AHCCCS-Mandated Performance Improvement Project Methodology for:

STATIN THERAPY FOR PATIENTS WITH DIABETES

CREATION DATE: *July 2025* **IMPLEMENTATION DATE:** *January 1, 2026*
APPLICABLE PROGRAM(S)/POPULATION(S)[1]**:** *ACC-RBHA (SMI Designated Population)*

BACKGROUND

According to the Centers for Disease Control and Prevention (CDC), among the U.S. population in 2021, 38 million (11.6%) Americans had diabetes, and 1.2 million adults were newly diagnosed with diabetes. Diabetes can lead to various chronic health conditions, and one of the most critical health conditions is atherosclerotic cardiovascular disease (ASCVD) as it is the leading cause of morbidity and mortality among people with diabetes. According to the CDC, adults with diabetes are at significantly increased risk of developing cardiovascular diseases, with rates two times higher than that of an adult without diabetes. Primary prevention for ASCVD is an important aspect of diabetes management, and statin therapy is a cornerstone of preventive cardiovascular care in diabetic patients aged 40 to 75 years (Arnett et al.).

Statin therapy has been proven to reduce major ASCVD events such as stroke, myocardial infarction (heart attack), and cardiovascular death in patients with diabetes. Despite the benefits of statin therapy for patients with diabetes, it is underutilized for patients with comorbid behavioral health conditions, including schizophrenia, bipolar disorder, and major depression. Research shows risk of major CVD events was higher in people with schizophrenia, bipolar disorder, and major depression compared with people without a history of mental illness. Serious mental illness (SMI) was also associated with an approximately twofold increased risk of CVD-specific and all-cause mortality (Fleetwood, et al.). Contributing factors to underutilization of cardiovascular treatment for patients with SMI include fragmented care across healthcare providers, poor medication adherence, stigma and discrimination, and reduced ASCVD risk screening (Polcwiartek et al.). As such, AHCCCS identified statin therapy for patients with diabetes as an area of focus and is implementing this project to promote statin therapy for patients with diabetes and behavioral health conditions.

PROJECT OVERVIEW[2]

Purpose

To promote health, this performance improvement project focuses on improving the use of statin therapy for SMI-Designated members with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD).

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[1] ACC-RBHA: AHCCCS Complete Care – Regional Behavioral Health Agreement

[2] PIP selected based on consideration of population/line of business and Contractor performance.

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

Aim

The goal of this project is to demonstrate a statistically significant and sustained improvement in each of the project indicators at the end of the second remeasurement period.

Timeline

Measurement Periods[3]	
Baseline Measurement	January 1, 2026, through December 31, 2026
First Remeasurement	January 1, 2027, through December 31, 2027
Second Remeasurement	January 1, 2028, through December 31, 2028

Study Question(s)

What is the number and percentage, overall and by Contractor, of members 40–75 years of age during the measurement year with diabetes who do not have clinical ASCVD who:

- Were dispensed at least one statin medication of any intensity during the measurement year, and
- Remained on a statin medication of any intensity for at least 80% of the treatment period?

PROJECT INDICATOR(S)

The project indicators shall be calculated and reported in alignment with the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®) technical specifications. For the purposes of this project, improvement shall be monitored and measured through the following indicators:

Title XIX[4]	
Indicator 1: Received Statin Therapy	
Description: Percentage of members 40–75 years of age during the measurement year with diabetes who do not have clinical ASCVD were dispensed at least one statin medication of any intensity during the measurement year.	**Numerator:** Number of members 40–75 years of age during the measurement year with diabetes who do not have clinical ASCVD who were dispensed at least one statin medication of any intensity during the measurement year.
	Denominator: The eligible population, as defined by the associated measure specifications.
Indicator 2: Statin Adherence 80%	
Description: Percentage of members 40–75 years of age during the measurement year with diabetes who do not have clinical ASCVD who remained on a statin medication of any intensity for at least 80% of the treatment period.	**Numerator:** Number of members 40–75 years of age during the measurement year with diabetes who do not have clinical ASCVD who remained on a statin medication of any intensity for at least 80% of the treatment period.
	Denominator: The eligible population, as defined by the associated measure specifications.

[3] Additional remeasurement periods may be required by AHCCCS.

[4] Title XIX is inclusive of M-CHIP members.

Eligible Population
The eligible population shall be determined based on the criteria outlined within the associated measure specifications.

Population Exclusions
All associated exclusions and exceptions shall be applied as outlined within the associated measure specifications.

Population Stratification
Project indicator results shall be stratified, analyzed, and reported in alignment with the requirements outlined within the Analysis Plan section below.

Sampling Requirements
None.

DATA COLLECTION METHODOLOGY AND VALIDATION

Frequency
Contractors shall report the project data annually as part of the AHCCCS-Mandated PIP report submission and in alignment with contract requirements.

Data Sources
Contractor-specific claims data (including all allowable data sources) will be used to identify indicator data.

Data Collection Methodology
Contractors shall utilize the Electronic Clinical Data System (ECDS) methodology to determine the indicator rate in alignment with the NCQA HEDIS® technical specifications.

Confidentiality
AHCCCS, its External Quality Review Organizations (EQROs), and its Contractors, maintain compliance with the Health Insurance Portability and Accountability Act (HIPAA) requirements. AHCCCS employees and EQRO staff who analyze data for this project may have access to the associated data. Member names are never identified or used in AHCCCS reporting; AHCCCS PIP data are used only for the purposes of performing health care operations, conducting oversight of the health care system, or conducting research.

Quality Assurance
Contractor-specific claims data, data collection methodology, data sources, performance measure results, and other indicator results will be reviewed and validated by an AHCCCS EQRO in alignment with CMS Protocols 1 and 2[5].

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[5] CMS External Quality Review (EQR) Protocols, February 2023:
https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf

ANALYSIS PLAN

Contractor Analysis Requirements

The Contractor shall conduct and report the following analyses:

- Geographic service area, county, age, and any other stratifications determined by AHCCCS or deemed meaningful for improvement by the Contractor,
- Statistical testing to determine improvement (e.g., statistical significance, relative change) in alignment with AHCCCS Medical Policy Manual (AMPM) Policy 980 and EQRO requirements, and
- Other analyses, as determined by the Contractor or as required by AHCCCS.

Comparative Analysis

AHCCCS will conduct analyses that are deemed appropriate and meaningful, including analyses that may compare the Contractor's results with:

- Prior year(s) to identify changes and trends,
- Other Contractor and aggregate results [which may include population/line of business results, overall project results, and statewide results], and
- Results of other similar studies, if available.

PROJECT/DATA LIMITATIONS

None noted at this time

AHCCCS KEY CONTACTS

For general questions regarding this methodology, please contact:
Jamie Robin, AHCCCS Quality Improvement Manager

For technical questions regarding this methodology, please contact:
Lindsey Irelan, AHCCCS Quality Improvement Supervisor

WORKS CITED

Arnett, Donna K., et al. "2019 ACA/AHA Guideline on the Primary Prevention of Cardiovascular Disease: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines." *Circulation*. Vol. 140, no. 11, 17 March. 2019, https://www.ahajournals.org/doi/10.1161/cir.0000000000000678.

Fleetwood, Kelly J., et al. "Severe Mental Illness and Type 2 Diabetes Outcomes and Complications: A Nationwide Cohort Study." *Diabetes Care*. vol. 46, no. 7, 2023, pp 1363-1371. https://diabetesjournals.org/care/article/46/7/1363/148822/Severe-Mental-Illness-and-Type-2-Diabetes-Outcomes

Polcwiartek, C, et al. "Severe mental illness: cardiovascular risk assessment and management." *European Heart Journal*, vol. 45, no. 12, 21 Mar. 2024, pp. 987-997. https://academic.oup.com/eurheartj/article/45/12/987/7611764#google_vignette.

"National Diabetes Statistica Report." *U.S. Centers for Disease Control and Prevention,* 15 May, 2024, https://www.cdc.gov/diabetes/php/data-research/?CDC_AAref_Val=https://www.cdc.gov/diabetes/data/statistics-report/index.html.