
Demographic Variable	**Subgroup**	**Group**	**Baseline**	**Denom.**	**Evaluation**	**Denom.**	**Change**
Race/ Ethnicity	Black	Non-TI	63.7%	16,504	41.0%	16,867	-22.7%
		TI	64.5%	9,794	41.8%	10,805	-22.7%
	P-Value		0.1919		0.1656		
	Hispanic/ Latino	Non-TI	62.7%	17,728	44.3%	18,716	-18.3%
		TI	64.7%	9,941	45.0%	11,074	-19.7%
	P-Value		0.0008		0.265		
	Multiracial and/or Multiethnic	Non-TI	62.7%	69,462	43.8%	72,349	-19.0%
		TI	64.2%	34,551	43.8%	37,532	-20.5%
	P-Value		<.0001		0.971		
	White	Non-TI	56.2%	44,483	37.8%	43,919	-18.4%
		TI	58.1%	18,690	38.2%	20,105	-19.9%
	P-Value		<.0001		0.2829		
Age Group	0 to 2	Non-TI	65.3%	47,330	48.6%	45,646	-16.7%

Measure 2-16: Number of potentially avoidable ED visits among children and adolescents							
Demographic Variable	**Subgroup**	**Group**	**Baseline**	**Denom.**	**Evaluation**	**Denom.**	**Change**
		TI	66.4%	25,790	49.6%	27,145	-16.8%
	P-Value		0.0034		0.0084		
	3 to 5	Non-TI	66.5%	33,762	46.9%	34,935	-19.7%
		TI	69.6%	17,138	46.9%	18,435	-22.7%
	P-Value		<.0001		0.8375		

Research Question 2.7: Have health disparities related to treatment or management of behavioral health concerns been reduced among children attributed to TI 2.0 providers compared to prior to the demonstration?

Key Findings

- TI-attributed children outperformed non-TI children in all measures related to treatment or management of behavioral health concerns.
- There were statistically significant differences in performance at both baseline and evaluation between various demographic subgroups across the TI and non-TI attributed populations. Both TI and non-TI children who identify as multiracial and/or multiethnic experienced larger declines in performance compared to other racial and ethnic groups.

Seven performance measures were used to assess disparities in the treatment or management of behavioral health concerns among child and adolescent beneficiaries.

	Behavioral Health Management	FFY 2022	FFY 2023
2-17	Percentage of child and adolescent beneficiaries with a follow-up visit within seven days after hospitalization for mental illness	76.4%	75.3%
2-18	Percentage of child and adolescent beneficiaries with a follow-up visit within thirty days after hospitalization for mental illness	93.5%	93.5%
2-19	Percentage of child and adolescent beneficiaries with a follow-up visit within seven days after an ED visit for mental illness	83.9%	80.6%
2-20	Percentage of child and adolescent beneficiaries with a follow-up visit within thirty days after an ED visit for mental illness	94%	93.8%
2-21	Percentage of adolescent beneficiaries with a follow-up visit within seven days after an ED visit for SUD	59.2%	55.5%
2-22	Percentage of adolescent beneficiaries with a follow-up visit within thirty days after an ED visit for SUD	80.8%	78.1%
2-23	Percentage of child and adolescent beneficiaries with ongoing antipsychotic medication use who have metabolic testing during the measurement year	40.4%	39.7%

Measure 2-17: Percentage of child and adolescent beneficiaries with a follow-up visit within seven days after hospitalization for mental illness					
		Time Period			
Evaluation Year	Group	Baseline	Evaluation	DiD Log-Odds Estimate (p-value)	DiD Odds Ratio [95% CI]
2023	TI	76.4% *N = 2,662*	75.3% *N = 3,266*	0.062 (0.01)	1.064 [1.01, 1.12]
	Non-TI	55.1% *N = 1,466*	47.4% *N = 1,339*		

Note: N represents the weighted denominator count.

Measure 2-17: Percentage of child and adolescent beneficiaries with a follow-up visit within seven days after hospitalization for mental illness							
Demographic Variable	Subgroup	Group	Baseline	Denom.	Evaluation	Denom.	Change
Sex	Female	Non-TI	55.8%	992	48.0%	920	-7.8%
		TI	77.8%	1,742	75.4%	2,059	-2.5%
	P-Value		<.0001		<.0001		
	Male	Non-TI	53.6%	474	46.1%	419	-7.5%
		TI	73.7%	920	75.1%	1,207	1.4%

Measure 2-17: Percentage of child and adolescent beneficiaries with a follow-up visit within seven days after hospitalization for mental illness							
Demographic Variable	**Subgroup**	**Group**	**Baseline**	**Denom.**	**Evaluation**	**Denom.**	**Change**
	P-Value		<.0001		<.0001		
Geography	Rural	Non-TI	57.0%	172	47.4%	171	-9.6%
		TI	72.4%	254	72.1%	305	-0.3%
	P-Value		0.0009		<.0001		
	Urban	Non-TI	54.8%	1,289	47.7%	1,162	-7.2%
		TI	76.8%	2,401	75.6%	2,942	-1.2%
	P-Value		<.0001		<.0001		
Language Spoken	English	Non-TI	54.4%	1,318	46.2%	1,225	-8.2%
		TI	76.4%	2,462	74.9%	3,015	-1.5%
	P-Value		<.0001		<.0001		
	Spanish	Non-TI	64.1%	142	60.6%	109	-3.5%
		TI	77.7%	193	80.8%	245	3.1%
	P-Value		0.0061		<.0001		

Measure 2-17: Percentage of child and adolescent beneficiaries with a follow-up visit within seven days after hospitalization for mental illness							
Demographic Variable	**Subgroup**	**Group**	**Baseline**	**Denom.**	**Evaluation**	**Denom.**	**Change**
Race/ Ethnicity	Black	Non-TI	42.0%	157	38.6%	145	-3.4%
		TI	72.4%	275	73.8%	378	1.4%
	P-Value		<.0001		<.0001		
	Hispanic/ Latino	Non-TI	53.6%	97	46.2%	78	-7.5%
		TI	70.6%	194	73.0%	252	2.4%
	P-Value		<.0001		<.0001		
	Multiracial and/or Multiethnic	Non-TI	59.5%	430	48.8%	441	-10.8%
		TI	78.2%	761	76.5%	911	-1.7%
	P-Value		<.0001		<.0001		
	White	Non-TI	55.8%	602	50.0%	496	-5.8%
		TI	77.4%	1,166	76.3%	1,386	-1.1%
	P-Value		<.0001		<.0001		
Age Group	6 to 12	Non-TI	60.5%	162	53.0%	134	-7.5%

Measure 2-17: Percentage of child and adolescent beneficiaries with a follow-up visit within seven days after hospitalization for mental illness							
Demographic Variable	**Subgroup**	**Group**	**Baseline**	**Denom.**	**Evaluation**	**Denom.**	**Change**
		TI	78.1%	383	80.5%	522	2.4%
	P-Value		<.0001		<.0001		
	13 to 17	Non-TI	54.8%	1,193	47.6%	1,088	-7.2%
		TI	76.1%	2,092	74.3%	2,523	-1.8%
	P-Value		<.0001		<.0001		

Measure 2-18: Percentage of child and adolescent beneficiaries with a follow-up visit within thirty days after hospitalization for mental illness					
		Time Period			
Evaluation Year	**Group**	**Baseline**	**Evaluation**	**DiD Log-Odds Estimate** (p-value)	**DiD Odds Ratio** [95% CI]
2023	TI	93.5% *N = 2,662*	93.5% *N = 3,266*	0.065 (0.05)	1.067 [1.00, 1.14]
	Non-TI	68.2% *N = 1,466*	62.4% *N = 1,339*		

Note: N represents the weighted denominator count.

Measure 2-18: Percentage of child and adolescent beneficiaries with a follow-up visit within thirty days after hospitalization for mental illness							
Demographic Variable	**Subgroup**	**Group**	**Baseline**	**Denom.**	**Evaluation**	**Denom.**	**Change**
Sex	Female	Non-TI	69.4%	992	62.2%	474	-7.2%
		TI	94.5%	1,742	93.2%	920	-1.3%
	P-Value		<.0001		<.0001		
	Male	Non-TI	65.8%	920	62.8%	419	-3.1%
		TI	91.5%	2,059	94.0%	1,207	2.4%
	P-Value		<.0001		<.0001		
Geography	Rural	Non-TI	68.6%	172	63.2%	171	-5.4%
		TI	92.1%	254	94.1%	305	2.0%
	P-Value		<.0001		<.0001		
	Urban	Non-TI	68.1%	1,289	62.2%	1,162	-5.9%
		TI	93.6%	2,401	93.4%	2,942	-0.2%
	P-Value		<.0001		<.0001		
Language Spoken	English	Non-TI	67.4%	1,318	61.1%	1,225	-6.3%

Measure 2-18: Percentage of child and adolescent beneficiaries with a follow-up visit within thirty days after hospitalization for mental illness							
Demographic Variable	**Subgroup**	**Group**	**Baseline**	**Denom.**	**Evaluation**	**Denom.**	**Change**
		TI	93.1%	2,462	93.3%	3,015	0.2%
	P-Value		<.0001		<.0001		
	Spanish	Non-TI	78.9%	142	77.1%	109	-1.8%
		TI	98.4%	193	96.3%	245	-2.1%
	P-Value		<.0001		<.0001		
Race/ Ethnicity	Black	Non-TI	56.7%	157	56.6%	145	-0.1%
		TI	93.5%	275	91.5%	378	-1.9%
	P-Value		<.0001		<.0001		
	Hispanic/ Latino	Non-TI	66.0%	97	55.1%	78	-10.9%
		TI	90.7%	194	94.4%	252	3.7%
	P-Value		<.0001		<.0001		
	Multiracial and/or Multiethnic	Non-TI	71.6%	430	66.0%	441	-5.6%
		TI	95.0%	761	94.0%	911	-1.0%

Measure 2-18: Percentage of child and adolescent beneficiaries with a follow-up visit within thirty days after hospitalization for mental illness							
Demographic Variable	**Subgroup**	**Group**	**Baseline**	**Denom.**	**Evaluation**	**Denom.**	**Change**
	P-Value		<.0001		<.0001		
	White	Non-TI	70.1%	602	63.7%	496	-6.4%
		TI	92.5%	1,166	93.9%	1,386	1.3%
	P-Value		<.0001		<.0001		
Age Group	6 to 12	Non-TI	69.8%	162	70.9%	134	1.1%
		TI	93.7%	383	96.2%	522	2.4%
	P-Value		<.0001		<.0001		
	13 to 17	Non-TI	68.3%	1,193	62.2%	1,088	-6.1%
		TI	93.4%	2,092	93.1%	2,523	-0.3%
	P-Value		<.0001		<.0001		

Measure 2-19: Percentage of child and adolescent beneficiaries with a follow-up visit within seven days after an ED visit for mental illness					
		Time Period			
Evaluation Year	Group	Baseline	Evaluation	DiD Log-Odds Estimate (p-value)	DiD Odds Ratio [95% CI]
2023	TI	83.9% *N = 620*	80.6% *N = 501*	0.05 (0.38)	1.048 [0.94, 1.16]
	Non-TI	54.3% *N = 420*	44.1% *N = 347*		

Note: N represents the weighted denominator count.

Measure 2-19: Percentage of child and adolescent beneficiaries with a follow-up visit within seven days after an ED visit for mental illness							
Demographic Variable	Subgroup	Group	Baseline	Denom.	Evaluation	Denom.	Change
Sex	Female	Non-TI	56.9%	269	46.3%	218	-10.5%
		TI	84.2%	349	81.1%	307	-3.1%
	P-Value		<.0001		<.0001		
	Male	Non-TI	49.7%	151	40.3%	129	-9.4%
		TI	83.4%	271	79.9%	194	-3.5%

Measure 2-19: Percentage of child and adolescent beneficiaries with a follow-up visit within seven days after an ED visit for mental illness							
Demographic Variable	**Subgroup**	**Group**	**Baseline**	**Denom.**	**Evaluation**	**Denom.**	**Change**
	P-Value		<.0001		<.0001		
Geography	Rural	Non-TI	53.3%	75	50.6%	81	-2.7%
		TI	78.2%	78	78.0%	59	-0.2%
	P-Value		0.0012		<.0001		
	Urban	Non-TI	54.4%	344	41.4%	263	-12.9%
		TI	84.8%	539	81.1%	438	-3.7%
	P-Value		<.0001		<.0001		
Language Spoken	English	Non-TI	53.6%	377	43.5%	315	-10.1%
		TI	84.1%	577	80.6%	459	-3.4%
	P-Value		<.0001		<.0001		
	Spanish	Non-TI	63.4%	41	50.0%	32	-13.4%
		TI	83.3%	42	79.5%	39	-3.8%
	P-Value		0.0398		0.009		

Measure 2-19: Percentage of child and adolescent beneficiaries with a follow-up visit within seven days after an ED visit for mental illness							
Demographic Variable	**Subgroup**	**Group**	**Baseline**	**Denom.**	**Evaluation**	**Denom.**	**Change**
Race/ Ethnicity	Black	Non-TI	46.9%	32	45.5%	33	-1.4%
		TI	86.3%	80	78.9%	57	-7.3%
	P-Value		<.0001		0.0012		
	Hispanic/ Latino	Non-TI	63.2%	38	22.7%	22	-40.4%
		TI	83.0%	47	78.9%	38	-4.0%
	P-Value		0.038		<.0001		
	Multiracial and/or Multiethnic	Non-TI	57.3%	124	48.2%	110	-9.1%
		TI	84.0%	163	78.1%	137	-5.9%
	P-Value		<.0001		<.0001		
	White	Non-TI	51.9%	181	44.9%	136	-7.1%
		TI	83.1%	278	82.5%	223	-0.6%
	P-Value		<.0001		<.0001		
Age Group	6 to 12	Non-TI	47.1%	70	37.2%	78	-10.0%

Measure 2-19: Percentage of child and adolescent beneficiaries with a follow-up visit within seven days after an ED visit for mental illness							
Demographic Variable	**Subgroup**	**Group**	**Baseline**	**Denom.**	**Evaluation**	**Denom.**	**Change**
		TI	80.6%	155	80.1%	136	-0.5%
	P-Value		<.0001		<.0001		
	13 to 17	Non-TI	55.2%	319	48.0%	244	-7.2%
		TI	85.3%	423	80.6%	341	-4.7%
	P-Value		<.0001		<.0001		

Measure 2-20: Percentage of child and adolescent beneficiaries with a follow-up visit within thirty days after an ED visit for mental illness					
		Time Period			
Evaluation Year	**Group**	**Baseline**	**Evaluation**	**DiD Log-Odds Estimate** (p-value)	**DiD Odds Ratio** [95% CI]
2023	TI	94% *N = 620*	93.8% *N = 501*	0.09 (0.19)	1.1 [0.95, 1.27]
	Non-TI	62.9% *N = 420*	52.7% *N = 347*		

Note: N represents the weighted denominator count.

Measure 2-20: Percentage of child and adolescent beneficiaries with a follow-up visit within thirty days after an ED visit for mental illness							
Demographic Variable	**Subgroup**	**Group**	**Baseline**	**Denom.**	**Evaluation**	**Denom.**	**Change**
Sex	Female	Non-TI	65.1%	269	52.8%	218	-12.3%
		TI	95.1%	349	94.8%	307	-0.3%
	P-Value		<.0001		<.0001		
	Male	Non-TI	58.9%	151	52.7%	129	-6.2%
		TI	92.6%	271	92.3%	194	-0.4%
	P-Value		<.0001		<.0001		
Geography	Rural	Non-TI	64.0%	75	51.9%	81	-12.1%
		TI	85.9%	78	89.8%	59	3.9%
	P-Value		0.0017		<.0001		
	Urban	Non-TI	62.5%	344	52.5%	263	-10.0%
		TI	95.2%	539	94.3%	438	-0.9%
	P-Value		<.0001		<.0001		
Language Spoken	English	Non-TI	62.1%	377	52.4%	315	-9.7%

Measure 2-20: Percentage of child and adolescent beneficiaries with a follow-up visit within thirty days after an ED visit for mental illness							
Demographic Variable	**Subgroup**	**Group**	**Baseline**	**Denom.**	**Evaluation**	**Denom.**	**Change**
		TI	93.9%	577	93.5%	459	-0.5%
	P-Value		<.0001		<.0001		
	Spanish	Non-TI	70.7%	41	56.3%	32	-14.5%
		TI	97.6%	42	97.4%	39	-0.2%
	P-Value		0.0008		<.0001		
Race/ Ethnicity	Black	Non-TI	53.1%	32	48.5%	33	-4.6%
		TI	95.0%	80	93.0%	57	-2.0%
	P-Value		<.0001		<.0001		
	Hispanic/ Latino	Non-TI	65.8%	38	50.0%	33	-15.8%
		TI	89.4%	47	97.4%	57	8.0%
	P-Value		0.0082		<.0001		
	Multiracial and/or Multiethnic	Non-TI	66.9%	124	50.9%	22	-16.0%
		TI	95.1%	163	92.0%	38	-3.1%

Measure 2-20: Percentage of child and adolescent beneficiaries with a follow-up visit within thirty days after an ED visit for mental illness							
Demographic Variable	**Subgroup**	**Group**	**Baseline**	**Denom.**	**Evaluation**	**Denom.**	**Change**
	P-Value		<.0001		<.0001		
	White	Non-TI	61.3%	181	55.9%	110	-5.4%
		TI	95.0%	278	95.1%	137	0.1%
	P-Value		<.0001		<.0001		
Age Group	6 to 12	Non-TI	51.4%	70	44.9%	78	-6.6%
		TI	93.5%	155	95.6%	136	2.0%
	P-Value		<.0001		<.0001		
	13 to 17	Non-TI	64.9%	319	57.4%	244	-7.5%
		TI	94.6%	423	93.0%	341	-1.6%
	P-Value		<.0001		<.0001		

Measure 2-21: Percentage of adolescent beneficiaries with a follow-up visit within seven days after an ED visit for SUD					
		Time Period			
Evaluation Year	Group	Baseline	Evaluation	DiD Log-Odds Estimate (p-value)	DiD Odds Ratio [95% CI]
2023	TI	59.2% *N = 120*	55.5% *N = 146*	0.09 (0.25)	1.1 [0.94, 1.28]
	Non-TI	21.5% *N = 344*	14% *N = 349*		

Note: N represents the weighted denominator count.

Please exercise caution when interpreting results for which the denominator is less than 11, as small sample sizes may limit the reliability and generalizability of the findings. These values are censored to protect patient confidentiality and align with CMS suppression policies.

Measure 2-21: Percentage of adolescent beneficiaries with a follow-up visit within seven days after an ED visit for SUD							
Demographic Variable	Subgroup	Group	Baseline	Denom.	Evaluation	Denom.	Change
Sex	Female	Non-TI	22.0%	177	17.2%	180	-4.8%
		TI	54.2%	48	51.6%	64	-2.6%
	P-Value		<.0001		<.0001		
	Male	Non-TI	21.0%	167	10.7%	169	-10.3%

Measure 2-21: Percentage of adolescent beneficiaries with a follow-up visit within seven days after an ED visit for SUD							
Demographic Variable	**Subgroup**	**Group**	**Baseline**	**Denom.**	**Evaluation**	**Denom.**	**Change**
		TI	62.5%	72	58.5%	82	-4.0%
	P-Value		<.0001		<.0001		
Geography	Rural	Non-TI	10.9%	55	12.9%	62	2.0%
		TI	55.6%	18	62.5%	16	6.9%
	P-Value		<.0001		<.0001		
	Urban	Non-TI	23.6%	288	14.3%	287	-9.3%
		TI	59.4%	101	53.9%	128	-5.5%
	P-Value		<.0001		<.0001		
Language Spoken	English	Non-TI	20.6%	291	13.3%	286	-7.3%
		TI	56.9%	109	52.9%	136	-3.9%
	P-Value		<.0001		<.0001		
	Spanish	Non-TI	25.0%	52	17.7%	62	-7.3%
		TI	81.8%	<11	90.0%	<11	8.2%

Measure 2-21: Percentage of adolescent beneficiaries with a follow-up visit within seven days after an ED visit for SUD							
Demographic Variable	**Subgroup**	**Group**	**Baseline**	**Denom.**	**Evaluation**	**Denom.**	**Change**
	P-Value		0.0%		<.0001		
Race/ Ethnicity	Black	Non-TI	15.2%	33	0.0%	29	-15.2%
		TI	50.0%	<11	57.1%	14	7.1%
	P-Value		3.3%		<.0001		
	Hispanic/ Latino	Non-TI	23.7%	38	10.0%	40	-13.7%
		TI	37.5%	<11	100.0%	<11	62.5%
	P-Value		41.9%		<.0001		
	Multiracial and/or Multiethnic	Non-TI	16.9%	130	13.5%	133	-3.4%
		TI	65.1%	43	47.9%	48	-17.2%
	P-Value		<.0001		<.0001		
	White	Non-TI	23.4%	94	13.3%	133	-10.1%
		TI	56.0%	50	54.7%	48	-1.3%
	P-Value		<.0001		<.0001		

Measure 2-21: Percentage of adolescent beneficiaries with a follow-up visit within seven days after an ED visit for SUD							
Demographic Variable	**Subgroup**	**Group**	**Baseline**	**Denom.**	**Evaluation**	**Denom.**	**Change**
Age Group	6 to 12	Non-TI	23.5%	285	13.7%	292	-9.8%
		TI	62.7%	102	56.9%	123	-5.8%
	P-Value		<.0001		<.0001		
	13 to 17	Non-TI	23.5%	59	15.8%	57	-7.7%
		TI	62.7%	18	47.8%	23	-14.9%
	P-Value		<.0001		<.0001		

Measure 2-22: Percentage of adolescent beneficiaries with a follow-up visit within thirty days after an ED visit for SUD					
		Time Period			
Evaluation Year	**Group**	**Baseline**	**Evaluation**	**DiD Log-Odds Estimate** (p-value)	**DiD Odds Ratio** [95% CI]
2023	TI	80.8% *N = 120*	78.1% *N = 146*	0.04 (0.62)	1.04 [0.98, 1.24]
	Non-TI	30.2% *N = 344*	23.5% *N = 349*		

Note: N represents the weighted denominator count

Measure 2-22: Percentage of adolescent beneficiaries with a follow-up visit within thirty days after an ED visit for SUD							
Demographic Variable	**Subgroup**	**Group**	**Baseline**	**Denom.**	**Evaluation**	**Denom.**	**Change**
Sex	Female	Non-TI	32.2%	177	27.2%	180	-5.0%
		TI	81.3%	48	81.3%	64	0.0%
	P-Value		<0.0001		<0.0001		
	Male	Non-TI	28.1%	167	19.5%	169	-8.6%
		TI	80.6%	72	75.6%	82	-4.9%
	P-Value		<0.0001		<0.0001		
Geography	Rural	Non-TI	20.0%	55	25.8%	62	5.8%
		TI	83.3%	18	93.8%	16	10.4%
	P-Value		<0.0001		<0.0001		
	Urban	Non-TI	32.3%	288	23.0%	287	-9.3%
		TI	80.2%	101	75.8%	128	-4.4%
	P-Value		<0.0001		<0.0001		

Measure 2-22: Percentage of adolescent beneficiaries with a follow-up visit within thirty days after an ED visit for SUD							
Demographic Variable	**Subgroup**	**Group**	**Baseline**	**Denom.**	**Evaluation**	**Denom.**	**Change**
Language Spoken	English	Non-TI	30.2%	291	21.7%	286	-8.6%
		TI	79.8%	109	77.2%	136	-2.6%
	P-Value		<0.0001		<0.0001		
	Spanish	Non-TI	28.8%	52	32.3%	62	3.4%
		TI	90.9%	<11	90.0%	<11	-0.9%
	P-Value		<0.0001		0.0006		
Race/ Ethnicity	Black	Non-TI	18.2%	33	6.9%	29	-11.3%
		TI	75.0%	<11	78.6%	14	3.6%
	P-Value		0.0015		<0.0001		
	Hispanic/ Latino	Non-TI	26.3%	38	22.5%	40	-3.8%
		TI	75.0%	<11	100.0%	<11	25.0%
	P-Value		0.0086		<0.0001		
		Non-TI	29.2%	130	22.6%	133	-6.7%

Measure 2-22: Percentage of adolescent beneficiaries with a follow-up visit within thirty days after an ED visit for SUD							
Demographic Variable	**Subgroup**	**Group**	**Baseline**	**Denom.**	**Evaluation**	**Denom.**	**Change**
	Multiracial and/or Multiethnic	TI	83.7%	43	70.8%	48	-12.9%
	P-Value		<0.0001		<0.0001		
	White	Non-TI	30.9%	94	24.5%	133	-6.4%
		TI	78.0%	50	81.1%	48	3.1%
	P-Value		<0.0001		<0.0001		
Age Group	6 to 12	Non-TI	30.9%	285	23.6%	292	-7.2%
		TI	81.4%	102	80.5%	123	-0.9%
	P-Value		<0.0001		<0.0001		
	13 to 17	Non-TI	27.1%	59	22.8%	57	-4.3%
		TI	77.8%	18	65.2%	23	-12.6%
	P-Value		0.0001		0.0003		

Measure 2-23: Percentage of child and adolescent beneficiaries with ongoing antipsychotic medication use who have metabolic testing during the measurement year					
		Time Period			
Evaluation Year	**Group**	**Baseline**	**Evaluation**	**DiD Log-Odds Estimate** (p-value)	**DiD Odds Ratio** [95% CI]
2023	TI	40.4% *N = 5,082*	39.7% *N = 5,351*	-0.0007 (0.62)	1.0 [0.96, 1.04]
	Non-TI	35.4% *N = 1,698*	34.9% *N = 1,397*		

Note: N represents the weighted denominator count.

Measure 2-23: Percentage of child and adolescent beneficiaries with ongoing antipsychotic medication use who have metabolic testing during the measurement year							
Demographic Variable	**Subgroup**	**Group**	**Baseline**	**Denom.**	**Evaluation**	**Denom.**	**Change**
Sex	Female	Non-TI	36.0%	761	32.3%	628	-3.7%
		TI	40.1%	2,413	41.0%	2,498	0.9%
	P-Value		0.0449		<.0001		
	Male	Non-TI	34.9%	937	36.9%	769	2.0%
		TI	40.6%	2,669	38.7%	2,853	-2.0%

Measure 2-23: Percentage of child and adolescent beneficiaries with ongoing antipsychotic medication use who have metabolic testing during the measurement year							
Demographic Variable	**Subgroup**	**Group**	**Baseline**	**Denom.**	**Evaluation**	**Denom.**	**Change**
	P-Value		0.002		0.3811		
Geography	Rural	Non-TI	35.8%	229	37.4%	214	1.6%
		TI	40.8%	517	42.5%	588	1.7%
	P-Value		0.1967		0.1913		
	Urban	Non-TI	35.3%	1,458	34.4%	1,176	-0.9%
		TI	40.4%	4,549	39.4%	4,741	-1.0%
	P-Value		0.0005		0.0014		
Language Spoken	English	Non-TI	33.9%	1,569	33.6%	1,290	-0.3%
		TI	39.4%	4,761	38.5%	5,023	-0.9%
	P-Value		0.0001		0.001		
	Spanish	Non-TI	53.1%	128	50.9%	106	-2.2%
		TI	54.8%	314	57.9%	321	3.2%
	P-Value		0.7518		0.2078		

Measure 2-23: Percentage of child and adolescent beneficiaries with ongoing antipsychotic medication use who have metabolic testing during the measurement year							
Demographic Variable	**Subgroup**	**Group**	**Baseline**	**Denom.**	**Evaluation**	**Denom.**	**Change**
Race/ Ethnicity	Black	Non-TI	32.6%	138	32.5%	114	-0.2%
		TI	35.0%	552	36.8%	609	1.8%
	P-Value		0.6027		0.3775		
	Hispanic/ Latino	Non-TI	38.1%	113	43.8%	89	5.8%
		TI	47.9%	351	50.0%	346	2.1%
	P-Value		0.0685		0.2982		
	Multiracial and/or Multiethnic	Non-TI	36.5%	458	35.5%	366	-0.9%
		TI	43.5%	1,320	41.1%	1,398	-2.4%
	P-Value		0.0086		0.054		
	White	Non-TI	33.9%	838	33.6%	696	-0.3%
		TI	39.0%	2,395	38.1%	2,478	-0.9%
	P-Value		0.0081		0.0308		

Measure 2-23: Percentage of child and adolescent beneficiaries with ongoing antipsychotic medication use who have metabolic testing during the measurement year							
Demographic Variable	**Subgroup**	**Group**	**Baseline**	**Denom.**	**Evaluation**	**Denom.**	**Change**
Age Group	6 to 12	Non-TI	35.3%	631	35.6%	1,061	0.3%
		TI	38.4%	1,831	41.5%	3,236	3.1%
	P-Value		0.1646		0.9252		
	13 to 17	Non-TI	37.1%	529	34.1%	851	-3.0%
		TI	36.8%	1,860	41.4%	3,473	4.6%
	P-Value		0.0007		<.0001		

Hypothesis 3: The TI 2.0 program will improve the delivery of care that addresses inequitable health outcomes for adults.

Hypothesis 3 uses administrative TI program data, claims/encounter data, and beneficiary surveys to test whether the demonstration improves the delivery of care that addresses inequitable health outcomes for adults impacted by the TI program. Seven research questions are used to assess Hypothesis 3.

Research Question 3.1: Have health disparities related to care coordination been reduced among adults attributed to TI 2.0 providers compared to prior to the demonstration?

Key Findings

- Among adult beneficiaries, 76% (N = 1,006) of TI participants reported that their doctor seemed informed about the care they received from specialists, compared to 77.4% (N = 2,835) of non-TI participants. The 1.4 percentage-point difference (p = 0.35) was not statistically significant, suggesting

comparable experiences of care coordination between TI and non-TI beneficiaries.

- Performance on care coordination measures remained consistent for TI-attributed adults over the demonstration period.
- Across all racial and ethnic groups, TI patients consistently outperformed their non-TI counterparts at both baseline and evaluation.

Two performance measures and one adult beneficiary survey question assessed care coordination disparities among adult beneficiaries.

Have care coordination disparities been reduced among adults attributed to TI?						
		TI Beneficiaries		Non-TI Beneficiaries		Difference in Rate
		Number of Responses	Rate	Number of Responses	Rate	(p-value)
3-1	Adult beneficiaries' response to their doctor seeming informed about the care they received from specialists	1,006	76%	2,835	77.4%	-1.4% (0.35)

	Care Coordination	FFY 2022	FFY 2023
3-2	Percentage of adult beneficiaries with follow-up after an ED visit for adult beneficiaries with multiple high-risk chronic conditions	67.1%	67.3%
3-3	Percentage of adult beneficiaries with patient engagement after discharge	63.5%	63.3%

Measure 3-2: Percentage of adult beneficiaries with follow-up after an ED visit for adult beneficiaries with multiple high-risk chronic conditions					
		Time Period			
Evaluation Year	Group	Baseline	Evaluation	DiD Log-Odds Estimate (p-value)	DiD Odds Ratio [95% CI]
2023	TI	67.1% *N = 24,121*	67.3% *N = 24,743*	0.02 (0.003)	1.03 [1.007, 1.03]
	Non-TI	51.9% *N = 29,422*	50.3% *N = 30,019*		

Note: N represents the weighted denominator count.

Measure 3-2: Percentage of adult beneficiaries with follow-up after an ED visit for adult beneficiaries with multiple high-risk chronic conditions							
Demographic Variable	Subgroup	Group	Baseline	Denom.	Evaluation	Denom.	Change
Sex	Female	Non-TI	53.0%	16,398	50.6%	13,024	-2.5%
		TI	68.7%	14,868	64.7%	9,253	-4.0%
	P-Value		<.0001		<.0001		
	Male	Non-TI	51.6%	16,422	48.6%	13,597	-3.1%
		TI	68.6%	14,925	65.5%	9,818	-3.1%

Measure 3-2: Percentage of adult beneficiaries with follow-up after an ED visit for adult beneficiaries with multiple high-risk chronic conditions							
Demographic Variable	**Subgroup**	**Group**	**Baseline**	**Denom.**	**Evaluation**	**Denom.**	**Change**
	P-Value		<.0001		<.0001		
Geography	Rural	Non-TI	45.8%	4,819	44.6%	5,025	-1.2%
		TI	61.7%	1,849	62.8%	1,822	1.1%
	P-Value		<.0001		<.0001		
	Urban	Non-TI	53.1%	24,539	51.3%	24,916	-1.8%
		TI	67.6%	22,202	67.7%	22,804	0.1%
	P-Value		<.0001		<.0001		
Language Spoken	English	Non-TI	51.5%	26,438	55.8%	2,739	4.2%
		TI	67.4%	22,930	61.4%	1,013	-6.0%
	P-Value		<.0001		<.0001		
	Spanish	Non-TI	49.9%	26,608	53.3%	3,144	3.5%
		TI	67.8%	23,490	57.9%	1,107	-9.9%
	P-Value		0.0019		0.0087		

Measure 3-2: Percentage of adult beneficiaries with follow-up after an ED visit for adult beneficiaries with multiple high-risk chronic conditions							
Demographic Variable	**Subgroup**	**Group**	**Baseline**	**Denom.**	**Evaluation**	**Denom.**	**Change**
Race/ Ethnicity	Black	Non-TI	51.8%	2,932	48.9%	2,986	-2.9%
		TI	65.9%	2,905	64.4%	2,838	-1.4%
	P-Value		<.0001		<.0001		
	Hispanic/ Latino	Non-TI	53.0%	3,368	50.6%	3,412	-2.4%
		TI	67.3%	2,388	66.1%	2,470	-1.2%
	P-Value		<.0001		<.0001		
	Multiracial and/or Multiethnic	Non-TI	52.8%	5,134	50.8%	5,186	-1.9%
		TI	64.7%	3,383	65.0%	3,672	0.3%
	P-Value		<.0001		<.0001		
	White	Non-TI	51.2%	15,372	50.4%	15,697	-0.8%
		TI	67.9%	13,591	69.1%	13,898	1.2%
	P-Value		<.0001		<.0001		
Age Group	35 to 44	Non-TI	51.6%	3,525	51.8%	3,152	0.2%

Measure 3-2: Percentage of adult beneficiaries with follow-up after an ED visit for adult beneficiaries with multiple high-risk chronic conditions							
Demographic Variable	**Subgroup**	**Group**	**Baseline**	**Denom.**	**Evaluation**	**Denom.**	**Change**
		TI	68.6%	3,960	68.7%	3,934	0.1%
	P-Value		<.0001		<.0001		
	45 to 54	Non-TI	52.1%	5,901	52.1%	5,576	0.0%
		TI	69.0%	5,899	69.4%	5,675	0.4%
	P-Value		<.0001		<.0001		

Measure 3-3: Percentage of adult beneficiaries with patient engagement after discharge					
		Time Period			
Evaluation Year	**Group**	**Baseline**	**Evaluation**	**DiD Log-Odds Estimate** (p-value)	**DiD Odds Ratio** [95% CI]
2023	TI	63.5% *N = 52,641*	63.3% *N = 55,410*	0.004 (0.27)	1.004 [0.997, 1.01]
	Non-TI	50.7% *N = 86,499*	50.1% *N = 84,126*		

Note: N represents the weighted denominator count.

Measure 3-3: Percentage of adult beneficiaries with patient engagement after discharge							
Demographic Variable	**Subgroup**	**Group**	**Baseline**	**Denom.**	**Evaluation**	**Denom.**	**Change**
Sex	Female	Non-TI	47.7%	52,729	47.2%	51,284	-0.5%
		TI	62.8%	28,846	62.7%	30,453	-0.1%
	P-Value		<0.0001		<0.0001		
	Male	Non-TI	55.3%	33,770	54.5%	32,842	-0.8%
		TI	64.4%	23,795	64.1%	24,957	-0.2%
	P-Value		<0.0001		<0.0001		
Geography	Rural	Non-TI	52.8%	10,821	52.6%	10,827	-0.2%
		TI	63.2%	3,438	62.9%	3,964	-0.2%
	P-Value		<0.0001		<0.0001		
	Urban	Non-TI	50.4%	75,468	49.7%	73,084	-0.6%
		TI	63.5%	49,060	63.4%	51,281	-0.1%
	P-Value		<0.0001		<0.0001		
Language Spoken	English	Non-TI	49.4%	78,748	48.7%	76,204	-0.6%

Measure 3-3: Percentage of adult beneficiaries with patient engagement after discharge							
Demographic Variable	**Subgroup**	**Group**	**Baseline**	**Denom.**	**Evaluation**	**Denom.**	**Change**
		TI	63.3%	50,181	63.3%	52,686	0%
	P-Value		<0.0001		<0.0001		
	Spanish	Non-TI	63.8%	7,142	63.1%	7,279	-0.7%
		TI	67.8%	2,182	65%	2,407	-2.8%
	P-Value		0.0006		0.0921		
Race/ Ethnicity	Black	Non-TI	46.9%	8,037	45.7%	7,739	-1.3%
		TI	58.9%	5,960	60.8%	6,244	1.9%
	P-Value		<0.0001		<0.0001		
	Hispanic/ Latino	Non-TI	54.5%	8,593	53.3%	8,543	-1.2%
		TI	64.1%	4,475	64.1%	4,764	0%
	P-Value		<0.0001		<0.0001		
	Multiracial and/or Multiethnic	Non-TI	46.1%	22,509	46.3%	21,945	0.2%
		TI	57.8%	10,496	56.2%	11,357	-1.6%

Measure 3-3: Percentage of adult beneficiaries with patient engagement after discharge							
Demographic Variable	**Subgroup**	**Group**	**Baseline**	**Denom.**	**Evaluation**	**Denom.**	**Change**
	P-Value		<0.0001		<0.0001		
	White	Non-TI	52.9%	37,790	52.4%	36,750	-0.5%
		TI	66.8%	26,336	66.5%	27,802	-0.3%
	P-Value		<0.0001		<0.0001		
Age Group	55 to 64	Non-TI	68.1%	13,669	67.3%	13,076	-0.8%
		TI	74.7%	8,493	74.9%	8,737	0.2%
	P-Value		<0.0001		<0.0001		
	65 to 74	Non-TI	69.6%	6,851	66.8%	7,082	-2.8%
		TI	72.2%	2,908	70.7%	3,148	-1.5%
	P-Value		0.009		0.0002		

Research Question 3.2: Have general and mental health outcomes maintained or improved among adults attributed to TI 2.0 providers compared to prior to the demonstration?

Key Findings

- Among adult beneficiaries, 28.6% (N = 1,775) of TI participants reported their overall health as very good or excellent, compared to 31.4% (N = 5,546) of non-TI participants. The 3.3 percentage-point difference was statistically

significant (p = 0.03), demonstrating greater self-reported overall health among non-TI beneficiaries.
- For emotional or mental health, 39.6% (N = 1,775) of TI participants reported very good or excellent ratings, compared to 41.8% (N = 5,544) of non-TI participants. The 2.2 percentage-point difference was not statistically significant (p = 0.09), suggesting generally comparable mental health outcomes between TI and non-TI beneficiaries.

Two measures from the adult beneficiary survey were used to assess research question 3.2. Beneficiary survey data prior to the demonstration period were not available at the time of the interim evaluation report; as a result, only the Fall 2025 survey results are presented.

Have general and mental health outcomes improved among adults attributed to TI?						
		TI Beneficiaries		Non-TI Beneficiaries		Difference in Rate
		Number of Responses	Rate	Number of Responses	Rate	(p-value)
3-4	Percentage of adult beneficiaries who reported a rating of overall health as very good or excellent	1,775	28.6%	5,546	31.4%	-2.8% (0.03)
3-5	Percentage of adult beneficiaries who reported a rating of emotional or mental health as very good or excellent	1,775	39.6%	5,544	41.8%	-2.2% (0.09)

Research Question 3.3: Have health disparities related to access to care been reduced among adults attributed to TI 2.0 providers compared to prior to the demonstration?

Key Findings

- TI-attributed adults continued to access preventative/ambulatory health services over the demonstration period. Among both TI and non-TI adult patients, older adults had a higher performance, reflecting greater access to these services compared to younger adults.
- Among adult beneficiaries, TI and non-TI participants reported similar experiences of access to care. Across measures of doctors spending enough time (84.5% vs. 84.9%, N = 1,478 vs. 4,421, p = 0.71), receiving needed care right away (75.2% vs. 75.7%, N = 863 vs. 2,496, p = 0.78), and getting routine care appointments as soon as needed (72.9% vs. 75.2%, N = 1,503 vs. 4,527, p = 0.07), differences were not statistically significant, indicating generally comparable access to care between TI and non-TI adult beneficiaries.

One performance measure and three beneficiary survey questions assessed access-to-care rates among adult beneficiaries. Beneficiary survey data prior to the demonstration period were not available at the time of the interim evaluation report; as a result, only the Fall 2025 survey results are presented.

	Preventive/Ambulatory Health Services	FFY 2022	FFY 2023
3-6	Percentage of adult beneficiaries who accessed preventive/ambulatory health services	77.8%	77%

Measure 3-6: Percentage of adult beneficiaries who accessed preventive/ambulatory health services

Evaluation Year	Group	Time Period: Baseline	Time Period: Evaluation	DiD Log-Odds Estimate (p-value)	DiD Odds Ratio [95% CI]
2023	TI	77.8% *N = 212,419*	77% *N = 205,005*	0.016 (<0.0001)	1.016 [1.01, 1.02]
	Non-TI	71.6%	69.3%		

Measure 3-6: Percentage of adult beneficiaries who accessed preventive/ambulatory health services					
		Time Period			
Evaluation Year	Group	Baseline	Evaluation	DiD Log-Odds Estimate (p-value)	DiD Odds Ratio [95% CI]
		N = *777,261*	*N* = *700,409*		

Note: N represents the weighted denominator count.

Measure 3-6: Percentage of adult beneficiaries who accessed preventive/ambulatory health services							
Demographic Variable	**Subgroup**	**Group**	**Baseline**	**Denom.**	**Evaluation**	**Denom.**	**Change**
Sex	Female	Non-TI	78.3%	452,325	76.7%	403,864	-1.6%
		TI	83.0%	126,245	82.6%	121,753	-0.5%
	P-Value		<.0001		<.0001		
	Male	Non-TI	62.2%	324,936	59.2%	296,545	-3.0%
		TI	70.2%	86,174	68.9%	83,252	-1.3%
	P-Value		<.0001		<.0001		
Geography	Rural	Non-TI	70.5%	111,614	69.0%	101,675	-1.5%

Measure 3-6: Percentage of adult beneficiaries who accessed preventive/ambulatory health services							
Demographic Variable	**Subgroup**	**Group**	**Baseline**	**Denom.**	**Evaluation**	**Denom.**	**Change**
		TI	76.0%	10,863	75.8%	10,986	-0.2%
	P-Value		<.0001		<.0001		
	Urban	Non-TI	71.7%	664,084	69.3%	597,216	-2.4%
		TI	77.9%	200,772	77.0%	193,156	-0.9%
	P-Value		<.0001		<.0001		
Language Spoken	English	Non-TI	70.7%	679,210	68.4%	607,597	-2.3%
		TI	77.3%	190,673	76.5%	183,128	-0.7%
	P-Value		<.0001		<.0001		
	Spanish	Non-TI	77.5%	88,552	75.0%	83,487	-2.5%
		TI	82.6%	18,948	80.7%	19,001	-1.8%
	P-Value		<.0001		<.0001		
Race/ Ethnicity	Black	Non-TI	67.5%	66,832	64.9%	60,547	-2.7%
		TI	75.3%	24,408	74.5%	23,352	-0.8%

Measure 3-6: Percentage of adult beneficiaries who accessed preventive/ambulatory health services							
Demographic Variable	**Subgroup**	**Group**	**Baseline**	**Denom.**	**Evaluation**	**Denom.**	**Change**
	P-Value		<.0001		<.0001		
	Hispanic/ Latino	Non-TI	71.6%	91,453	69.1%	83,855	-2.5%
		TI	77.4%	25,123	76.1%	24,336	-1.3%
	P-Value		<.0001		<.0001		
	Multiracial and/or Multiethnic	Non-TI	73.9%	206,520	71.7%	187,851	-2.2%
		TI	79.5%	47,813	78.6%	46,622	-0.9%
	P-Value		<.0001		<.0001		
	White	Non-TI	71.6%	329,630	69.6%	291,492	-1.9%
		TI	78.6%	92,771	78.0%	88,482	-0.6%
	P-Value		<.0001		<.0001		
Age Group	45 to 54	Non-TI	74.5%	112,167	72.1%	100,386	-2.4%
		TI	81.3%	33,982	80.4%	32,676	-0.9%
	P-Value		<.0001		<.0001		

Measure 3-6: Percentage of adult beneficiaries who accessed preventive/ambulatory health services							
Demographic Variable	**Subgroup**	**Group**	**Baseline**	**Denom.**	**Evaluation**	**Denom.**	**Change**
	55 to 64	Non-TI	80.3%	112,659	78.9%	100,976	-1.4%
		TI	85.8%	32,570	85.1%	31,782	-0.7%
	P-Value		<.0001		<.0001		

Have disparities in access to care been reduced among adults attributed to TI?						
		TI Beneficiaries		**Non-TI Beneficiaries**		**Difference in Rate**
		Number of Responses	**Rate**	**Number of Responses**	**Rate**	(p-value)
3-7	Percentage of adult beneficiaries who reported that their doctor usually or always spent enough time with them	1,478	84.5%	4,421	84.9%	-0.4% (0.71)
3-8	Percentage of adult beneficiaries who reported they received needed care right away as soon as they needed	863	75.2%	2,496	75.7%	-0.5% (0.78)
3-9	Percentage of adult beneficiaries who					

Have disparities in access to care been reduced among adults attributed to TI?		TI Beneficiaries		Non-TI Beneficiaries		Difference in Rate
		Number of Responses	Rate	Number of Responses	Rate	(p-value)
	reported they got an appointment for a checkup or routine care as soon as they needed	1,503	72.9%	4,527	75.2%	-2.3% (0.07)

Research Question 3.4: Have health disparities related to the experience of care been reduced among adults attributed to TI 2.0 providers compared to prior to the demonstration?

Key Findings

- Among adult beneficiaries, 89.4% of TI participants (N = 1,477) and 89.1% of non-TI participants (N = 4,428) reported that their doctor explained things clearly; 88.8% of TI participants (N = 1,476) and 88.1% of non-TI participants (N = 4,419) said their doctor listened carefully; and 90.7% of TI participants (N = 1,474) and 90.6% of non-TI participants (N = 4,422) felt their doctor showed respect. Although not statistically significant, these findings suggest comparable care experiences between TI and non-TI beneficiaries.
- Programmatic requirements led to the development of NMDOH screening and referral documentation using administrative methods, helping organizations systematically identify and address patients' social needs. This can improve patient experience by ensuring social determinants of health are recognized and managed, resulting in more comprehensive, coordinated care that better supports overall well-being.

Health disparities related to the experience of care among adult beneficiaries were assessed using three beneficiary survey questions, one administrative measure, and one claims/encounter data measure. Beneficiary survey data prior to the demonstration period were not available at the time of the interim evaluation report; as a result, only the Fall 2025 survey results are presented.

Have disparities in care experience among adults attributed to TI been reduced?		TI Beneficiaries		Non-TI Beneficiaries		Difference in Rate
		Number of Responses	Rate	Number of Responses	Rate	(p-value)
3-10	Percentage of adult beneficiaries who reported their doctor usually or always explained things in a way that was easy to understand	1,477	89.4%	4,428	89.1%	0.3% (0.73)
3-11	Percentage of adult beneficiaries who reported their doctor usually or always listened carefully to them	1,476	88.8%	4,419	88.1%	0.7% (0.53)
3-12	Percentage of adult beneficiaries who reported their doctor usually or always showed respect for what they had to say	1,474	90.7%	4,422	90.6%	0.1% (0.88)

Culturally Sensitive Workforce		FFY 2022	FFY 2023
3-13	Percentage of adult beneficiaries attributed/assigned to a TI provider with the same race/ethnicity and/or language	–	–

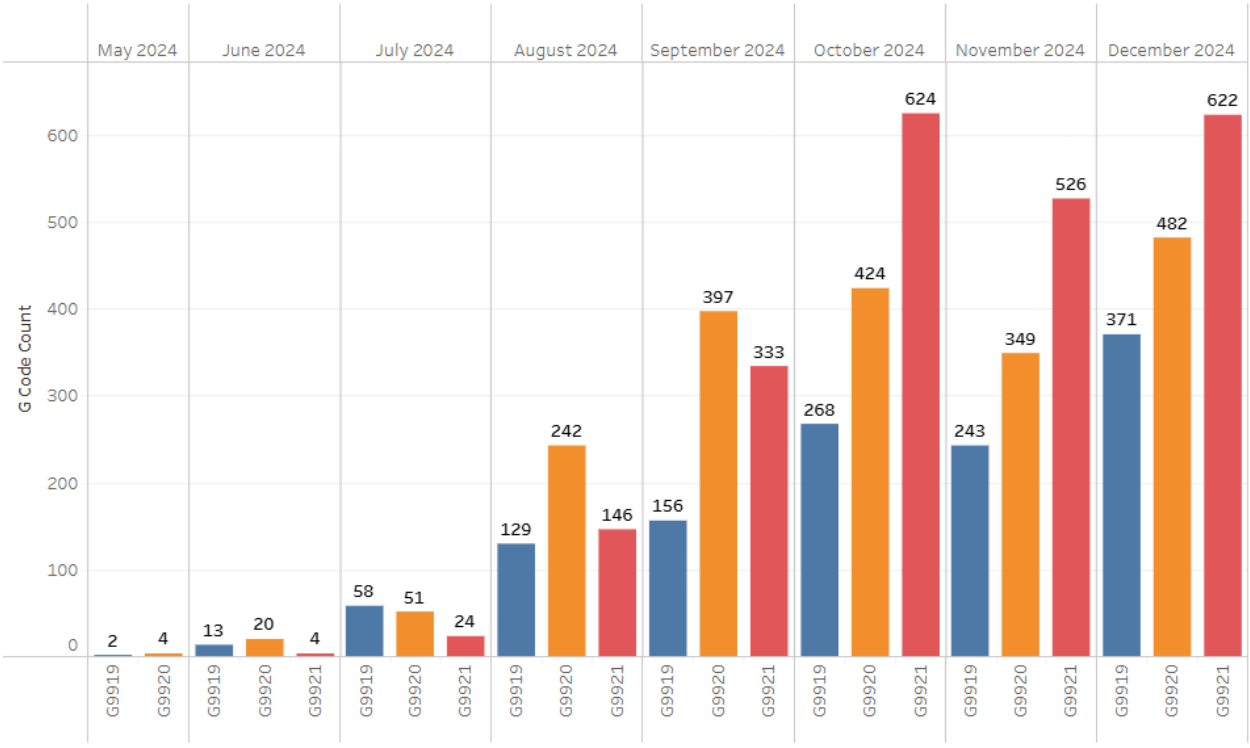
Note: Results for measure 3-13 are not presented due to insufficient data.

Due to limitations in provider data availability, as described in the Methodology Limitations section, rates for a culturally sensitive workforce (Measure 3-13) could not be calculated and are therefore not reported.

	HRSN/NMDOH Assessments	May 1, 2024 - December 31, 2024
3-14	Percentage of adult beneficiaries who received an HRSN/NMDOH screening assessment	34.5% *N = 4,925*

Screening results (Figure 6) were captured via G codes on claims for 4,925 unique TI-attributed adult beneficiaries who completed a comprehensive HRSN/NMDOH screening. Adults were more likely to screen positive for a HRSN/NMDOH but decline a referral to a CBO. No statistical tests were calculated for this measure.

Figure 6: HRSN/NMDOH Screening Assessment Results Among TI Adult Beneficiaries

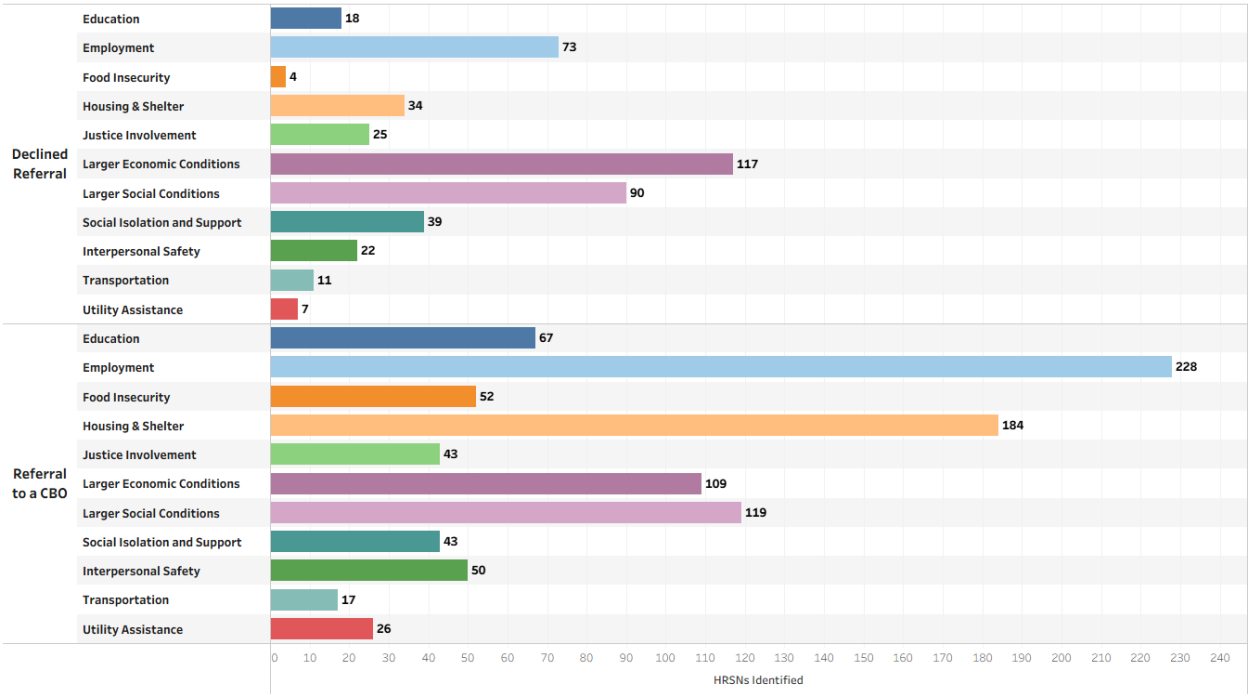


Note: Healthcare Common Procedure Coding System (HCPCS) codes G9919, G9920, and G9921 (prior

to its termination on December 31, 2024) were used on claims to indicate the result of a patient's NMDOH screening. G9919 indicates that at least one HRSN/NMDOH need was identified during the HRSN/NMDOH screening and the patient accepted a referral to address that need. G9920 indicates that no HRSN/NMDOH needs were identified. G9921 indicates that at least one HRSN/NMDOH was identified, but the patient declined a referral to address the need. Providers were required to include all relevant International Classification of Diseases, Tenth Revision (ICD-10) Z codes (Z55–Z65) associated with the identified NMDOH.

Figure 7 presents the distribution of HRSNs/NMDOH needs, categorized by whether patients accepted or declined referrals. Patients with needs related to housing and shelter, employment, or food insecurity were more likely to accept referrals than decline them. This pattern suggests that adults experiencing these social needs may be more motivated to engage with supportive services, possibly due to the immediate and pressing nature of these challenges. The tendency to accept referrals for such needs also reflects adults' episodic care-seeking behavior, where individuals seek assistance primarily during times of acute need or crisis.

Figure 7: HRSNs/NMDOH Needs Identified Among Adult Beneficiaries by Referral Status



Research Question 3.5: Have health disparities related to maternal health been reduced among adults attributed to TI 2.0 providers compared to prior to the demonstration?

Key Findings

- Prenatal and postpartum care performance remained stable over the demonstration period.
- TI patients aged 35 to 44 experienced greater performance improvements compared to younger TI patients.

One claims/encounter measure and two performance measures assessed maternal health disparities among adult beneficiaries.

	Maternal Health	FFY 2022	FFY 2023
3-15	Percentage of adult beneficiaries with postpartum depression screening	–	–
3-15	Percentage of adult beneficiaries with a positive postpartum depression screening and follow-up	–	–
3-16	Timeliness of prenatal care	65.3%	64.5%
3-17	Timeliness of postpartum care	38.8%	37.1%

Note: Results for measure 3-15 are not presented due to insufficient data and calculated rates that are artificially low from using administrative data.

Although rates for screening for postpartum depression (Measure 3-15) were calculated, as described in the Methodology Limitations section, this measure relies on level II Healthcare Common Procedure Coding System (HCPCS) codes to identify numerator compliance, which yields artificially low rates calculated through administrative data. Therefore, no results for this measure are displayed.

Measure 3-16: Timeliness of prenatal care					
		Time Period			
Evaluation Year	Group	Baseline	Evaluation	DiD Log-Odds Estimate (p-value)	DiD Odds Ratio [95% CI]
2023	TI	65.3% *N = 5,191*	64.5% *N = 5,915*	0.01 (0.32)	1.01 [0.99, 1.03]
	Non-TI	63.2% *N = 23,938*	61.3% *N = 22,946*		

Note: N represents the weighted denominator count.

Measure 3-16: Timeliness of prenatal care							
Demographic Variable	Subgroup	Group	Baseline	Denom.	Evaluation	Denom.	Change
Geography	Rural	Non-TI	59.5%	2,887	58.9%	2,838	-0.6%
		TI	63.6%	253	58.2%	285	-5.4%
	P-Value		0.2027		0.8268		
	Urban	Non-TI	63.7%	20,979	61.6%	20,037	-2.0%
		TI	65.4%	4,911	64.7%	5,595	-0.6%
	P-Value		0.0259		<.0001		

Measure 3-16: Timeliness of prenatal care							
Demographic Variable	**Subgroup**	**Group**	**Baseline**	**Denom.**	**Evaluation**	**Denom.**	**Change**
Language Spoken	English	Non-TI	63.9%	21,822	61.7%	20,796	-2.2%
		TI	65.3%	4,771	64.8%	5,412	-0.6%
	P-Value		0.0614		<.0001		
	Spanish	Non-TI	55.7%	2,015	57.3%	2,046	1.6%
		TI	65.2%	374	60.4%	437	-4.8%
	P-Value		0.0006		0.2292		
Race/ Ethnicity	Black	Non-TI	64.4%	2,404	59.7%	2,209	-4.6%
		TI	64.1%	760	66.3%	817	2.3%
	P-Value		0.8914		0.0009		
	Hispanic/ Latino	Non-TI	63.3%	2,251	61.0%	2,182	-2.3%
		TI	65.7%	519	60.4%	578	-5.3%
	P-Value		0.2968		0.7865		
		Non-TI	65.0%	9,918	63.4%	9,700	-1.5%

Measure 3-16: Timeliness of prenatal care							
Demographic Variable	**Subgroup**	**Group**	**Baseline**	**Denom.**	**Evaluation**	**Denom.**	**Change**
	Multiracial and/or Multiethnic	TI	66.8%	1,944	66.4%	2,317	-0.4%
	P-Value		0.1196		0.0082		
	White	Non-TI	62.4%	7,578	60.7%	7,173	-1.7%
		TI	64.5%	1,560	62.9%	1,761	-1.6%
	P-Value		0.1189		0.091		
Age Group	18 to 24	Non-TI	62.6%	7,630	59.4%	7,245	-3.2%
		TI	65.1%	1,558	64.6%	1,696	-0.6%
	P-Value		<.0001		0.0004		
	25 to 34	Non-TI	64.3%	12,999	63.0%	12,378	-1.3%
		TI	66.7%	2,857	64.8%	3,339	-1.9%
	P-Value		0.0339		<.0001		
	35 to 44	Non-TI	61.3%	2,966	59.7%	2,969	-1.6%
		TI	60.9%	764	63.5%	864	2.7%

Measure 3-16: Timeliness of prenatal care							
Demographic Variable	**Subgroup**	**Group**	**Baseline**	**Denom.**	**Evaluation**	**Denom.**	**Change**
	P-Value		0.3871		<.0001		

Measure 3-17: Timeliness of postpartum care					
		Time Period			
Evaluation Year	**Group**	**Baseline**	**Evaluation**	**DiD Log-Odds Estimate** (p-value)	**DiD Odds Ratio** [95% CI]
2023	TI	38.8% *N = 5,191*	37.1% *N = 5,915*	0.0002 (0.98)	1.0 [0.98, 1.02]
	Non-TI	42.7% *N = 23,938*	40.9% *N = 22,946*		

Note: N represents the weighted denominator count.

Measure 3-17: Timeliness of postpartum care							
Demographic Variable	**Subgroup**	**Group**	**Baseline**	**Denom.**	**Evaluation**	**Denom.**	**Change**
Geography	Rural	Non-TI	42.3%	2,887	43.1%	2,838	0.8%
		TI	39.9%	253	37.2%	285	-2.7%

Measure 3-17: Timeliness of postpartum care							
Demographic Variable	**Subgroup**	**Group**	**Baseline**	**Denom.**	**Evaluation**	**Denom.**	**Change**
	P-Value		0.4637		0.0534		
	Urban	Non-TI	42.7%	20,979	40.6%	20,037	-2.2%
		TI	38.7%	4,911	37.1%	5,595	-1.6%
	P-Value		<.0001		<.0001		
Language Spoken	English	Non-TI	41.5%	21,822	39.6%	20,796	-1.9%
		TI	38.1%	4,771	36.4%	5,412	-1.7%
	P-Value		<.0001		<.0001		
	Spanish	Non-TI	55.0%	2,015	52.9%	2,046	-2.2%
		TI	46.5%	374	42.3%	437	-4.2%
	P-Value		0.0024		<.0001		
Race/ Ethnicity	Black	Non-TI	36.8%	2,404	35.4%	2,209	-1.5%
		TI	35.4%	760	37.0%	817	1.6%
	P-Value		0.4787		0.4124		

Measure 3-17: Timeliness of postpartum care							
Demographic Variable	**Subgroup**	**Group**	**Baseline**	**Denom.**	**Evaluation**	**Denom.**	**Change**
	Hispanic/ Latino	Non-TI	46.6%	2,251	41.8%	2,182	-4.8%
		TI	37.2%	519	37.4%	578	0.2%
	P-Value		0.0001		0.0543		
	Multiracial and/or Multiethnic	Non-TI	44.1%	9,918	41.8%	2,182	-2.3%
		TI	40.8%	1,944	37.4%	578	-3.4%
	P-Value		0.0071		<.0001		
	White	Non-TI	42.0%	7,578	39.7%	7,173	-2.3%
		TI	38.2%	1,560	36.5%	1,761	-1.7%
	P-Value		0.0057		0.0152		
Age Group	18 to 24	Non-TI	41.8%	7,630	40.9%	7,245	-0.9%
		TI	38.1%	1,558	37.5%	1,696	-0.6%
	P-Value		0.0069		0.0094		
	25 to 34	Non-TI	43.3%	12,999	40.8%	12,378	-2.6%

Measure 3-17: Timeliness of postpartum care							
Demographic Variable	**Subgroup**	**Group**	**Baseline**	**Denom.**	**Evaluation**	**Denom.**	**Change**
		TI	40.1%	2,857	36.1%	3,339	-4.0%
	P-Value		0.0019		<.0001		
	35 to 44	Non-TI	42.8%	2,966	40.8%	2,969	-2.0%
		TI	34.8%	764	39.9%	864	5.1%
	P-Value		<.0001		0.5145		

Research Question 3.6: Have health disparities related to ED and IP utilization been reduced among adults attributed to TI 2.0 providers compared to prior to the demonstration?

Key Findings

- While the total number of ED visits among TI-attributed adult patients increased, the percentage of potentially avoidable ED visits decreased significantly, suggesting that the program may have contributed to more appropriate use of emergency care.
- Among patients who live in urban areas, those attributed to TI had a greater reduction in potentially avoidable ED visits (15.5%) compared to non-TI patients (14.1%).

Two claims-based measures assessed ED utilization among adult beneficiaries. Only non-SMI and non-Medicare enrolled adult beneficiaries were used in this analysis.

ED Utilization		FFY 2022	FFY 2023
3-18	Number of ED visits among adult beneficiaries	132,457	145,046

	ED Utilization	FFY 2022	FFY 2023
3-19	Number of potentially avoidable ED visits among adult beneficiaries	39,712 (30%)	21,404 (14.8%)

Measure 3-18: Number of ED visits among adult beneficiaries

Evaluation Year	Group	Time Period: Baseline	Time Period: Evaluation	DiD Log-Odds Estimate (p-value)	DiD Odds Ratio [95% CI]
2023	TI	132,457 *N = 68,524*	145,046 *N = 74,131*	0.011 (0.02)	1.011 [1.002, 1.02]
	Non-TI	370,857 *N = 194,187*	367,932 *N = 192,406*		

Note: N represents the count of unique patients.

Measure 3-19: Number of potentially avoidable ED visits among adult beneficiaries

Evaluation Year	Group	Time Period: Baseline	Time Period: Evaluation	DiD Log-Odds Estimate (p-value)	DiD Odds Ratio [95% CI]
2023	TI	39,712 (30%) *N = 132,457*	21,404 (14.8%) *N = 145,046*	-0.028 (<0.0001)	0.972 [0.967, 0.977]

Measure 3-19: Number of potentially avoidable ED visits among adult beneficiaries					
		Time Period			
Evaluation Year	Group	Baseline	Evaluation	DiD Log-Odds Estimate (p-value)	DiD Odds Ratio [95% CI]
	Non-TI	108,047 (29.1%) *N = 370,857*	57,723 (15.7%) *N = 367,932*		

Note: N represents the weighted denominator count.

Measure 3-19: Number of potentially avoidable ED visits among adult beneficiaries							
Demographic Variable	Subgroup	Group	Baseline	Denom.	Evaluation	Denom.	Change
Sex	Female	Non-TI	28.5%	226,257	14.7%	226,045	-13.7%
		TI	29.5%	81,454	13.8%	89,732	-15.7%
	P-Value		<.0001		<.0001		
	Male	Non-TI	30.1%	144,600	17.2%	141,887	-13.0%
		TI	30.8%	51,003	16.3%	55,314	-14.5%
	P-Value		0.007		<.0001		
Geography	Rural	Non-TI	32.2%	58,544	22.2%	56,884	-10.0%

Measure 3-19: Number of potentially avoidable ED visits among adult beneficiaries							
Demographic Variable	**Subgroup**	**Group**	**Baseline**	**Denom.**	**Evaluation**	**Denom.**	**Change**
		TI	27.3%	7,087	17.5%	7,403	-9.9%
	P-Value		<.0001		<.0001		
	Urban	Non-TI	28.6%	311,490	14.5%	310,146	-14.1%
		TI	30.1%	124,908	14.6%	136,934	-15.5%
	P-Value		<.0001		0.2859		
Language Spoken	English	Non-TI	29.2%	343,036	15.7%	338,011	-13.5%
		TI	29.9%	122,981	14.5%	133,684	-15.4%
	P-Value		<.0001		<.0001		
	Spanish	Non-TI	28.4%	25,279	16.0%	27,302	-12.5%
		TI	31.4%	8,375	17.7%	10,255	-13.7%
	P-Value		<.0001		<.0001		
Race/ Ethnicity	Black	Non-TI	32.0%	38,976	15.6%	39,233	-16.4%
		TI	33.4%	18,530	15.8%	19,579	-17.6%
	P-Value		0.0009		0.5865		

Measure 3-19: Number of potentially avoidable ED visits among adult beneficiaries							
Demographic Variable	**Subgroup**	**Group**	**Baseline**	**Denom.**	**Evaluation**	**Denom.**	**Change**
	Hispanic/ Latino	Non-TI	29.4%	34,426	15.5%	35,233	-13.9%
		TI	30.7%	13,501	15.5%	15,177	-15.2%
	P-Value		0.0061		0.9635		
	Multiracial and/or Multiethnic	Non-TI	30.2%	102,326	16.4%	104,693	-13.9%
		TI	32.2%	33,948	16.1%	38,295	-16.2%
	P-Value		<.0001		0.1471		
	White	Non-TI	27.9%	160,563	15.3%	154,878	-12.7%
		TI	27.8%	54,395	13.6%	59,287	-14.2%
	P-Value		0.5335		<.0001		
Age Group	25 to 34	Non-TI	30.8%	102,667	16.6%	99,875	-14.3%
		TI	31.4%	36,458	15.6%	39,112	-15.8%
	P-Value		0.0339		<.0001		
	35 to 44	Non-TI	29.4%	82,239	15.3%	82,601	-14.1%

Measure 3-19: Number of potentially avoidable ED visits among adult beneficiaries							
Demographic Variable	**Subgroup**	**Group**	**Baseline**	**Denom.**	**Evaluation**	**Denom.**	**Change**
		TI	29.7%	30,225	14.0%	32,872	-15.7%
	P-Value		0.3871		<.0001		

Research Question 3.7: Have health disparities related to treatment or management of behavioral health concerns been reduced among adults attributed to TI 2.0 providers compared to prior to the demonstration?

Key Findings

- TI-attributed adults outperformed non-TI adults on all measures related to treatment or management of behavioral health concerns. For the FUH 7-day measure, TI providers performed 26.6 percentage points higher in FFY 2022 and 30.5 percentage points higher in FFY 2023 compared to non-TI providers.
- For many measures, there were statistically significant differences in performance at both baseline and evaluation between various demographic subgroups across the TI and non-TI attributed populations. White patients in both TI and non-TI groups tended to have higher performance on the metrics than non-White patients, although other racial and ethnic groups also showed improvements over time.

Nine performance measures were used to assess disparities in the treatment or management of behavioral health concerns among adult beneficiaries.

	Behavioral Health Management	FFY 2022	FFY 2023
3-20	Percentage of adult beneficiaries with a follow-up visit within seven days after hospitalization for mental illness	63.8%	65.5%
3-21	Percentage of adult beneficiaries with a follow-up visit within thirty days after hospitalization for mental illness	82%	83.4%

	Behavioral Health Management	FFY 2022	FFY 2023
3-22	Percentage of adult beneficiaries with a follow-up visit within seven days after an ED visit for mental illness	59.2%	57.8%
3-23	Percentage of adult beneficiaries with a follow-up visit within thirty days after an ED visit for mental illness	72.7%	72.2%
3-24	Percentage of adult beneficiaries who had initiation of SUD treatment		
	Total	51.7%	50.3%
	Alcohol	51.2%	52.2%
	Opioid	67.3%	66.4%
	Other Drug	50.1%	48.7%
3-25	Percentage of adult beneficiaries who had engagement of SUD treatment		
	Total	21.1%	21.8%
	Alcohol	20%	22.7%
	Opioid	36.2%	35.8%
	Other Drug	17.6%	18.7%
3-26	Percentage of adult beneficiaries with a follow-up visit within seven days after an ED visit for SUD	51.4%	48.9%
3-27	Percentage of adult beneficiaries with a follow-up visit within thirty days after an ED visit for SUD	66.7%	65.2%

Behavioral Health Management		FFY 2022	FFY 2023
3-28	Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications	75%	74.7%

Measure 3-20: Percentage of adult beneficiaries with a follow-up visit within seven days after hospitalization for mental illness					
		Time Period			
Evaluation Year	Group	Baseline	Evaluation	DiD Log-Odds Estimate (p-value)	DiD Odds Ratio [95% CI]
2023	TI	63.8% *N = 15,627*	65.5% *N = 15,990*	0.043 (0.0001)	1.043 [1.02, 1.07]
	Non-TI	37.2% *N = 6,664*	35% *N = 6,007*		

Note: N represents the weighted denominator count.

Measure 3-20: Percentage of adult beneficiaries with a follow-up visit within seven days after hospitalization for mental illness							
Demographic Variable	Subgroup	Group	Baseline	Denom.	Evaluation	Denom.	Change
Sex	Female	Non-TI	38.2%	2,712	34.6%	2,461	-3.6%
		TI	65.6%	7,078	67.4%	7,321	1.8%
	P-Value		<.0001		<.0001		

Measure 3-20: Percentage of adult beneficiaries with a follow-up visit within seven days after hospitalization for mental illness							
Demographic Variable	**Subgroup**	**Group**	**Baseline**	**Denom.**	**Evaluation**	**Denom.**	**Change**
	Male	Non-TI	36.5%	3,952	35.2%	3,546	-1.3%
		TI	62.4%	8,549	64.0%	8,669	1.6%
	P-Value		<.0001		<.0001		
Geography	Rural	Non-TI	42.4%	728	37.0%	664	-5.4%
		TI	63.9%	1,182	63.8%	1,232	-0.1%
	P-Value		<.0001		<.0001		
	Urban	Non-TI	36.6%	5,928	34.7%	5,333	-1.8%
		TI	63.8%	14,404	65.6%	14,711	1.8%
	P-Value		<.0001		<.0001		
Language Spoken	English	Non-TI	37.2%	6,540	34.9%	5,873	-2.3%
		TI	63.8%	15,313	65.5%	15,603	1.7%
	P-Value		<.0001		<.0001		
	Spanish	Non-TI	35.8%	109	37.6%	125	1.8%

Measure 3-20: Percentage of adult beneficiaries with a follow-up visit within seven days after hospitalization for mental illness							
Demographic Variable	**Subgroup**	**Group**	**Baseline**	**Denom.**	**Evaluation**	**Denom.**	**Change**
		TI	64.6%	288	64.4%	351	-0.2%
	P-Value		<.0001		<.0001		
Race/ Ethnicity	Black	Non-TI	34.5%	751	33.8%	733	-0.7%
		TI	57.3%	1,731	60.7%	1,922	3.4%
	P-Value		<.0001		<.0001		
	Hispanic/ Latino	Non-TI	34.2%	421	36.4%	368	2.2%
		TI	64.1%	1,104	66.3%	1,214	2.2%
	P-Value		<.0001		<.0001		
	Multiracial and/or Multiethnic	Non-TI	37.5%	1,202	34.4%	1,069	-3.1%
		TI	61.9%	2,595	64.9%	2,734	3.0%
	P-Value		<.0001		<.0001		
	White	Non-TI	39.2%	3,533	35.6%	3,162	-3.5%
		TI	65.9%	8,507	66.7%	8,544	0.8%

Measure 3-20: Percentage of adult beneficiaries with a follow-up visit within seven days after hospitalization for mental illness							
Demographic Variable	**Subgroup**	**Group**	**Baseline**	**Denom.**	**Evaluation**	**Denom.**	**Change**
	P-Value		<.0001		<.0001		
Age Group	18 to 24	Non-TI	31.5%	1,156	29.4%	1,074	-2.1%
		TI	64.7%	2,484	66.4%	2,509	1.7%
	P-Value		<.0001		<.0001		
	25 to 34	Non-TI	38.3%	2,180	36.8%	1,861	-1.5%
		TI	64.0%	4,669	65.5%	4,667	1.5%
	P-Value		<.0001		<.0001		

Measure 3-21: Percentage of adult beneficiaries with a follow-up visit within thirty days after hospitalization for mental illness					
		Time Period			
Evaluation Year	**Group**	**Baseline**	**Evaluation**	**DiD Log-Odds Estimate** (p-value)	**DiD Odds Ratio** [95% CI]
2023	TI	82% *N = 15,627*	83.4% *N = 15,990*	0.037 (0.002)	1.037 [1.014, 1.061]
	Non-TI	50.8% *N = 6,664*	49.4% *N = 6,007*		

Note: N represents the weighted denominator count.

Measure 3-21: Percentage of adult beneficiaries with a follow-up visit within thirty days after hospitalization for mental illness							
Demographic Variable	**Subgroup**	**Group**	**Baseline**	**Denom.**	**Evaluation**	**Denom.**	**Change**
Sex	Female	Non-TI	51.4%	2,712	49.5%	2,461	-1.9%
		TI	84.2%	7,078	85.5%	7,321	1.3%
	P-Value		<.0001		<.0001		
	Male	Non-TI	50.3%	3,952	49.4%	3,546	-0.9%
		TI	80.2%	8,549	81.6%	8,669	1.4%

Measure 3-21: Percentage of adult beneficiaries with a follow-up visit within thirty days after hospitalization for mental illness							
Demographic Variable	**Subgroup**	**Group**	**Baseline**	**Denom.**	**Evaluation**	**Denom.**	**Change**
	P-Value		<.0001		<.0001		
Geography	Rural	Non-TI	55.9%	728	52.0%	664	-3.9%
		TI	83.2%	1,182	83.4%	1,232	0.2%
	P-Value		<.0001		<.0001		
	Urban	Non-TI	50.1%	5,928	49.1%	5,333	-1.0%
		TI	81.9%	14,404	83.3%	14,711	1.4%
	P-Value		<.0001		<.0001		
Language Spoken	English	Non-TI	50.8%	6,540	49.3%	5,873	-1.5%
		TI	81.9%	15,313	83.4%	15,603	1.4%
	P-Value		<.0001		<.0001		
	Spanish	Non-TI	47.7%	109	55.2%	125	7.5%
		TI	84.4%	288	82.9%	351	-1.5%
	P-Value		<.0001		<.0001		

Measure 3-21: Percentage of adult beneficiaries with a follow-up visit within thirty days after hospitalization for mental illness							
Demographic Variable	**Subgroup**	**Group**	**Baseline**	**Denom.**	**Evaluation**	**Denom.**	**Change**
Race/ Ethnicity	Black	Non-TI	47.0%	751	46.9%	733	-0.1%
		TI	78.3%	1,731	79.1%	1,922	0.7%
	P-Value		<.0001		<.0001		
	Hispanic/ Latino	Non-TI	49.4%	421	52.7%	368	3.3%
		TI	83.9%	1,104	83.4%	1,214	-0.5%
	P-Value		<.0001		<.0001		
	Multiracial and/or Multiethnic	Non-TI	51.1%	1,202	49.8%	1,069	-1.3%
		TI	80.7%	2,595	82.6%	2,734	1.9%
	P-Value		<.0001		<.0001		
	White	Non-TI	53.0%	3,533	50.3%	3,162	-2.6%
		TI	83.0%	8,507	84.5%	8,544	1.4%
	P-Value		<.0001		<.0001		
Age Group	18 to 24	Non-TI	43.3%	1,156	43.9%	1,074	0.6%

Measure 3-21: Percentage of adult beneficiaries with a follow-up visit within thirty days after hospitalization for mental illness							
Demographic Variable	**Subgroup**	**Group**	**Baseline**	**Denom.**	**Evaluation**	**Denom.**	**Change**
		TI	83.0%	2,484	83.5%	2,509	0.4%
	P-Value		<.0001		<.0001		
	25 to 34	Non-TI	51.8%	2,180	50.9%	1,861	-0.9%
		TI	81.8%	4,669	82.9%	4,667	1.2%
	P-Value		<.0001		<.0001		

Measure 3-22: Percentage of adult beneficiaries with a follow-up visit within seven days after an ED visit for mental illness					
		Time Period			
Evaluation Year	**Group**	**Baseline**	**Evaluation**	**DiD Log-Odds Estimate** (p-value)	**DiD Odds Ratio** [95% CI]
2023	TI	59.2% *N = 2,466*	57.8% *N = 2,320*	0.049 (0.10)	1.05 [0.99, 1.11]
	Non-TI	20.1% *N = 1,242*	16.3% *N = 1,151*		

Note: N represents the weighted denominator count.

Measure 3-22: Percentage of adult beneficiaries with a follow-up visit within seven days after an ED visit for mental illness							
Demographic Variable	**Subgroup**	**Group**	**Baseline**	**Denom.**	**Evaluation**	**Denom.**	**Change**
Sex	Female	Non-TI	18.9%	593	14.8%	586	-4.0%
		TI	60.9%	1,258	58.0%	1,187	-2.9%
	P-Value		<.0001		<.0001		
	Male	Non-TI	21.3%	649	17.9%	565	-3.4%
		TI	57.5%	1,208	57.5%	1,133	0.1%
	P-Value		<.0001		<.0001		
Geography	Rural	Non-TI	17.1%	298	21.1%	943	4.0%
		TI	62.8%	325	58.7%	2,141	-4.1%
	P-Value		<.0001		<.0001		
	Urban	Non-TI	16.0%	231	16.3%	918	0.3%
		TI	59.5%	326	57.5%	1,984	-2.0%
	P-Value		<.0001		<.0001		
Language Spoken	English	Non-TI	20.4%	1,194	11.1%	45	-9.3%

Measure 3-22: Percentage of adult beneficiaries with a follow-up visit within seven days after an ED visit for mental illness							
Demographic Variable	**Subgroup**	**Group**	**Baseline**	**Denom.**	**Evaluation**	**Denom.**	**Change**
		TI	58.9%	2,394	69.5%	59	10.6%
	P-Value		<.0001		<.0001		
	Spanish	Non-TI	16.2%	1,092	19.2%	52	3.0%
		TI	57.5%	2,235	63.4%	82	5.9%
	P-Value		<.0001		<.0001		
Race/ Ethnicity	Black	Non-TI	12.8%	133	14.2%	127	1.4%
		TI	60.1%	291	54.6%	280	-5.5%
	P-Value		<.0001		<.0001		
	Hispanic/ Latino	Non-TI	21.6%	88	11.9%	84	-9.7%
		TI	63.2%	201	58.9%	168	-4.3%
	P-Value		<.0001		<.0001		
	Multiracial and/or Multiethnic	Non-TI	16.4%	220	16.9%	219	0.5%
		TI	58.4%	385	59.4%	426	0.9%

Measure 3-22: Percentage of adult beneficiaries with a follow-up visit within seven days after an ED visit for mental illness							
Demographic Variable	**Subgroup**	**Group**	**Baseline**	**Denom.**	**Evaluation**	**Denom.**	**Change**
	P-Value		<.0001		<.0001		
	White	Non-TI	21.4%	667	16.2%	587	-5.3%
		TI	58.1%	1,322	57.9%	1,171	-0.2%
	P-Value		<.0001		<.0001		
Age Group	25 to 34	Non-TI	19.9%	372	20.5%	317	0.6%
		TI	62.6%	652	58.8%	624	-3.8%
	P-Value		<.0001		<.0001		
	35 to 44	Non-TI	17.6%	296	17.9%	274	0.3%
		TI	51.8%	566	53.1%	490	1.3%
	P-Value		<.0001		<.0001		

Measure 3-23: Percentage of adult beneficiaries with a follow-up visit within thirty days after an ED visit for mental illness					
		Time Period			
Evaluation Year	Group	Baseline	Evaluation	DiD Log-Odds Estimate (p-value)	DiD Odds Ratio [95% CI]
2023	TI	72.7% *N = 2,466*	72.2% *N = 2,320*	0.05 (0.07)	1.051 [0.99, 1.11]
	Non-TI	28.3% *N = 1,242*	24% *N = 1,151*		

Note: N represents the weighted denominator count.

Measure 3-23: Percentage of adult beneficiaries with a follow-up visit within thirty days after an ED visit for mental illness							
Demographic Variable	Subgroup	Group	Baseline	Denom.	Evaluation	Denom.	Change
Sex	Female	Non-TI	28.2%	593	23.7%	586	-4.4%
		TI	74.1%	1,258	73.1%	1,187	-1.0%
	P-Value		<.0001		<.0001		
	Male	Non-TI	28.5%	649	24.2%	565	-4.3%
		TI	71.4%	1,208	71.3%	1,133	0.0%

Measure 3-23: Percentage of adult beneficiaries with a follow-up visit within thirty days after an ED visit for mental illness							
Demographic Variable	**Subgroup**	**Group**	**Baseline**	**Denom.**	**Evaluation**	**Denom.**	**Change**
	P-Value		<.0001		<.0001		
Geography	Rural	Non-TI	24.5%	298	23.4%	943	-1.1%
		TI	77.8%	325	73.3%	2,141	-4.5%
	P-Value		<.0001		<.0001		
	Urban	Non-TI	29.6%	231	24.1%	918	-5.5%
		TI	72.0%	326	72.0%	1,984	0.1%
	P-Value		<.0001		<.0001		
Language Spoken	English	Non-TI	29.0%	1,194	23.7%	45	-5.3%
		TI	72.4%	2,394	72.2%	59	-0.2%
	P-Value		<.0001		<.0001		
	Spanish	Non-TI	11.1%	1,092	30.8%	52	19.7%
		TI	83.1%	2,235	73.2%	82	-9.9%
	P-Value		<.0001		<.0001		

Measure 3-23: Percentage of adult beneficiaries with a follow-up visit within thirty days after an ED visit for mental illness							
Demographic Variable	**Subgroup**	**Group**	**Baseline**	**Denom.**	**Evaluation**	**Denom.**	**Change**
Race/ Ethnicity	Black	Non-TI	18.0%	133	21.3%	127	3.2%
		TI	73.5%	291	70.4%	280	-3.2%
	P-Value		<.0001		<.0001		
	Hispanic/ Latino	Non-TI	29.5%	88	16.7%	84	-12.9%
		TI	72.6%	201	75.6%	168	3.0%
	P-Value		<.0001		<.0001		
	Multiracial and/or Multiethnic	Non-TI	25.9%	220	26.9%	219	1.0%
		TI	72.5%	385	70.9%	426	-1.6%
	P-Value		<.0001		<.0001		
	White	Non-TI	29.8%	667	23.7%	587	-6.2%
		TI	72.5%	1,322	72.6%	1,171	0.1%
	P-Value		<.0001		<.0001		
Age Group	25 to 34	Non-TI	28.2%	372	27.4%	317	-0.8%

Measure 3-23: Percentage of adult beneficiaries with a follow-up visit within thirty days after an ED visit for mental illness							
Demographic Variable	**Subgroup**	**Group**	**Baseline**	**Denom.**	**Evaluation**	**Denom.**	**Change**
		TI	75.0%	652	72.4%	624	-2.6%
	P-Value		<.0001		<.0001		
	35 to 44	Non-TI	26.7%	296	25.9%	274	-0.8%
		TI	67.5%	566	69.0%	490	1.5%
	P-Value		<.0001		<.0001		

Measure 3-24: Percentage of adult beneficiaries who had initiation of SUD treatment - Total					
		Time Period			
Evaluation Year	**Group**	**Baseline**	**Evaluation**	**DiD Log-Odds Estimate** (p-value)	**DiD Odds Ratio** [95% CI]
2023	TI	51.7% *N = 17,490*	50.3% *N = 19,257*	-0.01 (0.09)	0.99 [0.98, 1.0]
	Non-TI	47% *N = 30,070*	46.7% *N = 32,301*		

Note: N represents the weighted denominator count.

Measure 3-24: Percentage of adult beneficiaries who had initiation of SUD treatment - Total							
Demographic Variable	**Subgroup**	**Group**	**Baseline**	**Denom.**	**Evaluation**	**Denom.**	**Change**
Sex	Female	Non-TI	44.2%	12,973	43.4%	13,898	-0.9%
		TI	49.7%	8,569	47.4%	9,461	-2.3%
	P-Value		<.0001		<.0001		
	Male	Non-TI	49.1%	17,097	49.1%	18,403	0.1%
		TI	53.6%	8,921	53.0%	9,796	-0.6%
	P-Value		<.0001		<.0001		
Geography	Rural	Non-TI	39.0%	4,853	39.4%	5,071	0.3%
		TI	48.1%	1,503	46.4%	1,563	-1.7%
	P-Value		<.0001		<.0001		
	Urban	Non-TI	48.5%	25,153	48.0%	27,164	-0.5%
		TI	52.1%	15,944	50.6%	17,637	-1.4%
	P-Value		<.0001		<.0001		
Language Spoken	English	Non-TI	47.3%	29,036	47.1%	31,117	-0.2%

Measure 3-24: Percentage of adult beneficiaries who had initiation of SUD treatment - Total							
Demographic Variable	**Subgroup**	**Group**	**Baseline**	**Denom.**	**Evaluation**	**Denom.**	**Change**
		TI	51.9%	17,050	50.4%	18,750	-1.5%
	P-Value		<.0001		<.0001		
	Spanish	Non-TI	38.9%	981	35.6%	1,117	-3.3%
		TI	44.8%	415	45.4%	474	0.5%
	P-Value		0.041		0.0003		
Race/ Ethnicity	Black	Non-TI	47.3%	2,789	47.8%	3,189	0.5%
		TI	51.8%	1,818	48.2%	2,170	-3.5%
	P-Value		0.003		0.724		
	Hispanic/ Latino	Non-TI	46.0%	2,413	44.4%	2,609	-1.6%
		TI	47.9%	1,398	47.5%	1,463	-0.3%
	P-Value		0.2691		0.0581		
	Multiracial and/or Multiethnic	Non-TI	47.2%	6,618	46.6%	7,219	-0.6%
		TI	53.0%	3,567	51.0%	3,975	-2.0%

Measure 3-24: Percentage of adult beneficiaries who had initiation of SUD treatment - Total							
Demographic Variable	**Subgroup**	**Group**	**Baseline**	**Denom.**	**Evaluation**	**Denom.**	**Change**
	P-Value		<.0001		<.0001		
	White	Non-TI	47.8%	15,185	47.3%	16,183	-0.5%
		TI	51.8%	9,254	50.8%	10,109	-1.0%
	P-Value		<.0001		<.0001		
45 to 54	25 to 34	Non-TI	51.7%	7,807	51.2%	8,151	-0.5%
		TI	55.9%	4,685	52.6%	4,998	-3.3%
	P-Value		<.0001		0.1176		
	35 to 44	Non-TI	49.8%	7,082	50.1%	7,638	0.3%
		TI	54.5%	4,300	53.5%	4,728	-1.0%
	P-Value		<.0001		0.0002		

Measure 3-24: Percentage of adult beneficiaries who had initiation of SUD treatment - Alcohol, Opioid, or Other Drug					
		Time Period			
Evaluation Year	**Group**	**Baseline**	**Evaluation**	**DiD Log-Odds Estimate** (p-value)	**DiD Odds Ratio** [95% CI]
Alcohol					
2023	TI	51.2% *N = 5,896*	52.2% *N = 6,692*	-0.02 (0.08)	0.98 [0.96, 1.0]
	Non-TI	41.7% *N = 10,671*	44.7% *N = 11,412*		
Opioid					
2023	TI	67.3% *N = 4,222*	66.4% *N = 4,371*	0.005 (0.74)	1.0 [0.98, 1.03]
	Non-TI	67.6% *N = 8,115*	66.3% *N = 8,505*		
Other Drug					
2023	TI	50.1% *N = 9,526*	48.7% *N = 10,627*	-0.005 (0.55)	0.99 [0.98, 1.01]
	Non-TI	45.1% *N = 14,760*	44.2% *N = 16,439*		

Note: N represents the weighted denominator count.

Measure 3-25: Percentage of adult beneficiaries who had engagement of SUD treatment - Total					
		Time Period			
Evaluation Year	Group	Baseline	Evaluation	DiD Log-Odds Estimate (p-value)	DiD Odds Ratio [95% CI]
2023	TI	21.1% *N = 17,463*	21.8% *N = 19,226*	-0.003 (0.74)	1.0 [0.98, 1.01]
	Non-TI	17% *N = 30,051*	17.7% *N = 32,285*		

Note: N represents the weighted denominator count.

Measure 3-25: Percentage of adult beneficiaries who had engagement of SUD treatment - Total							
Demographic Variable	Subgroup	Group	Baseline	Denom.	Evaluation	Denom.	Change
Sex	Female	Non-TI	15.2%	12,965	15.6%	13,889	0.4%
		TI	20.8%	8,557	19.7%	9,449	-1.1%
	P-Value		<.0001		<.0001		
	Male	Non-TI	18.4%	17,086	19.3%	18,396	0.9%
		TI	21.4%	8,906	23.7%	9,777	2.3%

Measure 3-25: Percentage of adult beneficiaries who had engagement of SUD treatment - Total							
Demographic Variable	**Subgroup**	**Group**	**Baseline**	**Denom.**	**Evaluation**	**Denom.**	**Change**
	P-Value		<.0001		<.0001		
Geography	Rural	Non-TI	13.5%	4,851	13.7%	5,069	0.2%
		TI	19.9%	1,498	21.5%	1,560	1.6%
	P-Value		<.0001		<.0001		
	Urban	Non-TI	17.7%	25,136	18.5%	27,150	0.8%
		TI	21.3%	15,922	21.8%	17,610	0.5%
	P-Value		<.0001		<.0001		
Language Spoken	English	Non-TI	17.3%	29,017	18.0%	31,101	0.7%
		TI	21.3%	17,023	21.9%	18,719	0.6%
	P-Value		<.0001		<.0001		
	Spanish	Non-TI	11.2%	981	11.5%	1,117	0.2%
		TI	14.2%		16.2%	474	2.0%
	P-Value		0.1158		0.0092		

Measure 3-25: Percentage of adult beneficiaries who had engagement of SUD treatment - Total							
Demographic Variable	**Subgroup**	**Group**	**Baseline**	**Denom.**	**Evaluation**	**Denom.**	**Change**
Race/ Ethnicity	Black	Non-TI	15.8%	2,787	19.0%	3,186	3.3%
		TI	19.9%	1,813	20.3%	2,164	0.4%
	P-Value		0.0003		0.2517		
	Hispanic/ Latino	Non-TI	16.3%	2,411	16.8%	2,607	0.6%
		TI	20.1%	1,395	18.0%	1,463	-2.0%
	P-Value		0.003		0.3288		
	Multiracial and/or Multiethnic	Non-TI	18.8%	6,616	19.2%	7,218	0.4%
		TI	23.9%	3,564	24.0%	3,967	0.1%
	P-Value		<.0001		<.0001		
	White	Non-TI	17.3%	15,175	17.2%	16,175	-0.1%
		TI	20.7%	9,242	21.7%	10,095	0.9%
	P-Value		<.0001		<.0001		
Age Group	0 to 2	Non-TI	22.9%	7,805	22.9%	8,148	-0.1%

Measure 3-25: Percentage of adult beneficiaries who had engagement of SUD treatment - Total							
Demographic Variable	**Subgroup**	**Group**	**Baseline**	**Denom.**	**Evaluation**	**Denom.**	**Change**
		TI	26.5%	4,679	25.7%	4,991	-0.8%
	P-Value		<.0001		0.0002		
	3 to 5	Non-TI	20.6%	7,076	21.9%	7,634	1.3%
		TI	24.1%	4,296	25.8%	4,720	1.8%
	P-Value		<.0001		<.0001		

Measure 3-25: Percentage of adult beneficiaries who had engagement of SUD treatment - Alcohol, Opioid, or Other Drug					
		Time Period			
Evaluation Year	**Group**	**Baseline**	**Evaluation**	**DiD Log-Odds Estimate** (p-value)	**DiD Odds Ratio** [95% CI]
Alcohol					
2023	TI	20% *N = 5,896*	22.7% *N = 6,692*	-0.03 (0.04)	0.97 [0.94, 0.99]
	Non-TI	11.2% *N = 10,671*	14.4% *N = 11,412*		
Opioid					

Measure 3-25: Percentage of adult beneficiaries who had engagement of SUD treatment - Alcohol, Opioid, or Other Drug					
		Time Period			
Evaluation Year	Group	Baseline	Evaluation	DiD Log-Odds Estimate (p-value)	DiD Odds Ratio [95% CI]
2023	TI	36.2% *N = 4,222*	35.8% *N = 4,371*	0.01 (0.61)	1.01 [0.98, 1.04]
	Non-TI	35.2% *N = 8,115*	34.2% *N = 8,505*		
Other Drugs					
2023	TI	17.6% *N = 9,526*	18.7% *N = 10,627*	-0.003 (0.83)	1.0 [0.97, 1.02]
	Non-TI	12.7% *N = 14,760*	13.6% *N = 16,439*		

Note: N represents the weighted denominator count.

Measure 3-26: Percentage of adult beneficiaries with a follow-up visit within seven days after an ED visit for SUD					
		Time Period			
Evaluation Year	Group	Baseline	Evaluation	DiD Log-Odds Estimate (p-value)	DiD Odds Ratio [95% CI]
2023	TI	51.4% *N = 4,645*	48.9% *N = 4,718*	-0.01 (0.64)	0.99 [0.96, 1.02]

Measure 3-26: Percentage of adult beneficiaries with a follow-up visit within seven days after an ED visit for SUD					
		Time Period			
Evaluation Year	**Group**	**Baseline**	**Evaluation**	**DiD Log-Odds Estimate** (p-value)	**DiD Odds Ratio** [95% CI]
	Non-TI	21.6% *N = 5,844*	20.4% *N = 5,790*		

Note: N represents the weighted denominator count.

Measure 3-26: Percentage of adult beneficiaries with a follow-up visit within seven days after an ED visit for SUD							
Demographic Variable	**Subgroup**	**Group**	**Baseline**	**Denom.**	**Evaluation**	**Denom.**	**Change**
Sex	Female	Non-TI	20.3%	2,148	20.3%	2,119	0.1%
		TI	49.5%	1,887	49.0%	1,944	-0.5%
	P-Value		<.0001		<.0001		
	Male	Non-TI	22.4%	3,696	20.5%	3,671	-1.9%
		TI	52.6%	2,758	48.8%	2,774	-3.8%
	P-Value		<.0001		<.0001		
Geography	Rural	Non-TI	20.8%	1,035	22.3%	955	1.5%

Measure 3-26: Percentage of adult beneficiaries with a follow-up visit within seven days after an ED visit for SUD							
Demographic Variable	**Subgroup**	**Group**	**Baseline**	**Denom.**	**Evaluation**	**Denom.**	**Change**
		TI	51.5%	501	51.2%	543	-0.3%
	P-Value		<.0001		<.0001		
	Urban	Non-TI	21.8%	4,798	20.1%	4,818	-1.7%
		TI	51.4%	4,136	48.6%	4,157	-2.8%
	P-Value		<.0001		<.0001		
Language Spoken	English	Non-TI	21.9%	5,657	20.6%	5,598	-1.3%
		TI	51.5%	4,538	49.2%	4,614	-2.3%
	P-Value		<.0001		<.0001		
	Spanish	Non-TI	14.5%	172	17.2%	180	2.7%
		TI	47.5%	101	36.1%	97	-11.4%
	P-Value		<.0001		0.0004		
Race/ Ethnicity	Black	Non-TI	22.0%	533	19.8%	580	-2.1%
		TI	49.8%	420	44.9%	472	-4.8%

Measure 3-26: Percentage of adult beneficiaries with a follow-up visit within seven days after an ED visit for SUD							
Demographic Variable	**Subgroup**	**Group**	**Baseline**	**Denom.**	**Evaluation**	**Denom.**	**Change**
	P-Value		<.0001		<.0001		
	Hispanic/ Latino	Non-TI	18.6%	462	18.4%	413	-0.2%
		TI	47.5%	358	44.2%	342	-3.3%
	P-Value		<.0001		<.0001		
	Multiracial and/or Multiethnic	Non-TI	20.5%	1,223	18.2%	1,261	-2.3%
		TI	48.7%	986	47.3%	935	-1.4%
	P-Value		<.0001		<.0001		
	White	Non-TI	21.9%	2,812	21.2%	2,728	-0.6%
		TI	53.0%	2,297	50.9%	2,472	-2.1%
	P-Value		<.0001		<.0001		
Age Group	55 to 64	Non-TI	21.0%	653	22.9%	707	1.9%
		TI	54.7%	554	49.3%	588	-5.4%
	P-Value		<.0001		<.0001		

Measure 3-26: Percentage of adult beneficiaries with a follow-up visit within seven days after an ED visit for SUD							
Demographic Variable	**Subgroup**	**Group**	**Baseline**	**Denom.**	**Evaluation**	**Denom.**	**Change**
	65 to 74	Non-TI	20.4%	181	17.3%	231	-3.1%
		TI	50.4%	115	48.8%	127	-1.6%
	P-Value		<.0001		<.0001		

Measure 3-27: Percentage of adult beneficiaries with a follow-up visit within thirty days after an ED visit for SUD					
		Time Period			
Evaluation Year	**Group**	**Baseline**	**Evaluation**	**DiD Log-Odds Estimate** (p-value)	**DiD Odds Ratio** [95% CI]
2023	TI	66.7% *N = 4,645*	65.2% *N = 4,718*	-0.003 (0.82)	1.0 [0.97, 1.03]
	Non-TI	31% *N = 5,844*	29.8% *N = 5,790*		

Note: N represents the weighted denominator count.

Measure 3-27: Percentage of adult beneficiaries with a follow-up visit within thirty days after an ED visit for SUD							
Demographic Variable	**Subgroup**	**Group**	**Baseline**	**Denom.**	**Evaluation**	**Denom.**	**Change**
Sex	Female	Non-TI	30.9%	2,148	31.0%	2,119	0.1%
		TI	65.6%	1,887	66.7%	1,944	1.1%
	P-Value		<.0001		<.0001		
	Male	Non-TI	31.1%	3,696	29.2%	3,671	-1.9%
		TI	67.5%	2,758	64.1%	2,774	-3.4%
	P-Value		<.0001		<.0001		
Geography	Rural	Non-TI	30.6%	1,035	33.1%	955	2.5%
		TI	69.9%	501	70.2%	543	0.3%
	P-Value		<.0001		<.0001		
	Urban	Non-TI	31.1%	4,798	29.2%	4,818	-1.9%
		TI	66.4%	4,136	64.4%	4,157	-1.9%
	P-Value		<.0001		<.0001		
Language Spoken	English	Non-TI	31.3%	5,657	29.9%	5,598	-1.3%

Measure 3-27: Percentage of adult beneficiaries with a follow-up visit within thirty days after an ED visit for SUD							
Demographic Variable	**Subgroup**	**Group**	**Baseline**	**Denom.**	**Evaluation**	**Denom.**	**Change**
		TI	67.0%	4,538	65.5%	4,614	-1.5%
	P-Value		<.0001		<.0001		
	Spanish	Non-TI	23.8%	172	29.9%	5,598	6.1%
		TI	56.4%	101	65.5%	4,614	9.0%
	P-Value		<.0001		<.0001		
Race/ Ethnicity	Black	Non-TI	28.7%	533	28.1%	580	-0.6%
		TI	63.3%	420	59.3%	472	-4.0%
	P-Value		<.0001		<.0001		
	Hispanic/ Latino	Non-TI	26.2%	462	25.4%	413	-0.8%
		TI	63.7%	358	64.3%	342	0.6%
	P-Value		<.0001		<.0001		
	Multiracial and/or Multiethnic	Non-TI	26.4%	1,223	27.9%	1,261	1.5%
		TI	63.4%	986	62.0%	935	-1.4%

Measure 3-27: Percentage of adult beneficiaries with a follow-up visit within thirty days after an ED visit for SUD							
Demographic Variable	**Subgroup**	**Group**	**Baseline**	**Denom.**	**Evaluation**	**Denom.**	**Change**
	P-Value		<.0001		<.0001		
	White	Non-TI	33.6%	2,812	31.3%	2,728	-2.2%
		TI	69.5%	2,297	67.4%	2,472	-2.1%
	P-Value		<.0001		<.0001		
Age Group	18 to 24	Non-TI	19.6%	831	22.2%	801	2.6%
		TI	58.8%	522	57.2%	474	-1.6%
	P-Value		<.0001		<.0001		
	25 to 34	Non-TI	29.7%	1,819	28.6%	1,723	-1.1%
		TI	64.8%	1,442	63.4%	1,376	-1.4%
	P-Value		<.0001		<.0001		

Measure 3-28: Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications					
		Time Period			
Evaluation Year	Group	Baseline	Evaluation	DiD Log-Odds Estimate (p-value)	DiD Odds Ratio [95% CI]
2023	TI	75% *N = 22,868*	74.7% *N = 20,569*	-0.03 (0.009)	0.97 [0.95, 0.99]
	Non-TI	71.5% *N = 6,714*	73.5% *N = 6,071*		

Note: N represents the weighted denominator count.

Measure 3-28: Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications							
Demographic Variable	Subgroup	Group	Baseline	Denom.	Evaluation	Denom.	Change
Sex	Female	Non-TI	72.4%	3,526	75.2%	3,258	2.8%
		TI	75.8%	11,906	76.6%	10,692	0.8%
	P-Value		<.0001		0.0887		
	Male	Non-TI	70.5%	3,188	71.6%	2,813	1.1%
		TI	74.2%	10,962	72.6%	9,877	-1.6%

Measure 3-28: Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications							
Demographic Variable	**Subgroup**	**Group**	**Baseline**	**Denom.**	**Evaluation**	**Denom.**	**Change**
	P-Value		<.0001		0.2661		
Geography	Rural	Non-TI	75.3%	1,053	74.4%	1,032	-0.9%
		TI	77.2%	1,938	76.5%	1,884	-0.7%
	P-Value		0.2455		0.2129		
	Urban	Non-TI	70.8%	5,646	73.3%	5,027	2.5%
		TI	74.8%	20,865	74.5%	18,613	-0.3%
	P-Value		<.0001		0.0789		
Language Spoken	English	Non-TI	71.4%	6,589	73.5%	5,943	2.1%
		TI	75.0%	22,340	74.6%	20,042	-0.4%
	P-Value		<.0001		0.0911		
	Spanish	Non-TI	76.3%	118	74.8%	119	-1.5%
		TI	78.4%	458	79.2%	457	0.8%
	P-Value		0.6215		0.2972		

Measure 3-28: Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications							
Demographic Variable	**Subgroup**	**Group**	**Baseline**	**Denom.**	**Evaluation**	**Denom.**	**Change**
Race/ Ethnicity	Black	Non-TI	70.4%	621	74.2%	601	3.8%
		TI	73.0%	2,455	71.9%	2,211	-1.1%
	P-Value		0.1841		0.2641		
	Hispanic/ Latino	Non-TI	71.7%	367	67.6%	358	-4.1%
		TI	76.9%	1,799	74.1%	1,598	-2.8%
	P-Value		0.0331		0.0125		
	Multiracial and/or Multiethnic	Non-TI	71.8%	1,131	74.6%	1,025	2.8%
		TI	75.7%	3,421	75.7%	3,315	0.0%
	P-Value		0.0092		0.4816		
	White	Non-TI	71.9%	3,961	73.9%	3,576	2.1%
		TI	75.0%	13,136	75.3%	11,536	0.3%
	P-Value		<.0001		0.0906		
Age Group	35 to 44	Non-TI	71.1%	1,638	72.6%	1,510	1.6%

Measure 3-28: Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications							
Demographic Variable	**Subgroup**	**Group**	**Baseline**	**Denom.**	**Evaluation**	**Denom.**	**Change**
		TI	74.9%	5,819	74.8%	5,355	-0.1%
	P-Value		0.0018		0.0926		
	45 to 54	Non-TI	74.1%	1,176	75.1%	1,062	1.0%
		TI	74.2%	4,454	74.1%	3,805	-0.2%
	P-Value		0.9454		0.4761		

Hypothesis 4: The TI 2.0 program will improve the delivery of care for AHCCCS enrolled adults released from criminal justice facilities and who are referred to a TI Justice clinic.

Hypothesis 4 uses administrative TI program data, claims/encounter data, and beneficiary surveys to test whether the demonstration improves the delivery of care for AHCCCS enrolled adults eighteen years and older released from criminal justice facilities and who are referred to a TI Justice clinic. Eight research questions are used to assess Hypothesis 4. Results for measures in this section are representative of TI beneficiaries released during the year prior to each measurement year and were referred to a TI provider.

A synthetic Justice control group was used for Hypothesis 4 because a traditional control group was not available. This was created by combining data from similar comparison units to closely mirror the treated unit's outcomes and characteristics prior to the intervention. Matching was informed by the treated unit's performance outcomes and key covariates, including the attributed members' racial composition, urbanicity, primary language spoken, age, and sex. Weights for the comparison units were calculated separately for each measure where historical data was available and are listed for each respective measure. This synthetic control provides a baseline for estimating what would have happened to the treated unit in the absence of the

intervention, helping to isolate the effect of the intervention itself. Since synthetic controls represent weighted aggregates rather than individual patients, only Justice members were included in the health outcomes analysis. Synthetic control weights for each applicable measure can be found in the appendix.

Research Question 4.1: Do adult beneficiaries who are recently released from a criminal justice facility and who are referred to a TI Justice clinic have better care coordination than those who were not subject to the demonstration?

Key Findings

- 73.5% (N = 34 total respondents) of TI adult beneficiaries recently released from criminal justice facilities reported that their doctor usually or always seemed informed about the care they received from specialists.
- TI adult beneficiaries recently released from criminal justice facilities experienced better overall care coordination compared to the control group, although the difference was not statistically significant.
- Care coordination may vary by language among TI adult beneficiaries recently released from criminal justice facilities; English speakers demonstrated a slight increase in performance, whereas Spanish speakers, despite a small sample size, experienced a significant decrease.

One performance measure and one Justice beneficiary survey question assessed care coordination disparities among adult recently released beneficiaries. Beneficiary survey data prior to the demonstration period were unavailable at the time of the interim evaluation report; consequently, only Fall 2025 survey results are presented, and synthetic control weights could not be calculated for this measure.

Have care coordination disparities been reduced among recently released beneficiaries who were referred to a TI Justice clinic?

		TI Beneficiaries	
		Number of Responses	Rate
4-1	Recently released beneficiaries' response to their doctor seeming informed about the care they received from specialists	34	73.5%

Care Coordination		FFY 2022	FFY 2023
4-2	Percentage of recently released beneficiaries with patient engagement after discharge	50.9%	52%

Measure 4-2: Percentage of recently released beneficiaries with patient engagement after discharge					
		Time Period			
Evaluation Year	Group	Baseline	Evaluation	DiD Log-Odds Estimate (p-value)	DiD Odds Ratio [95% CI]
2023	TI	50.9% *N = 3,216*	52% *N = 2,148*	0.01 (0.85)	1.01 [0.93, 1.1]
	Synthetic Controls	51.5% *N = 274.33*	51.9% *N = 327.97*		

Note: N represents the weighted denominator count.

Measure 4-2: Percentage of recently released beneficiaries with patient engagement after discharge							
Demographic Variable	Subgroup	Group	Baseline	Denom.	Evaluation	Denom.	Change
Sex	Female	TI	51.5%	887	49.2%	592	-2.4%
	Male	TI	50.6%	2,329	53.1%	1,556	2.5%
Geography	Rural	TI	58.5%	212	50.9%	116	-7.6%

Measure 4-2: Percentage of recently released beneficiaries with patient engagement after discharge							
Demographic Variable	**Subgroup**	**Group**	**Baseline**	**Denom.**	**Evaluation**	**Denom.**	**Change**
	Urban	TI	50.3%	3,003	52.2%	2,026	1.9%
Language Spoken	English	TI	50.8%	3,198	52.2%	2,136	1.4%
	Spanish	TI	61.1%	18	25.0%	12	-36.1%
Race/ Ethnicity	Black	TI	48.8%	383	46.5%	254	-2.4%
	Hispanic/ Latino	TI	46.4%	220	51.7%	174	5.4%
	Multiracial and/or Multiethnic	TI	47.6%	722	47.1%	437	-0.5%
	White	TI	53.7%	1,692	54.9%	1,175	1.2%
Age Group	25 to 34	TI	46.4%	1,335	47.1%	879	0.7%
	35 to 44	TI	52.9%	926	54.9%	605	2.0%

Research Question 4.2: Do adult beneficiaries who are recently released from a criminal justice facility and who are referred to a TI Justice clinic have better general and mental health outcomes than those who were not subject to the demonstration?

Key Findings

- Among TI adult beneficiaries recently released from criminal justice facilities (N = 79), a smaller proportion rated their overall physical health as very good or excellent (24%) compared with their emotional or mental health (34.1%), suggesting that beneficiaries may perceive their mental well-being more positively than their physical health.

Two measures from the Justice beneficiary survey were used to assess research question 4.2. Beneficiary survey data prior to the demonstration period were unavailable at the time of the interim evaluation report; consequently, only Fall 2025 survey results are presented, and synthetic control weights could not be calculated for this measure.

Have general and mental health outcomes improved among recently released beneficiaries referred to TI?		TI Beneficiaries	
		Number of Responses	Rate
4-3	Percentage of recently released beneficiaries who reported a rating of overall health as very good or excellent	79	24%
4-4	Percentage of recently released beneficiaries who reported a rating of emotional or mental health as very good or excellent	79	34.1%

Research Question 4.3: Do adult beneficiaries who are recently released from a criminal justice facility and who are referred to a TI Justice clinic have higher rates of access to care than those who were not subject to the demonstration?

Key Findings

- Access to preventive and ambulatory care decreased among TI adult beneficiaries recently released from criminal justice facilities from baseline to evaluation.
- TI adult beneficiaries recently released from criminal justice facilities who identify as female consistently outperformed males at both baseline and evaluation. However, both females and males experienced declines in accessing preventive health services over time, with females showing a 4.1% decrease and males a slightly larger 5.0% decrease.
- Overall, most TI adult beneficiaries recently released from criminal justice facilities reported positive experiences with their doctors in terms of time spent (77.5%, N = 49) and receiving needed care promptly (71.1%, N = 45), though timely routine care appointments were slightly less consistent (63.2%, N = 68).

One performance measure and three Justice beneficiary survey questions assessed access-to-care rates among recently released beneficiaries.

	Preventive/Ambulatory Health Services	FFY 2022	FFY 2023
4-5	Percentage of recently released beneficiaries who accessed preventive/ambulatory health services	73.6%	68.7%

Measure 4-5: Percentage of recently released beneficiaries who accessed preventive/ambulatory health services				
		Time Period		
Evaluation Year	Group	Baseline	Evaluation	Change
2023	TI	73.6% *N = 8,996*	68.7% *N = 6,308*	-4.9%

Note: N represents the weighted denominator count.

Historical data for this measure were unavailable; therefore, synthetic control weights were not calculated, and no comparison could be made.

Measure 4-5: Percentage of recently released beneficiaries who accessed preventive/ambulatory health services							
Demographic Variable	Subgroup	Group	Baseline	Denom.	Evaluation	Denom.	Change
Sex	Female	TI	81.7%	2,549	77.6%	1,710	-4.1%
	Male	TI	70.5%	6,447	65.4%	4,598	-5.0%
Geography	Rural	TI	73.7%	653	71.8%	393	-1.9%

Measure 4-5: Percentage of recently released beneficiaries who accessed preventive/ambulatory health services							
Demographic Variable	**Subgroup**	**Group**	**Baseline**	**Denom.**	**Evaluation**	**Denom.**	**Change**
	Urban	TI	73.6%	8,326	68.5%	5,903	-5.1%
Language Spoken	English	TI	73.7%	8,841	68.8%	6,212	-4.9%
	Spanish	TI	68.9%	151	63.0%	92	-5.8%
Race/ Ethnicity	Black	TI	70.8%	1,093	65.0%	814	-5.8%
	Hispanic/ Latino	TI	69.5%	802	66.8%	621	-2.6%
	Multiracial and/or Multiethnic	TI	71.7%	2,159	67.3%	1,506	-4.4%
	White	TI	76.1%	4,362	71.5%	2,986	-4.6%
Age Group	18 to 24	TI	72.7%	2,877	67.6%	2,084	-5.1%
	25 to 34	TI	77.3%	1,394	72.1%	1,014	-5.2%

Beneficiary survey data prior to the demonstration period were unavailable at the time of the interim evaluation report; consequently, only the Fall 2025 survey results are presented, and synthetic control weights could not be calculated for this measure. Therefore, no comparison can be made.

Have disparities in access to care been reduced among recently released beneficiaries referred to TI?			
		TI Beneficiaries	
		Number of Responses	Rate
4-6	Percentage of recently released beneficiaries who reported that their doctor usually or always spent enough time with them	49	77.5%
4-7	Percentage of recently released beneficiaries who reported they received needed care right away as soon as they needed	45	71.1%
4-8	Percentage of recently released beneficiaries who reported they got an appointment for a checkup or routine care as soon as they needed	68	63.2%

Research Question 4.4: Do adult beneficiaries who are recently released from a criminal justice facility and who are referred to a TI Justice clinic have better experiences of care than those who were not subject to the demonstration?

Key Findings

- Overall, TI adult beneficiaries recently released from criminal justice facilities reported very positive experiences with their doctors, particularly in terms of clear communication (87.8%, N = 49), attentive listening (87.8%, N = 49), and respect for what they had to say (91.2%, N = 49).

Health disparities related to the experience of care among recently released beneficiaries were assessed using three Justice beneficiary survey questions and one administrative measure. Beneficiary survey data prior to the demonstration period were unavailable at the time of the interim evaluation report; consequently, only the Fall 2025

survey results are presented, and synthetic control weights could not be calculated for this measure. Therefore, no comparison can be made.

Have disparities in care experience among recently released beneficiaries referred to TI been reduced?			
		TI Beneficiaries	
		Number of Responses	Rate
4-9	Percentage of recently released beneficiaries who reported their doctor usually or always explained things in a way that was easy to understand	49	87.8%
4-10	Percentage of recently released beneficiaries who reported their doctor usually or always listened carefully to them	49	87.8%
4-11	Percentage of recently released beneficiaries who reported their doctor usually or always showed respect for what they had to say	49	91.2%

Culturally Sensitive Workforce		FFY 2022	FFY 2023
4-12	Percentage of recently released beneficiaries referred to a TI provider with the same race/ethnicity and/or language	–	–

Note: Results for measure 4-12 are not presented due to insufficient data.

Due to limitations in provider data availability, as described in the Methodology Limitations section, rates for a culturally sensitive workforce (Measure 4-12) could not be calculated and are therefore not reported.

Research Question 4.5: Do adult beneficiaries who are recently released from a criminal justice facility and who are referred to a TI Justice clinic have higher rates of SUD treatment and adherence than those who were not subject to the demonstration?

Key Findings

- Performance on SUD treatment initiation and engagement remained stable from 2022 to 2023 for recently released beneficiaries, showing no statistically significant differences when compared to the synthetic control.
- Initiation of SUD treatment increased slightly overall, driven primarily by a statistically significant improvement in opioid-related treatment initiation. Engagement in SUD treatment remained stable overall, with slight improvements observed in engagement for opioid- and alcohol-related treatment.
- TI adult beneficiaries recently released from criminal justice facilities aged 25–34 experienced improvements in both SUD treatment initiation and engagement.

Two performance measures were used to assess research question 4.5.

	SUD Treatment and Adherence	FFY 2022	FFY 2023
4-13	Percentage of recently released beneficiaries who had initiation of SUD treatment		
	Total	61.3%	63.1%
	Alcohol	62.1%	59.6%
	Opioid	77%	84.9%
	Other Drug	57.3%	56.6%
4-14	Percentage of recently released beneficiaries who had engagement of SUD treatment		
	Total	36.8%	36.3%
	Alcohol	34.7%	35.4%
	Opioid	48.8%	52%
	Other Drug	33.1%	29.2%

Measure 4-13: Percentage of recently released beneficiaries who had initiation of SUD treatment - Total					
		Time Period			
Evaluation Year	Group	Baseline	Evaluation	DiD Log-Odds Estimate (p-value)	DiD Odds Ratio [95% CI]
2023	TI	61.3% *N = 1,796*	63.1% *N = 1,038*	0.026 (0.67)	1.026 [0.91, 1.16]
	Synthetic Controls	64.6% *N = 150.30*	64% *N = 173.89*		

Note: N represents the weighted denominator count.

Measure 4-13: Percentage of recently released beneficiaries who had initiation of SUD treatment - Total							
Demographic Variable	Subgroup	Group	Baseline	Denom.	Evaluation	Denom.	Change
Sex	Female	TI	60.0%	503	60.1%	288	0.0%
	Male	TI	61.8%	1,293	64.3%	750	2.5%
Geography	Rural	TI	54.1%	157	60.4%	48	6.3%
	Urban	TI	62.0%	1,637	63.2%	988	1.2%
	English	TI	61.4%	1,759	63.6%	1,021	2.2%

Measure 4-13: Percentage of recently released beneficiaries who had initiation of SUD treatment - Total							
Demographic Variable	**Subgroup**	**Group**	**Baseline**	**Denom.**	**Evaluation**	**Denom.**	**Change**
Language Spoken	Spanish	TI	55.6%	36	35.3%	17	-20.3%
Race/ Ethnicity	Black	TI	58.3%	187	59.7%	139	1.4%
	Hispanic/ Latino	TI	59.6%	161	58.9%	90	-0.7%
	Multiracial and/or Multiethnic	TI	61.5%	496	65.5%	267	4.1%
	White	TI	63.0%	825	64.7%	476	1.7%
Age Group	18 to 24	TI	63.6%	151	51.6%	64	-12.0%
	25 to 34	TI	64.6%	683	69.8%	384	5.2%

Measure 4-13: Percentage of recently released beneficiaries who had initiation of SUD treatment - Alcohol, Opioid, or Other Drug					
		Time Period			
Evaluation Year	Group	Baseline	Evaluation	DiD Log-Odds Estimate (p-value)	DiD Odds Ratio [95% CI]
Alcohol					
2023	TI	62.1% *N = 441*	59.6% *N = 240*	-0.11 (0.37)	0.90 [0.71, 1.13]
	Synthetic Controls	63% *N = 39.94*	70.1% *N = 53.53*		
Opioid					
2023	TI	77% *N = 586*	84.9% *N = 377*	0.23 (0.01)	1.26 [1.05, 1.52]
	Synthetic Controls	83.2% *N = 101.67*	76.7% *N = 127.54*		
Other Drug					
2023	TI	57.3% *N = 1,106*	56.6% *N = 657*	-0.002 (0.99)	1.0 [0.84, 1.19]
	Synthetic Controls	62.3% *N = 66.39*	61.8% *N = 72.01*		

Note: N represents the weighted denominator count.

Measure 4-14: Percentage of recently released beneficiaries who had engagement of SUD treatment - Total					
		Time Period			
Evaluation Year	Group	Baseline	Evaluation	DiD Log-Odds Estimate (p-value)	DiD Odds Ratio [95% CI]
2023	TI	36.8% *N = 1,794*	36.3% *N = 1,038*	-0.03 (0.63)	0.97 [0.85, 1.1]
	Synthetic Controls	30.8% *N = 148.04*	33% *N = 154.27*		

Note: N represents the weighted denominator count.

Measure 4-14: Percentage of recently released beneficiaries who had engagement of SUD treatment - Total							
Demographic Variable	Subgroup	Group	Baseline	Denom.	Evaluation	Denom.	Change
Sex	Female	TI	36.5%	502	37.8%	288	1.4%
	Male	TI	37.0%	1,292	35.7%	750	-1.3%
Geography	Rural	TI	29.9%	157	37.5%	48	7.6%
	Urban	TI	37.5%	1,635	36.1%	988	-1.4%
	English	TI	36.9%	1,757	36.5%	1,021	-0.4%

Measure 4-14: Percentage of recently released beneficiaries who had engagement of SUD treatment - Total							
Demographic Variable	**Subgroup**	**Group**	**Baseline**	**Denom.**	**Evaluation**	**Denom.**	**Change**
Language Spoken	Spanish	TI	30.6%	36	23.5%	17	-7.0%
Race/ Ethnicity	Black	TI	32.1%	187	28.1%	139	-4.0%
	Hispanic/ Latino	TI	36.0%	161	33.3%	90	-2.7%
	Multiracial and/or Multiethnic	TI	37.6%	495	41.2%	267	3.6%
	White	TI	38.6%	824	37.0%	476	-1.6%
Age Group	25 to 34	TI	38.5%	683	43.5%	384	5.0%
	35 to 44	TI	36.9%	534	35.1%	319	-1.8%

Measure 4-14: Percentage of adult beneficiaries who had engagement of SUD treatment - Alcohol, Opioid, or Other Drug					
		Time Period			
Evaluation Year	Group	Baseline	Evaluation	DiD Log-Odds Estimate (p-value)	DiD Odds Ratio [95% CI]
Alcohol					
2023	TI	34.7% *N = 441*	35.4% *N = 240*	0.07 (0.62)	1.08 [0.81, 1.44]
	Synthetic Controls	42.6% *N = 23.67*	36.4% *N = 29.33*		
Opioid					
2023	TI	48.8% *N = 586*	52% *N = 377*	-0.01 (0.86)	0.99 [0.86, 1.14]
	Synthetic Controls	35.8% *N = 112.93*	40.1% *N = 145.03*		
Other Drugs					
2023	TI	33.1% *N = 1,106*	29.2% *N = 657*	-0.16 (0.1)	0.85 [0.7, 1.03]
	Synthetic Controls	23.6% *N = 67.88*	33.1% *N = 73.74*		

Note: N represents the weighted denominator count.

Research Question 4.6: Do adult beneficiaries recently released from a criminal justice facility and who are referred to a TI Justice clinic have lower rates of ED utilization than those who were not subject to the demonstration?

Key Findings

- Unlike adult and pediatric patients, the total number of ED visits among TI adult beneficiaries recently released from criminal justice facilities decreased.
- The program may have helped promote more appropriate emergency care use among TI adult beneficiaries recently released from criminal justice facilities, evidenced by a 16% decrease in the percentage of avoidable ED visits.
- TI adult beneficiaries recently released from criminal justice facilities identifying as Hispanic/Latino experienced a larger decrease in preventable ED visits compared to those identifying as Multiracial and/or Multiethnic.

Two claims-based measures assessed ED utilization among TI adult beneficiaries recently released from criminal justice facilities. Only non-SMI and non-Medicare-enrolled Justice-involved beneficiaries were used in this analysis. Historical data for this measure were unavailable; therefore, synthetic control weights were not calculated, and no comparison could be made.

ED Utilization		FFY 2022	FFY 2023
4-15	Number of ED visits among recently released beneficiaries	11,677	7,544
4-16	Number of potentially avoidable ED visits among recently released beneficiaries	3,876 (33.2%)	1,295 (17.2%)

Measure 4-15: Number of ED visits among recently released beneficiaries

Evaluation Year	Group	Time Period		Change
		Baseline	Evaluation	
2023	TI	11,677 *N = 5,305*	7,544 *N = 3,416*	(4,133)

Note: N represents the count of unique patients.

Measure 4-16: Number of potentially avoidable ED visits among recently released beneficiaries				
		Time Period		
Evaluation Year	Group	Baseline	Evaluation	Change
2023	TI	3,876 (33.2%) *N = 11,677*	1,295 (17.2%) *N = 7,544*	(16%)

Note: N represents the weighted denominator count.

Measure 4-16: Number of potentially avoidable ED visits among recently released beneficiaries							
Demographic Variable	Subgroup	Group	Baseline	Denom.	Evaluation	Denom.	Change
Sex	Female	TI	32.7%	3,295	15.3%	2,210	-17.4%
	Male	TI	33.4%	8,382	17.9%	5,334	-15.5%
Geography	Rural	TI	28.4%	831	21.5%	433	-6.9%
	Urban	TI	33.6%	10,828	16.9%	7,101	-16.7%
Language Spoken	English	TI	33.2%	3,843	17.1%	7,466	-16.1%
	Spanish	TI	31.7%	104	23.3%	73	-8.4%
Race/ Ethnicity	Black	TI	32.3%	1,608	17.5%	937	-14.8%
	Hispanic/ Latino	TI	34.8%	877	17.3%	655	-17.5%

Measure 4-16: Number of potentially avoidable ED visits among recently released beneficiaries							
Demographic Variable	**Subgroup**	**Group**	**Baseline**	**Denom.**	**Evaluation**	**Denom.**	**Change**
	Multiracial and/or Multiethnic	TI	33.7%	2,700	19%	1,718	-14.6%
	White	TI	33.4%	5,568	16.2%	3,728	-17.2%
Age Group	25 to 34	TI	35.7%	4,238	18.7%	2,662	-17.0%
	35 to 44	TI	32.0%	3,821	17.0%	2,513	-15.0%

Research Question 4.7: Do adult beneficiaries recently released from a criminal justice facility and who are referred to a TI Justice clinic have better management of alcohol and other drugs than those who were not subject to the demonstration?

Key Findings

- Performance on alcohol and other drug management metrics remained stable from baseline to evaluation among TI adult beneficiaries recently released from criminal justice facilities, relative to a synthetic control. However, these differences were not statistically significant.
- TI adult beneficiaries recently released from criminal justice facilities who identify as female improved more on these performance metrics than those identifying as male.

Three performance measures were used to assess management of alcohol and other drugs among recently released beneficiaries.

Behavioral Health Management		FFY 2022	FFY 2023
4-17	Percentage of recently released beneficiaries with a follow-up visit within seven days after an ED visit for SUD	42.6%	41.5%
4-18	Percentage of recently released beneficiaries with a follow-up visit within thirty days after an ED visit for SUD	53.2%	55.8%
4-19	Percentage of recently released beneficiaries who received prescription opioids from multiple providers	61.2%	62%

Measure 4-17: Percentage of recently released beneficiaries with a follow-up visit within seven days after an ED visit for SUD

Evaluation Year	Group	Time Period: Baseline	Time Period: Evaluation	DiD Log-Odds Estimate (p-value)	DiD Odds Ratio [95% CI]
2023	TI	42.6% *N = 481*	41.5% *N = 301*	-0.004 (0.97)	1.0 [0.79, 1.25]
	Synthetic Controls	41.2% *N = 38.05*	40.5% *N = 48.94*		

Note: N represents the weighted denominator count.

Please exercise caution when interpreting results for which the denominator is less than 11, as small sample sizes may limit the reliability and generalizability of the findings. These values are censored to protect patient confidentiality and align with CMS suppression policies.

Measure 4-17: Percentage of recently released beneficiaries with a follow-up visit within seven days after an ED visit for SUD							
Demographic Variable	**Subgroup**	**Group**	**Baseline**	**Denom.**	**Evaluation**	**Denom.**	**Change**
Sex	Female	TI	43.3%	120	53.4%	73	10.1%
	Male	TI	42.4%	361	37.7%	228	-4.7%
Geography	Rural	TI	47.5%	40	40.0%	20	-7.5%
	Urban	TI	42.2%	441	41.4%	280	-0.7%
Language Spoken	English	TI	42.6%	476	41.6%	296	-1.1%
	Spanish	TI	40.0%	<11	50.0%	<11	10.0%
Race/ Ethnicity	Black	TI	37.3%	59	41.7%	36	4.4%
	Hispanic/ Latino	TI	34.9%	43	47.2%	36	12.3%
	Multiracial and/or Multiethnic	TI	40.5%	111	32.6%	86	-8.0%
	White	TI	46.2%	221	44.3%	131	-1.9%
Age Group	25 to 34	TI	38.3%	188	43.4%	113	5.1%
	35 to 44	TI	46.7%	150	42.9%	98	-3.8%

Measure 4-18: Percentage of recently released beneficiaries with a follow-up visit within thirty days after an ED visit for SUD					
		Time Period			
Evaluation Year	Group	Baseline	Evaluation	DiD Log-Odds Estimate (p-value)	DiD Odds Ratio [95% CI]
2023	TI	53.2% *N = 481*	55.8% *N = 301*	0.16 (0.16)	1.18 [0.94, 1.48]
	Synthetic Controls	60.1% *N = 34.91*	46.5% *N = 51.99*		

Note: N represents the weighted denominator count.

Please exercise caution when interpreting results for which the denominator is less than 11, as small sample sizes may limit the reliability and generalizability of the findings. These values are censored to protect patient confidentiality and align with CMS suppression policies.

Measure 4-18: Percentage of recently released beneficiaries with a follow-up visit within thirty days after an ED visit for SUD							
Demographic Variable	Subgroup	Group	Baseline	Denom.	Evaluation	Denom.	Change
Sex	Female	TI	55.8%	120	67.1%	73	11.3%
	Male	TI	52.4%	361	52.2%	228	-0.2%
Geography	Rural	TI	55.0%	40	60.0%	20	5.0%
	Urban	TI	53.1%	441	55.4%	280	2.3%

Measure 4-18: Percentage of recently released beneficiaries with a follow-up visit within thirty days after an ED visit for SUD							
Demographic Variable	**Subgroup**	**Group**	**Baseline**	**Denom.**	**Evaluation**	**Denom.**	**Change**
Language Spoken	English	TI	53.4%	476	55.7%	296	2.4%
	Spanish	TI	40.0%	<11	75.0%	<11	35.0%
Race/ Ethnicity	Black	TI	42.4%	59	52.8%	36	10.4%
	Hispanic/ Latino	TI	46.5%	43	52.8%	36	6.3%
	Multiracial and/or Multiethnic	TI	48.6%	111	47.7%	86	-1.0%
	White	TI	56.6%	221	61.1%	131	4.5%
Age Group	25 to 34	TI	50.0%	188	57.5%	113	7.5%
	35 to 44	TI	55.3%	150	56.1%	98	0.8%

Measure 4-19: Percentage of recently released beneficiaries who received prescription opioids from multiple providers					
		Time Period			
Evaluation Year	**Group**	**Baseline**	**Evaluation**	**DiD Log-Odds Estimate** (p-value)	**DiD Odds Ratio** [95% CI]
2023	TI	61.2%	62%	0.1	1.1

Measure 4-19: Percentage of recently released beneficiaries who received prescription opioids from multiple providers					
		Time Period			
Evaluation Year	Group	Baseline	Evaluation	DiD Log-Odds Estimate (p-value)	DiD Odds Ratio [95% CI]
		N = 286	*N = 150*	(0.79)	[0.53, 2.3]
	Synthetic Controls	62.4% *N < 11*	53.8% *N < 11*		

Note: N represents the weighted denominator count. Synthetic control sample sizes are lower than required for sufficient statistical power and may not allow detection of meaningful differences between groups.

Please exercise caution when interpreting results for which the denominator is less than 11, as small sample sizes may limit the reliability and generalizability of the findings. These values are censored to protect patient confidentiality and align with CMS suppression policies.

Measure 4-19: Percentage of recently released beneficiaries who received prescription opioids from multiple providers							
Demographic Variable	Subgroup	Group	Baseline	Denom.	Evaluation	Denom.	Change
Sex	Female	TI	57.3%	103	63.4%	183	6.1%
	Male	TI	61.1%	54	62.5%	96	1.4%
Geography	Rural	TI	51.9%	27	45.5%	<11	-6.4%

Measure 4-19: Percentage of recently released beneficiaries who received prescription opioids from multiple providers							
Demographic Variable	**Subgroup**	**Group**	**Baseline**	**Denom.**	**Evaluation**	**Denom.**	**Change**
	Urban	TI	62.2%	259	63.8%	138	1.6%
Language Spoken	English	TI	61.3%	284	62.8%	148	1.6%
	Spanish	TI	50.0%	<11	0%	0	-50.0%
Race/ Ethnicity	Black	TI	63.2%	57	63.9%	36	0.7%
	Hispanic/ Latino	TI	68.8%	16	66.7%	<11	-2.1%
	Multiracial and/or Multiethnic	TI	64.3%	42	61.9%	21	-2.4%
	White	TI	59.5%	158	59.7%	77	0.2%
Age Group	25 to 34	TI	57.0%	86	53.7%	41	-3.3%
	35 to 44	TI	67.7%	62	60.0%	40	-7.7%

Research Question 4.8: Do adult beneficiaries recently released from a criminal justice facility and who are referred to a TI Justice clinic have better success with tobacco cessation than those who were not subject to the demonstration?

Key Findings

- Among TI adult beneficiaries recently released from criminal justice facilities identified as tobacco users (N = 27 total respondents), less than one-third reported receiving advice to quit from a doctor or health provider (29.6%, N < 11). Even fewer indicated that cessation medications (18.5%, N < 11) or strategies/methods (22.2%, N < 11) were discussed. Despite this, over half of

tobacco users (55.5%, N = 15) reported having tried to quit in the past 12 months.

Tobacco cessation efforts among recently released beneficiaries were assessed using two beneficiary survey questions. Beneficiary survey data prior to the demonstration period were unavailable at the time of the interim evaluation report; consequently, only the Fall 2025 survey results are presented, and synthetic control weights could not be calculated for this measure. Therefore, no comparison can be made.

Tobacco Cessation Success			
		TI Beneficiaries	
		Number of Responses	Rate
4-20	Percentage of recently released beneficiaries identified as a tobacco user who received tobacco cessation intervention	27	70.3%
	Number of recently released beneficiaries who indicated that they received advice to quit from a doctor or other health provider	< 11	29.6%
	Number of recently released beneficiaries who indicated that their doctor or health provider recommended or discussed cessation medications	< 11	18.5%
	Number of recently released beneficiaries who indicated that their doctor or health provider discussed or provided cessation methods or strategies.	< 11	22.2%
4-21	Percentage of recently released beneficiaries who responded that they have tried quitting in the past 12 months	27	55.5%

Hypothesis 5: The care costs for TI 2.0 participants will be lower than the care costs of non-TI participants.

Research Question 5.1: Are the care costs for TI participants lower than the care costs for non-TI participants in TI 2.0?

Key Findings

- Cost trends were similar across both TI and non-TI attributed patients, with both experiencing an unadjusted ~$30 PMPM decrease; neither the unadjusted nor adjusted differences between groups were statistically significant.
- Pharmacy and professional service costs increased for both TI and Non-TI groups, while inpatient and outpatient costs remained relatively stable. Overall, spending patterns by service category were similar across groups over time.

Measure 5-1: Care Costs - Per Member Per Month (PMPM)

Non-SMI, Non-Dual Enrolled Medicaid Beneficiaries

Evaluation Year	Group	Time Period: Baseline	Time Period: Evaluation	Unadjusted DiD Estimate	Adjusted DiD Estimate
2023	TI	$375 *N = 420,471*	$407 *N = 437,475*	$5.8 (0.42)	$5.5 (0.44)
	Non-TI	$376 *N=1,026,436*	$407 *N=1,003,594*		

Linear mixed model with random intercepts by AHCCCS billing provider ID, using an unstructured covariance matrix and restricted maximum likelihood (REML) estimation. The model is weighted by the number of unique patients per billing provider ID per year.

The unadjusted model includes covariates time (0 = FFY 2022 1 = FFY 2023), TI Status (0 = Non-TI; 1 = TI), Provider Type (Certified Nurse Midwife, Community Health Center, Doctors of Osteopathic Medicine, Federally Qualified Health Center, Integrated Clinic, Doctors of Medicine, Physicians Assistant, Registered Nurse Practitioner, and Group Payment ID), and time*TI status interaction term.

The adjusted model includes all covariates from the unadjusted model, along with yearly aggregate patient percentages by sex, language spoken, race and ethnicity, geography, and age group at the billing provider ID level.

Measure 5-1: Care Costs - Categories of Service Non-SMI, Non-Dual Enrolled Medicaid Beneficiaries					
Year	**Group**	**IP**	**OP (ED and Non-ED)**	**Pharmacy**	**Professional**
2022	TI	$72	$51	$90	$162
2022	Non-TI	$70	$60	$86	$159
2023	TI	$71	$55	$100	$179
2023	Non-TI	$71	$62	$95	$179

Note: ED: emergency department; IP: Inpatient; OP: outpatient

Interpretations, Policy Implications, and Interactions with Other State Initiatives

Overview and Summary

The Interim Report evaluates performance results for the fiscal period 2023 (October 2022-September 2023), the first year of the Targeted Investments (TI) 2.0 program. Five sets of measures were discussed or analyzed for this report: 1) process milestones, 2) HEDIS® measures, 3) claims-based measures, 4) beneficiary surveys, and 5) qualitative research.

- **Process Milestones (n=23):** In Year 1 of TI 2.0, applicants were required to complete process milestones according to their AOCs (6 milestones each for Pediatric and Adult PCP; 4 milestones each for Pediatric and Adult BH; and 3 milestones for Justice) for a total of N = 23 process milestones. These milestones included bi-directional EHR/HIE connectivity, screening and care coordination for NMDOH, trauma-informed care protocols, population-health accountability structures, managing high-risk members with social complexity, and providing BH consultation and referral protocols. All organizations participating in TI 2.0 achieved their respective milestones.
- **HEDIS® Measures (n=33):** Thirty-three HEDIS® measures for the ACC and ACC-RBHA populations were calculated and analyzed. Thirty-two (96.9%) of these measures had an appropriate comparison group for statistical testing. Twenty-one (65.6%) measures improved (seven significantly), while 11 (34.4%)

measures declined (two significantly). Overall, 63.6% (21/33) of the HEDIS® measures showed care improvement for ACC and ACC-RBHA members in the TI 2.0 participating groups compared with the non-TI participating groups. 91% of measures (30/33) aligned with evaluation expectations.

- **Claims-Based Measures (n=8):** Eight claims-based measures encompassing the number of ED visits, the number of potentially avoidable ED visits, G-code usage among TI-attributed adult beneficiaries, and participant care costs were analyzed. Five (62.5%) of the eight measures had an appropriate comparison group for statistical testing: three (60%) of these measures improved (two significantly), and two measures (40%) declined (one significantly). Overall, the claims-based findings suggest a meaningful shift toward more appropriate utilization of ED services among TI beneficiaries. 80% of claims-based measures (4/5) aligned with evaluation expectations.
- **Beneficiary Survey Measures (n=29):** Approximately 1.3 million ACC and ACC-RBHA beneficiaries were contacted to complete a standardized healthcare survey assessing provider communication skills, ease of access to services, patient health status, and overall satisfaction with their provider. A total of 14,035 beneficiaries responded, for an overall survey response rate of 1%. Response rates by subgroup were as follows: pediatric members, 5,773 responses (1% response rate); adult members, 8,167 (1.1%); and justice-involved members, 95 (1.1%). Eleven survey measures had no comparison group and therefore were not tested statistically; all were specific to the Justice AOC. The remaining eighteen survey measures had appropriate comparison groups for statistical testing. Overall, ten (55.6%) survey measures improved (one significantly), and eight (44.4%) declined (one significantly). 94.4% of survey measures (17/18) aligned with evaluation expectations.
- **Qualitative Findings:** Qualitative data provided important context for understanding TI 2.0 implementation. Ten focus groups and key informant interviews were conducted with all six MCOs' executive staff, representative groups of providers, and AHCCCS staff. Several themes emerged from the findings. First, support from AHCCCS and ASU was essential in helping participating organizations understand requirements and improve performance. Second, a complex and often uncoordinated set of expectations from MCOs, Star Ratings, Leapfrog, and other stakeholder organizations makes systematic improvement efforts challenging. Third, while the time commitment required to participate in the TI program was significant, stakeholders consistently emphasized the value of the program and its potential to drive meaningful, sustained improvements in care delivery.

Interpretations

All capacity-building process milestones were accomplished in the first year of TI 2.0, establishing a strong foundation for future performance improvement efforts, as reflected by a generally positive trajectory across a large set of performance measures in key areas such as care coordination, BH integration, high-risk member identification, and support for members with complex social and clinical needs.

These patterns also suggest sustained progress in many of the system-level improvements implemented under TI 1.0. Because TI 2.0 had not yet launched its full set of operational and clinical requirements, outcomes observed in this interim analysis largely reflect the residual impact of TI 1.0 rather than the intended effects of the enhanced TI 2.0 model. The positive trends reported in the TI 2.0 Year 1 findings may represent a combination of milestone implementation under TI 2.0 and spillover effects from improvements accomplished by the 81 provider organizations that also participated in TI 1.0. This suggests that earlier improvements may be sustainable. The milestone accomplishments observed in TI 2.0 Year 1 represent necessary conditions for future performance improvement but—on their own—are not sufficient to produce the clinical gains expected once TI 2.0 reaches full implementation. Infrastructure capacity-building must eventually be supplemented with reliably executed microsystem-level improvements, such as enhanced care pathways, redesigned workflows, failure-mode analysis, and deliberately engineered patient flow.

Conclusions

A total of 119 unique provider organizations serving approximately 500,000 AHCCCS members participated in Year 1 of TI 2.0. All participating provider organizations successfully completed the Year 1 process milestones, ranging from three to six milestones depending on the clinical AOC. This indicates strong provider engagement in capacity-building efforts to advance to the next stage of the TI 2.0 program.

The analysis also includes 70 quantitative performance and survey measures, 55 of which had appropriate comparison groups available for statistical testing. It is important to note that the TI 2.0 justice-involved population represents a unique cohort within the ACC and ACC-RBHA populations, for which no comparable non-TI group exists. Of the 55 comparable measures, 10 showed statistically significant improvement, and 4 showed statistically significant declines. The remaining 41 measures showed no significant change and were consistent with evaluation expectations. In total, statistical analyses of the TI 2.0 program showed that 93% of measures evaluated in the first year after program implementation aligned with the tested hypotheses. Overall, the interim evaluation provides encouraging evidence that the TI 2.0 program is on a positive trajectory to support clinical improvement as it moves into Year 2 and beyond.

Policy Implications

The interim evaluation findings highlight three important policy implications as Arizona continues advancing whole-person, integrated care through value-based initiatives.

1. **Practice Transformation.** Practice transformation is the development of clinical system capacity within a healthcare organization to provide better health care and improved experience of care for the patient. This involves supplementing the traditional focus on individual patient care with population health methods and techniques. AHCCCS designed TI 2.0 to provide resources for participating organizations to become proficient in population health management and to implement initiatives that promote practice transformation. Three mechanisms were provided to TI 2.0 participating organizations by AHCCCS: 1) technical assistance, 2) a peer-learning quality improvement collaborative, and 3) value-based payment.
2. **Change Mechanisms.** Clinical care improvement is a complex intervention based on a combination of capacity-building (necessary conditions) and patient-pathway flow mechanisms (sufficient conditions). A necessary condition must be present for an event to occur but alone does not cause the event, whereas only a sufficient condition (or set of conditions) will produce the event. The capacity-building activities implemented in TI 2.0 Year 1 focused on necessary conditions as the foundation for improved patient care. Going forward, additional practice transformation mechanisms focused on point-of-care redesign and direct clinical improvement work represent the sufficient conditions to advance practice transformation.
3. **Value-Based Payment.** The AHCCCS Medicaid 1115 Waiver for the TI 1.0 and TI 2.0 programs uses a value-based payment approach based on the Learning Action Network (LAN) Category 2C Fee-for-Service Pay-for-Performance model. Value-based payment models create resources and incentives for providers to improve care quality and the patient experience. However, value-based payment is a necessary condition, which by itself does not cause performance improvement. Financial incentives alone are not sufficient to produce the practice transformation necessary to improve clinical care. Many providers—especially smaller practices, safety-net organizations, and community-based providers—lack the capacity to translate value-based payment into meaningful performance improvement.

The TI 2.0 program is designed to provide the resources (technical assistance, quality improvement support, advanced data analysis, and financial incentives) so that small practices as well as large delivery systems can be successful in their practice transformation efforts. A value-based payment model is a necessary condition for

practice transformation, while the sufficient condition is quality improvement support and technical assistance at scale. A key implication for policymakers is that value-based payment models necessary for practice transformation require support, continuity, and technical assistance at scale to build capacity over time.

Lessons Learned and Recommendations

Five key lessons can be drawn to inform the mechanisms that drive practice transformation at scale to achieve population-level care improvements:

1. **Infrastructure and Capacity Building are Foundational to Program Success.** One of the clearest lessons from the first year of the TI 2.0 program is that investments in health IT, policies and procedures, bi-directional EHR/IT connectivity, risk stratification, and protocols for managing high-risk members help clinics build the foundation to become proficient in population health management and prepare to implement practice transformation mechanisms to improve care management. For future initiatives, upfront capacity building is essential—especially for safety-net, rural, and smaller practices that face resource constraints.
2. **Practice Transformation at the Point of Care Is Essential for Performance Improvement.** Clinical practice transformation is the primary driver of improvement in performance measures. Without intentional efforts to modify workflows and clinical processes, measurable gains are less likely to occur. The process milestones in TI 2.0 Year 1 represent important infrastructure mechanisms, which become effective only when combined with consistent operational changes at the point of care.
3. **Data Accuracy, Interoperability, and Standardization Remain Persistent Challenges.** The first year of TI 2.0 identified ongoing challenges across payers regarding interoperability, data reliability, accuracy of various patient attribution methods, inconsistent reporting systems, and competing quality priorities—all of which create significant care management burdens. There is a clear need to create better cross-system alignment to reduce fragmentation, confusion, and inefficiency. Future initiatives could include improving patient assignment and attribution accuracy, as well as reducing duplicative administrative work.
4. **Cross-Sector Collaboration Is Difficult to Implement.** Integrated care requires effective coordination between primary care, BH, and social services. Providers noted meaningful opportunities at the beginning of TI 2.0 to build these partnerships but also anticipated challenges such as data-sharing barriers, misaligned incentives, and capacity limitations among community partners. To strengthen whole-person care, policymakers can establish clear frameworks,

shared accountability structures, and financial incentives that enable collaboration across sectors.

5. **Continued Practice Transformation Will Promote Ongoing Progress.** TI 2.0 has already demonstrated meaningful progress on several metrics, laying the groundwork for continued practice transformation. The program is well-positioned to advance strengthened population health management proficiency. These lessons provide a foundation for future value-based initiatives and underscore the need for coordinated, well-supported implementation to achieve lasting improvements in outcomes for the populations served.

Appendix

Full Measure Calculation Results

RQ	Measure Number	Measure Description	FFY 2022		FFY 2023	
			Denom.	Rate	Denom.	Rate
Hypothesis 2: The TI 2.0 program will improve the delivery of care that addresses inequitable health outcomes for children.						
2.3	2-4	Percentage of child beneficiaries that had six or more well-child visits with a PCP during the first 15 months of life	11,397	57.9%	11,589	57.6%
	2-4	Percentage of child beneficiaries that had two well-child visits with a PCP between ages 15 months and 30 months	11,771	62.9%	11,108	63.9%
	2-5	Percentage of child and adolescent beneficiaries who had a well-care visit with a PCP or OB/GYN	178,101	54.7%	169,660	54.2%
2.5	2-13	Percentage of child and adolescent beneficiaries receiving topical varnish	199,230	23.8%	190,943	26.7%
	2-14	Percentage of child and adolescent beneficiaries who received a comprehensive or periodic evaluation with a dental provider during the measurement year	214,009	51.9%	224,142	53.2%
2.6	2-15	Number of ED visits among children and adolescents	83,287	N/A	92,107	N/A
	2-16	Number of potentially avoidable ED visits among children and adolescents	83,287	62.8%	92,107	42.6%
2.7	2-17	Percentage of child and adolescent beneficiaries with a follow-up visit seven days after hospitalization for mental illness	2,662	76.4%	3,266	75.3%
	2-18	Percentage of child and adolescent beneficiaries with a follow-up visit thirty days after hospitalization for mental illness	2,662	93.5%	3,266	93.5%
	2-19	Percentage of child and adolescent beneficiaries with a follow-up visit seven days after an emergency department (ED) visit for mental illness	620	83.9%	501	80.6%

	2-20	Percentage of child and adolescent beneficiaries with a follow-up visit thirty days after an ED visit for mental illness	620	94%	501	93.8%
	2-21	Percentage of ED visits among adolescent beneficiaries with a principal diagnosis of SUD, or any diagnosis of drug overdose, for which there was follow-up within seven days	120	59.2%	146	55.5%
	2-22	Percentage of ED visits among adolescent beneficiaries with a principal diagnosis of SUD, or any diagnosis of drug overdose, for which there was follow-up within thirty days	120	80.8%	146	78.1%
	2-23	Percentage of child and adolescent beneficiaries with ongoing antipsychotic medication use who have metabolic testing during the year	5,082	40.4%	5,351	39.7%
Hypothesis 3: The TI 2.0 program will improve the delivery of care that addresses inequitable health outcomes for adults.						
3.1	3-2	Percentage of adult beneficiaries with follow-up after an ED visit for adult beneficiaries with multiple high-risk chronic conditions	24,121	67.1%	24,743	67.3%
	3-3	Percentage of adult beneficiaries with patient engagement after discharge	52,641	63.5%	55,410	63.3%
3.3	3-6	Percentage of adult beneficiaries who accessed preventive/ambulatory health services	212,419	77.8%	205,005	77%
3.4	3-14	Percentage/number of adult beneficiaries who received a NMDOH screening assessment	May 1, 2024 - December 31, 2024 4,925 (34.5%)			
3.5	3-16	Timeliness of prenatal care	5,191	65.3%	5,915	64.5%
	3-17	Timeliness of postpartum care	5,191	38.8%	5,915	37.1%
3.6	3-18	Number of ED visits among adult beneficiaries	132,457	N/A	145,046	N/A
	3-19	Number of potentially avoidable ED visits among adult beneficiaries	132,457	28.7%	145,046	14.4%
3.7	3-20	Percentage of adult beneficiaries with a follow-up	15,627	63.8%	15,990	65.5%

		visit seven days after hospitalization for mental illness				
	3-21	Percentage of adult beneficiaries with a follow-up visit thirty days after hospitalization for mental illness	15,627	82%	15,990	83.4%
	3-22	Percentage of adult beneficiaries with a follow-up visit seven days after an ED visit for mental illness	2,466	59.2%	2,320	57.8%
	3-23	Percentage of adult beneficiaries with a follow-up visit thirty days after an ED visit for mental illness	2,466	72.7%	2,320	72.2%
	3-24	Percentage of adult beneficiaries who had initiation of SUD treatment				
		Alcohol Use Disorder	5,896	51.2%	6,692	52.2%
		Opioid Use Disorder	4,222	67.3%	4,371	66.4%
		Other Substance Use Disorder	9,526	50.1%	10,627	48.7%
		Overall	17,490	51.7%	19,257	50.3%
	3-25	Percentage of adult beneficiaries who had engagement of SUD treatment				
		Alcohol Use Disorder	5,896	20%	6,692	22.7%
		Opioid Use Disorder	4,222	36.2%	4,371	35.8%
		Other Substance Use Disorder	9,526	17.6%	10,627	18.7%
		Overall	17,463	21.1%	19,226	21.8%
	3-26	Percentage of ED visits among adult beneficiaries with a principal diagnosis of SUD, or any diagnosis of drug overdose, for which there was follow-up within seven days	4,645	51.4%	4,718	48.9%
	3-27	Percentage of ED visits among adult beneficiaries with a principal diagnosis of SUD, or any diagnosis of drug overdose, for which there was follow-up within thirty days	4,645	66.7%	4,718	65.2%
	3-28	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	22,868	75%	20,569	74.7%
Hypothesis 4: The TI 2.0 program will improve the delivery of care for AHCCCS enrolled adults released from criminal justice facilities and who are referred to a TI Justice clinic.						
4.1	4-2	Percentage of recently released beneficiaries with patient engagement after discharge	3,216	50.9%	2,148	52%
4.3	4-5	Percentage of recently released beneficiaries who had a	8,996	73.6%	6,308	68.7%

		preventive/ambulatory health service visit				
4.5	4-13	Percentage of recently released beneficiaries who had initiation of SUD treatment				
		Alcohol Use Disorder	441	62.1%	240	59.6%
		Opioid Use Disorder	586	77%	377	84.9%
		Other Substance Use Disorder	1,106	57.3%	657	56.6%
		Overall	1,796	61.3%	1,038	63.1%
	4-14	Percentage of recently released beneficiaries who had engagement of SUD treatment				
		Alcohol Use Disorder	441	34.7%	240	35.4%
		Opioid Use Disorder	586	48.8%	377	52%
		Other Substance Use Disorder	1,106	33.1%	657	29.2%
		Overall	1,794	36.8%	1,038	36.3%
4.6	4-15	Number of ED visits among recently released beneficiaries	11,677	N/A	7,544	N/A
	4-16	Number of potentially avoidable ED visits among recently released beneficiaries	11,677	33.2%	7,544	17.2%
4.7	4-17	Percentage of ED visits among recently released beneficiaries with a principal diagnosis of SUD, or any diagnosis of drug overdose, for which there was follow-up within seven days	481	42.6%	301	41.5%
	4-18	Percentage of ED visits among recently released beneficiaries with a principal diagnosis of SUD, or any diagnosis of drug overdose, for which there was follow-up within thirty days	481	53.2%	301	55.8%
	4-19	Percentage of recently released beneficiaries who received prescription opioids from multiple providers	286	61.2%	150	62%

*** indicates a value that has been suppressed due to a denominator less than 11

Justice Synthetic Control Weights

Measure	Clinic 1	Clinic 2	Clinic 3	Clinic 4	Clinic 5	Clinic 6	Clinic 7	Clinic 8	Clinic 9	Clinic 10
4-2	0	0	0.137	0	0.250	0	0.089	0	0.281	0.243
4-13: Overall	0	0.144	0.088	0	0.209	0	0.173	0	0.185	0.202
4-13: Alcohol	0	0.208	0.086	0	0.282	0	0.136	0	0.16	0.127
4-13: Opioid	0.019	0.413	0.042	0	0.225	0.1	0.087	0	0.11	0.005
4-13: Other	0.108	0	0.024	0	0.223	0.105	0.117	0	0.299	0.124
4-14: Overall	0.219	0.098	0.047	0.003	0.251	0.032	0.095	0	0.207	0.049
4-14: Alcohol	0.087	0.042	0.084	0.011	0.228	0	0.056	0.272	0	0.22
4-14: Opioid	0	0.501	0.015	0.104	0.314	0	0.032	0	0.032	0.002
4-14: Other	0.001	0	0	0	0.28	0.218	0.074	0	0.307	0.119
4-17	0	0	0.139	0	0.183	0	0.141	0	0.386	0.15
4-18	0	0.111	0.021	0.127	0.155	0	0.091	0	0.346	0.15

Note: Only three decimal places are displayed in the weights above