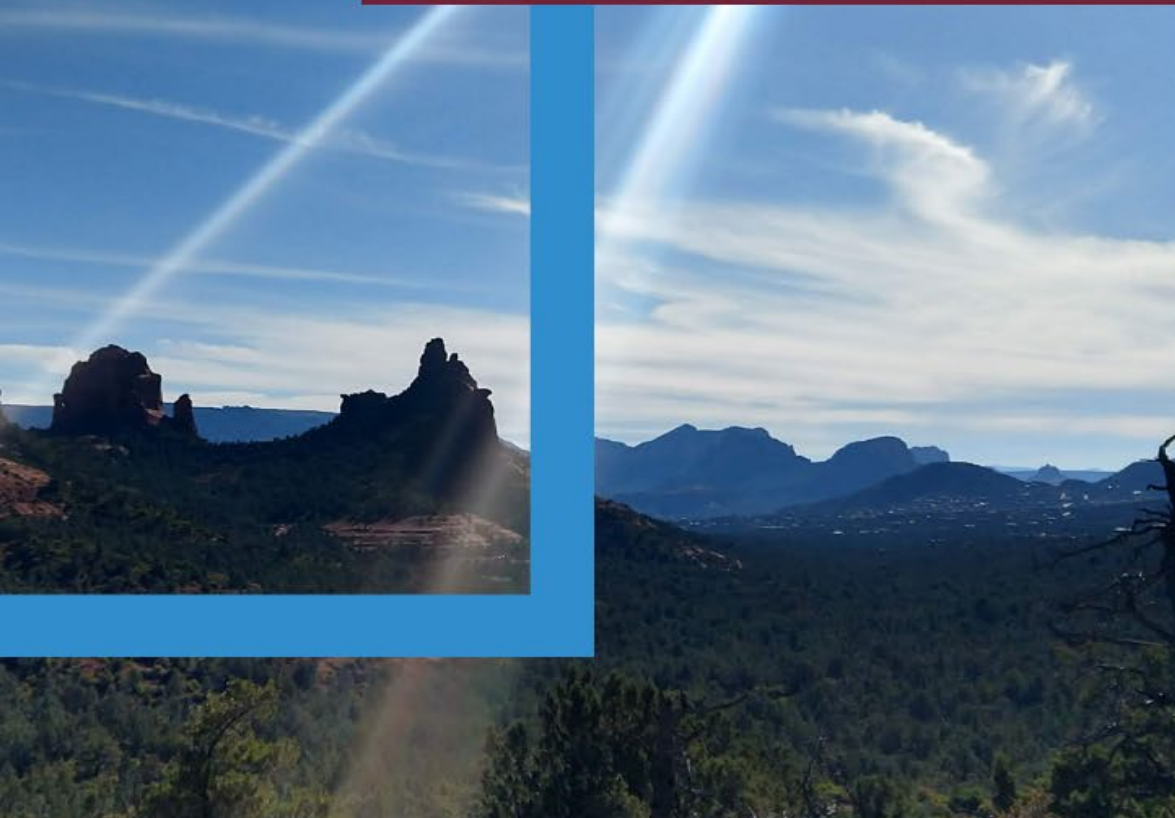


# 2022–2026 Arizona Health Care Cost Containment System

## Health IT Strategy – History and Future



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# Executive Summary

## Executive Summary

The Arizona Health Care Cost Containment System (AHCCCS) envisions a transformed, integrated health care system in which health information technology (health IT) and health information exchange (HIE) efforts ensure comprehensive quality health care for those in need. AHCCCS is Arizona’s Medicaid program, providing health care to more than 2 million Arizonans.

In 2021, AHCCCS contracted with Myers and Stauffer LC (Myers and Stauffer) to complete the final environmental scan (eScan) and State Medicaid Health Information Technology Plan (SMHP) as part of the Centers for Medicare and Medicaid Services (CMS) closeout requirements of the Health Information Technology for Economic and Clinical Health (HITECH) Act. AHCCCS leveraged the required eScan and SMHP to create the 2022–2026 Health Information Technology (health IT) Strategy. The Health IT Strategy builds upon previous Arizona roadmap efforts, and establishes stakeholder-driven goals, priorities, and tactics to further advance the health IT and HIE environment after the sunset of HITECH.

AHCCCS would like to thank the individuals and organizations who contributed to the development of this detailed strategy. AHCCCS and representatives from stakeholder organizations, including the statewide HIE, Contexture, were invaluable in the development of this plan, providing well-researched material and resources critical to inform this strategic plan. The information was collected through a variety of methods, including surveys and interviews, research, and data and documentation requests. Although discussions in this report highlight many opportunities, it should be noted Arizona stakeholders are actively engaged and are willing participants in transformation efforts already initiated across the state.

### Document Purpose

The purpose of the Strategic Plan is to showcase the state’s current and future health IT and data exchange environment with the goal of improving population health, enhancing the patient experience, and lowering cost. This plan documents current challenges and is a forward-looking resource for AHCCCS that identifies the agency’s health IT priorities and goals. Understanding the characteristics of Arizona’s health IT and HIE efforts, both existing and planned, will improve targeting of initiatives and focus areas for stakeholders across the state to improve quality of care and benefit the experience for Arizona beneficiaries.

### AHCCCS Health IT Strategy

AHCCCS’ 2022–2026 Health IT Strategy provides a framework and a recommended direction for AHCCCS and Arizona healthcare stakeholders to prioritize initiatives while guiding the state’s health IT efforts. The strategy is in alignment with the AHCCCS Health IT mission statement to ensure Arizona’s health IT investments aligns with population, community and individual health improvements, cost containment, and health care quality goals. The priorities and goals detailed within this plan were developed by



AHCCCS in collaboration with 62 stakeholders representing 17 community partners and 11 state representatives of state agencies, divisions, or teams. This strategic plan demonstrates AHCCCS' ongoing and coordinated focus on improving the access, exchange, and use of electronic health information. The following priorities and goals are guided by stakeholder engagement and feedback, as well as the overarching priorities of AHCCCS.

This strategy includes three priorities and five goals, each of which includes specific strategies and tactics aligned to a timeline. Priorities include the following and are further detailed in [Section 5](#):

- **Priority: Continue Health IT Collaboration**
  - ◆ Goal 1: Establish cross agency collaboration to maximize utilization of Contexture to advance interoperability across the enterprise, the state, and the community.
- **Priority: Create Efficiencies & Improve Healthcare Quality**
  - ◆ Goal 2: Support data integration to enhance the data exchange infrastructure.
  - ◆ Goal 3: Increase provider access to care information in a standardized format.
- **Priority: Improve Data Quality & Modernization**
  - ◆ Goal 4: Improve operations by modernizing agency technology.
  - ◆ Goal 5: Increase agency data access and information exchange.

Taken together, these priorities and goals should not be viewed as sequential, but as interdependent with the collective purpose of advancing Arizona's health IT and HIE infrastructure leading to a more cohesive data sharing environment while improving Medicaid beneficiary health outcomes using data-driven insights. When implemented, the goals will provide a robust foundation supporting Arizona in promoting the health and well-being of its citizens.

This health IT strategy provides a path forward for AHCCCS to work collaboratively to address:

- The requirement that whole person care needs additional social determinants of health (SDOH) information which is not widely available or shared,
- The stakeholder desire for more streamlined and comprehensive data,
- The fact that not all providers have the resources to upgrade and adopt new technology,
- Future health care delivery models and their need for more robust data,
- Improving access to more real-time clinical data through current and future federal rules,
- Planning and funding investments to address aging IT Systems,
- The ongoing need for staffing to implement current and future health IT strategies and tools, and



- The continued need for enhanced security and privacy requirements.

Recognizing its strengths, AHCCCS will leverage the following:

- Higher physician and hospital adoption of certified EHR technology,
- Greater interoperability between providers to share clinical data,
- More robust HIE functionality and data at Contexture,
- Increased diversity and recruitment of high volume providers participating in the HIE,
- More access to health plan information,
- Prior investments in tools, education, and programs to support providers, and
- Future federal funding, grants, and rules to support future health IT adoption.

### Report Structure

The inputs of the strategic plan are separated into five main areas culminating with the AHCCCS Health IT Strategy as follows:

1. **The State of Health in Arizona.** Provides a brief narrative of the health status and health issues impacting Arizona. This section sets the stage in providing baseline health statistics. Measuring the health status of populations is vital to planning efforts to ensure optimal health outcomes. Details ongoing and planned initiatives to address disparities in health and provides a discussion on the impact of the public health emergency in the State.
2. **Overview of AHCCCS.** Details a narrative of AHCCCS' care delivery system, population-based programs, and an overview of AHCCCS health plans. Lists the current AHCCCS strategic plan goals and agency initiatives.
3. **Improving Health through Health IT.** Summarizes the national health IT federal guidance and vision and provides a brief narrative on SDOH trends.
4. **Current Health IT Landscape in Arizona.** Highlights the progress made in areas of health IT adoption and exchange, both of which are key to healthcare transformation. Describes the current health IT and HIE landscape of Arizona and draws information from various data sources including the 2021 Arizona eScan, Arizona Promoting Interoperability Program, Arizona State University (ASU) surveys, among others. Details the ongoing and planned work of Contexture, health IT and HIE incentive payment programs, and the public health environment.
5. **AHCCCS Health IT Strategy.** Presents the collaboratively crafted AHCCCS 2022–2026 Health IT Strategy. Recognizes current strengths and leverages the immense health IT and HIE efforts of the past decade to present the AHCCCS 2022–2026 Health IT priorities and goals.





# State of Health in Arizona



# 1. State of Health in Arizona

## Overview

Health is a state of complete physical, mental, and social well-being, and not the mere absence of disease or infirmity.<sup>1</sup> The health status of a population can be measured by a wide range of factors including economic status, social status, other items related to SDOH, chronic diseases, health conditions, infant and maternal mortality, and mortality and morbidities. Successful initiatives to improve health are realistic, well-focused, and ensure the competency and commitment of institutions to be accomplished. This section presents an overview of the health status of Arizona, including health statistics, which can be used as a baseline understanding of potential opportunities where increased use of health IT and information exchange can play a role in increasing health equity, quality, and access.

### *Population and Geography*

Arizona, the sixth largest state by size, covers 113,635 square miles,<sup>2</sup> and is the 14<sup>th</sup> most populous state, with 7.28 million residents as of 2019.<sup>3</sup> Arizona is one of fastest growing states, experiencing an 11.9 percent growth in population between 2010 and 2020, based on current estimates.<sup>4</sup>

Of Arizona's 15 counties, 13 are rural areas where approximately 25 percent of the state's citizens reside.<sup>5</sup> The largest urban area by population is Maricopa County and includes the main urban area of Phoenix. Approximately three quarters of the population reside in Maricopa and Pima counties. In 2019, 82.6 percent of the state's population identified as white, 31.7 percent as Hispanic or Latino, 5.3 percent as American Indian or Alaska Native, 5.2 percent as African-American, 3.7 percent as Asian, and .3 percent as Native Hawaiian or Other Pacific Islander.<sup>6</sup> In that same year, Arizona was among the top 10 states with the largest American Indian and Alaska Native populations.<sup>7</sup>

### *Poverty and Income*

The median per capita income for Arizona in 2019 was \$35,824 in the rural areas and \$46,579 in the urban areas.<sup>8</sup> In 2019, Arizona's median household income was \$62,055.<sup>9</sup> Arizona ranked 35<sup>th</sup> and 38<sup>th</sup> for percentage of working-age women and working age men living in poverty, respectively.<sup>10</sup>

<sup>1</sup> World Health Organization. 1946. Preamble to the constitution of the World Health Organization as adopted by the International Health Conference, New York, 19–22 June, 1946.

<sup>2</sup> USDA. Economic Research Service. U.S. Department of Agriculture. Data Products. State Fact Sheet.

<sup>3</sup> U.S. Census Bureau. Population Estimates July 1, 2019.

<sup>4</sup> U.S. Census Bureau.

<sup>5</sup> Arizona 2018 State Health Assessment.

<sup>6</sup> U.S. Census Bureau. Population Estimates July 1, 2019.

<sup>7</sup> U.S. Department of Health and Human Services Office of Minority Health. Policy and Data. Minority Population Profiles.

<sup>8</sup> Ibid.

<sup>9</sup> <https://www.deptofnumbers.com/income/arizona/>. Department of Numbers. Arizona State Household Income. Accessed July 26, 2021.

<sup>10</sup> USDA. Economic Research Service. U.S. Department of Agriculture. Data Products. State Fact Sheet.



Arizona's poverty rate in 2019 was 19.1 percent for Arizonans under the age of 18, compared to the national average of 16.8 percent.<sup>11</sup> The state ranked 39<sup>th</sup> in childhood poverty,<sup>12</sup> however, since 2015, Arizona's poverty rate has declined 3.4 percentage points, which is the fastest rate in the nation.<sup>13</sup>

### Education

Currently, Arizona ranks 43<sup>rd</sup> in the nation in the ratings for high school graduation. The state's high school graduation rate increased 3.0 percent; from 75.7 percent to 78.7 percent of students, and children aged 0 to 17 in poverty decreased 6.4 percent, from 26.5 percent to 20.1 percent over the past five years.<sup>14</sup> Among residents in the rural areas, 17.7 percent did not complete high school compared to 12.6 percent in urban areas.<sup>15</sup>

## Health System

### Health Care Facilities in Arizona

There are 144 hospitals in Arizona.<sup>16</sup> According to a Kaiser Family Foundation (KFF) report, the number of U.S. hospital beds was 2.4 per 1,000 individuals in 2018.<sup>17</sup> Arizona was below the national average with 1.9 beds per 1,000 individuals. As of March 2020, there were 16,000 licensed hospital beds within Arizona. In rural areas, there are 15 critical access hospitals (CAHs), 36 rural health clinics (RHCs), 70 federally qualified health centers (FQHCs) and 19 short-term hospitals located outside of urban areas.<sup>18</sup> Arizona has 146 licensed long-term care facilities/nursing homes and 768 assisted living facilities.

### Provider Shortages

As of 2019, Arizona has experienced shortages of primary care providers in both urban and rural areas. Recent data show that Arizona ranks 44<sup>th</sup> in total active primary care physicians and 31<sup>st</sup> in total active physicians, despite currently being the fourth fastest growing state in the nation.<sup>19</sup> In 2018, all counties and all tribal nations experienced some kind of primary care shortage (*Figure 1*).<sup>20</sup> It is estimated that the state will need to increase its primary care work force 50 percent by 2030 to meet the population demands.<sup>21</sup>

<sup>11</sup> <https://cronkitenews.azpbs.org/2020/09/28/arizona-poverty-rate-continued-fall-in-2019-still-topped-national-rate/>

<sup>12</sup> USDA. Economic Research Service. U.S. Department of Agriculture. Data Products. State Fact Sheet.

<sup>13</sup> Arizona Leads the Nation in Poverty Reduction. News Release. Office of the Governor Doug Ducey. January 22, 2020.

<sup>14</sup> [www.AmericasHealthRankings.org](http://www.AmericasHealthRankings.org). *America's Health Rankings*. Annual Report 2020. Accessed July 26, 2021.

<sup>15</sup> <https://data.ers.usda.gov/reports.aspx?ID=17854>. USDA Economic Research Service. U.S. Department of Agriculture. Accessed July 26, 2021.

<sup>16</sup> <https://www.officialusa.com/stateguides/health/hospitals/arizona.html>. List of Arizona Hospitals. Accessed July 27, 2021.

<sup>17</sup> <https://www.azcentral.com/story/news/local/arizona-health/2020/03/15/number-hospital-beds-doctors-arizona-low-compared-rest-u-s/5038216002/>. Number of hospital beds, doctors in Arizona are low compared with rest of U.S. Accessed August 4, 2021.

<sup>18</sup> <https://www.ruralhealthinfo.org/states/arizona>. Rural health for Arizona Overview. Rural Health Information Hub. Accessed July 23, 2021.

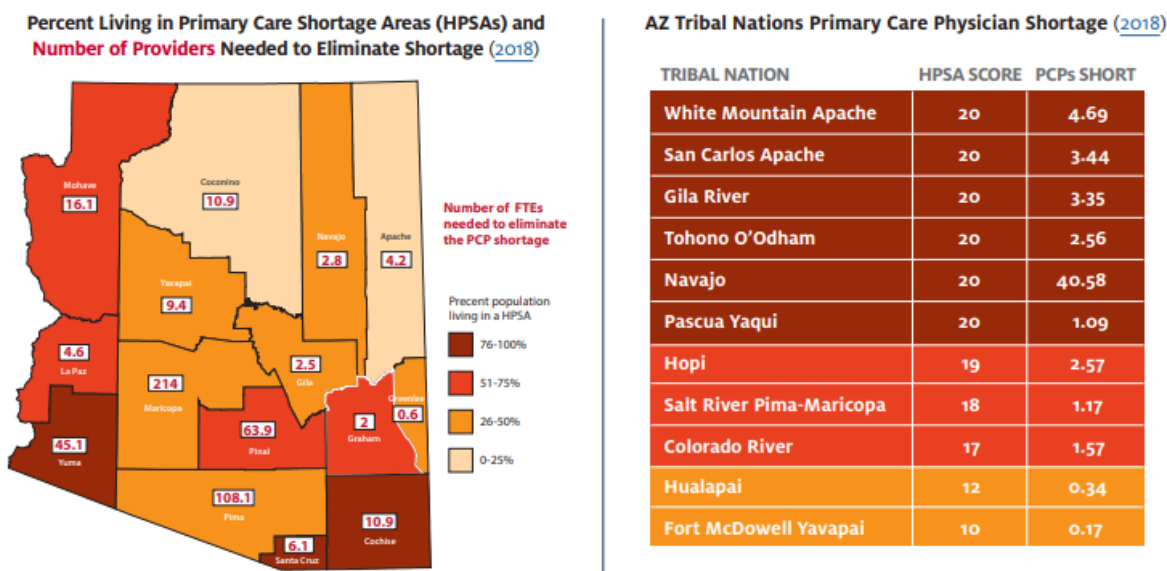
<sup>19</sup> Koch B, Coates S, Carter H, Derksen D: Tackling the Primary Care Physician Shortage in Arizona. Arizona Center for Rural Health Policy Brief. 3/07/2019.

<sup>20</sup> Ibid.

<sup>21</sup> Ibid.



Figure 1. Arizona Provider Shortage



*Health Care Cost and Access*

Cost is a significant barrier to some individuals seeking health care services in Arizona. KFF performed a random digit dialed telephone survey of adults in 2019. 11.1 percent of Whites, 14.9 percent of Blacks, 19.9 percent of Hispanics, 15.4 percent of American Indian/Alaska Native, and 20.1 percent of individuals categorized as Other reported that there was a time in the past year when they needed to seek an appointment with a health care professional and did not due to cost.<sup>22</sup> There were no Asian, Native Hawaiian or Pacific Islander responses to the survey. A second KFF survey revealed that 22.1 percent of White, 21.2 percent of Blacks, 42.4 percent of Hispanics, 37.7 percent of Asian/Native Hawaiian or Pacific Islander, 38.6 percent of American Indian/Alaska Native, and 28.3 percent of individuals categorized as Other reported that they did not have a personal doctor or health care provider.<sup>23</sup> Additionally, 6.8 percent of the adults surveyed reported that they felt a perceived need for mental health treatment or counseling in the past year and did not seek or receive it.<sup>24</sup>

*Uninsured Arizonans*

The percentage of the population not covered by either private or public health insurance represents the uninsured rate. Arizona accepted federal funding to expand Medicaid in 2014, and as a result, the state’s rate of uninsured dropped from 17.1 percent in 2013 to 10 percent in 2016.<sup>25</sup> The state continued to see significant changes in the uninsured rate between 2018 and 2019 with a year increase

<sup>22</sup> [www.kff.org/state-category/providers-service-use/?state=AZ](http://www.kff.org/state-category/providers-service-use/?state=AZ). Arizona Providers and Service Use. Accessed August 1, 2021.

<sup>23</sup> Ibid.

<sup>24</sup> Ibid.

<sup>25</sup> Expansion of Medicaid Eligibility. AHCCCS. Program Summary Document.



of 7 percent.<sup>26</sup> As of May 1, 2021, there were 2,217,132 residents (i.e., about 30 percent according to recent population estimates) enrolled in AHCCCS' programs and those numbers have been growing steadily.<sup>27</sup> The state enrolled 16,991 new members between April 1 and May 1, 2021, alone, which was attributed to the Families First Coronavirus Response Act.<sup>28</sup>

Arizona ranked 46<sup>th</sup> in public health spending in 2020, per *America's Health Rankings*.<sup>29</sup> State and federal dollars in the amount of \$57.00 per person was dedicated to public health that year, falling well below the national health-spending amount of \$91.00 per person. From the Medicaid and Children's Health Insurance Program (CHIP) Payment and Access Commission (MACPAC), Arizona ranks better than most states in terms of costs per Medicaid member.<sup>30</sup> From the December 2021 Medicaid and CHIP Data Book (MACStats), Arizona spends \$7,439 per Medicaid enrollee which is below the national average of \$8,621. Additionally, Arizona has a lower ratio of Medicaid administration costs at 1.99 percent versus the national average of 4.36 percent.

## Health Statistics

While no single set of measures can completely characterize the health of a large and diverse population, the Centers for Disease Control and Prevention (CDC) and other health agencies worldwide consistently have viewed life expectancy and mortality data as indicators of overall population health because they represent the cumulative effects of social and physical environmental factors, behavioral and genetic risk factors, and the level and quality of health care.<sup>31</sup> Additional statistics key to understanding the health status of Arizona are provided in the narrative below.

### *Life Expectancy and Mortality*

Life expectancy metrics can vary by geography but are useful in examining how environmental, political, socioeconomic, and structural conditions impact health outcomes. The average life expectancy for an Arizona resident is 79.9 years, 1.4 years greater than the U.S. average life expectancy of 78.5 years. In six of Arizona's 15 counties, the average life expectancy is below the U.S. average – significantly lower in counties with higher proportions of non-White residents.<sup>32</sup>

Mortality is a component of health outcomes and an indicator of the general health of a community. In 2017, mortality due to firearms in Arizona was 15.8 percent, which was 3.8 percent higher than the national rate, which was 12 percent. In the same year, mortality due to homicide was 6.6 percent which was 0.4 percent higher than the national rate which was 6.2 percent. Mortality due to drug overdose

<sup>26</sup> Americas Health Rankings. 2020 Annual Report.

<sup>27</sup> AHCCCS Population Highlights. May 2021.

<sup>28</sup> Ibid.

<sup>29</sup> [www.AmericasHealthRankings.org](http://www.AmericasHealthRankings.org). *America's Health Rankings*. Annual Report 2020. Accessed July 26, 2021.

<sup>30</sup> <https://www.macpac.gov/wp-content/uploads/2021/12/MACStats-Medicaid-and-CHIP-Data-Book-December-2021.pdf>

<sup>31</sup> <https://www.epa.gov/report-environment/health-status>

<sup>32</sup> [https://waysandmeans.house.gov/sites/democrats.waysandmeans.house.gov/files/documents/Arizona%20Health%20Equity%20Facts\\_0.pdf#:~:text=Life%20expectancy%20metrics%20can%20vary%20drastically%20by%20geography,in%20counties%20with%20higher%20proportions%20of%20non-White%20residents.](https://waysandmeans.house.gov/sites/democrats.waysandmeans.house.gov/files/documents/Arizona%20Health%20Equity%20Facts_0.pdf#:~:text=Life%20expectancy%20metrics%20can%20vary%20drastically%20by%20geography,in%20counties%20with%20higher%20proportions%20of%20non-White%20residents.)



was 22.2 percent, which was 0.5 percent higher than the national rate, which was 21.7 percent in 2017.<sup>33</sup>

### *Infant and Maternal Mortality*

Arizona’s infant mortality rate is currently 5.7 deaths per 1000 live births; this is a tenth of a percent lower than the national rate, which is 5.8 deaths per 1,000 live births. Arizona is ranked as 16<sup>th</sup> in the nation in low birth rate.<sup>34</sup> The most recent data show an increase in low birth weight from 7.1 percent of live births in 2008 to 7.6 percent of live births in 2018. The maternal mortality rate for Arizona in 2018 was 22.3 deaths per every 100,000 live births compared to the national rate of 17.4.<sup>35</sup>

### **Health Outcomes**

Health outcomes are a change in health status (i.e., mortality and morbidity) that result from the provision of health (or other) services.<sup>36</sup> The narrative below highlights risk factors to chronic health conditions, disparities in health outcomes, and the impact of the COVID-19 pandemic.

Arizona ranks 29<sup>th</sup> in national health outcomes according to the United Health Care Foundation’s report, *America’s Health Rankings, 2020*. In 2017, according to the CDC National Center for Health Statistics, the top five causes of death in Arizona were heart disease, cancer, accidents, chronic lower respiratory disease, and Alzheimer’s disease.<sup>37</sup>

### *Risk Factors to Chronic Health Conditions*

Obesity, high blood pressure, and high cholesterol are risk factors that can lead to serious and/or chronic health conditions. In 2020, Arizona ranked 20<sup>th</sup> in the nation for obesity with 31.4 percent of the adults reporting that they were diagnosed by a health care professional as being obese.<sup>38</sup> Obesity is valued as the percentage of adults with a body mass index of 30.0 or greater based on the individuals height and weight. In 2019, Arizona ranked 15<sup>th</sup> in the nation and tied with Alaska and Nevada with 29.5 percent of the adult population classified as obese. Arizona ranked 25<sup>th</sup> in the nation for high blood pressure with 32.5 percent of the adults diagnosed by a health care professional as having high blood pressure.<sup>39</sup> Arizona ranks 26<sup>th</sup> in the nation for high cholesterol with 33.4 percent of the adults reporting that they were diagnosed by a health care professional as having high cholesterol.<sup>40</sup> Between 2011 and 2019, high cholesterol decreased 17 percent from 40.2 percent to 33.4 percent of adults

### *Disparities in Health*

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<sup>33</sup> <https://www.cdc.gov/nchs/pressroom/states/arizona/arizona.htm>. Centers for Disease Control and Prevention. Stats of the State of Arizona. Accessed August 3, 2021.

<sup>34</sup> Ibid.

<sup>35</sup> Maternal Mortality by State, 2018 - CDC <https://www.cdc.gov>. Maternal Mortality by State 2018. Accessed August 1, 2021.

<sup>36</sup> World Health Organization, European Observatory on Health Systems and Policies Glossary, 2009.

<sup>37</sup> <https://www.cdc.gov/nchs/pressroom/states/arizona/az.htm>. CDC NCHS Arizona. Accessed July 28, 2021.

<sup>38</sup> [www.AmericasHealthRankings.org](http://www.AmericasHealthRankings.org). *America’s Health Rankings*. Annual Report 2020. Accessed July 26, 2021.

<sup>39</sup> [www.AmericasHealthRankings.org](http://www.AmericasHealthRankings.org). *America’s Health Rankings*. Annual Report 2020. Accessed July 26, 2021.

<sup>40</sup> Ibid.



As seen nationally, there are differences in various factors leading to disparities in health among racial/ethnic groups in Arizona. In 2017 and prior years, Asian and White non-Hispanics respectively ranked highest in overall health status according to the Arizona Department of Health Services (ADHS). Asian residents ranked first and/or second best in measures of health including low incidence of drug or alcohol induced deaths, low post-neonatal mortality, mortality from reportable diseases, chronic diseases and injuries.<sup>41</sup> White non-Hispanics ranked second best in health among racial/ethnic groups in Arizona, ranking first and/or second in measures of health including low teen pregnancy rates, high utilization of prenatal care, and low premature mortality while ranking worse than all other racial/ethnic groups in mortality due to drug-induced deaths, chronic lower respiratory diseases, and suicide.<sup>42</sup> Hispanics or Latinos ranked third for healthiness and with worse outcomes than the Arizona average for chronic liver disease and cirrhosis, cerebrovascular disease, influenza and pneumonia, cervical cancer, high teen pregnancy rates, and low utilization of prenatal care.<sup>43</sup> American Indians or Alaska Natives ranked fourth due to poor outcomes on health indicators including infant mortality, chronic liver disease and cirrhosis, diabetes, motor vehicle accidents, and mortality from unintentional injuries, contributing to a high premature death rate. Additionally, American Indians or Alaska Natives ranked poorly in maternal lifestyle, maternal health, and utilization of prenatal care.<sup>44</sup> African Americans or Blacks, ranked last of the five racial groups. Measures of health including high mortality among children, high mortality among middle-aged adults, high ratios of low birthweight and preterm births, high incidence of many reportable diseases, high mortality rates for almost all of the leading causes of death, and a high rate of premature death contributed to the low ranking for the African American or Black population.<sup>45</sup>

Some key AHCCCS initiatives that are addressing health disparities include:

- [Arizona Health Improvement Plan \(AzHIP\) 2021–2025](#) was originally created in 2016 with a focus on improving health equity. ADHS has updated the plan to reflect updated community health priorities, policy changes, and measurable health outcomes for 2021–2025.
- [AHCCCS Targeted Investment \(TI\) Program](#) is focused on creating interconnected, whole person care, and the state is dedicated to expanding the program to address SDOH.
- [AHCCCS' 5-Year Strategic Plan](#) for State Fiscal Years (SFYs) 2018–2023 addresses the role of AHCCCS in meeting its short- and long-term challenges and is updated annually within context of Arizona's economy and with a view of the future health and economic well-being of Arizonans.

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<sup>41</sup> Pub.azdhs.gov. Differences in the Health Status among Racial/Ethnic Groups. Accessed August 4, 2021.

<sup>42</sup> Ibid.

<sup>43</sup> Ibid.

<sup>44</sup> Ibid.

<sup>45</sup> Ibid.

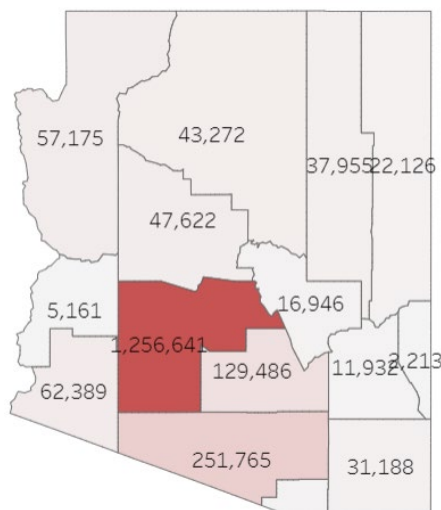


- [Health Equity Committee](#) was established by AHCCCS in 2020, which is responsible for overseeing and managing health equity issues as they relate to policy, data, health plan oversight and emerging health care innovation.
- [Healthy People 2030](#) defines health equity as the “attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities.”<sup>46</sup>

### COVID-19 Impact

COVID-19 is a highly contagious infectious disease caused by a newly discovered coronavirus that emerged in December of 2019. COVID-19, also called SARS-CoV-2, has caused a pandemic of infectious respiratory illness. COVID-19 has caused millions of deaths around the world and many survivors are left with lasting health problems.<sup>47</sup> As of March 16, 2022, there have been 1,992,471 confirmed cases of COVID-19 in Arizona (*Figure 2*). Maricopa County had the most confirmed cases at 1,256,641. Pima County was second with 251,765 confirmed cases, and Pinal County with 129,486 confirmed cases ranked third.<sup>48</sup>

Figure 2: Number of Confirmed COVID-19 Cases in Arizona<sup>49</sup>



As of March 16, 2022, there were a total of 108,057 hospitalizations due to COVID-19 since the pandemic began. ADHS publishes updated COVID-19 figures for hospitalizations by race/ethnicity and

<sup>46</sup> <https://health.gov/our-work/national-health-initiatives/healthy-people/healthy-people-2030/questions-answers#q9> Accessed March 21, 2022.

<sup>47</sup> <https://www.hopkinsmedicine.org/health/conditions-and-diseases/coronavirus>. What is Coronavirus? Accessed August 19, 2021.

<sup>48</sup> <https://www.azdhs.gov/covid19/data/index.php#demographics>. COVID-19. Data. Demographic. Accessed November 30, 2021.

<sup>49</sup> <https://www.azdhs.gov/covid19/data/index.php#demographics>. COVID-19. Data. Demographic. Accessed November 30, 2021.



they are as follows: White, Non-Hispanic residents make up 51 percent; Hispanic or Latino residents make up 30 percent; American Indian or Alaska Natives make up seven percent; Black or African American, non-Hispanic make up five percent; Asian or Pacific Islander, non-Hispanic make up two percent; Other Race make up four percent and Unknown race/ethnicity make up two percent of the hospitalized cases.<sup>50</sup>

ADHS reported 28,547 deaths from COVID-19 as of March 16, 2022. 54 percent of COVID-19 deaths occurred among those that identified as White, Non-Hispanic and 27 percent of COVID-19 deaths occurred amongst Hispanics/Latinos. Those that identified as American Indian or Alaska Native represented seven percent of COVID-19 deaths. COVID-19 deaths are lowest amongst those that identify as Black or Other Race and Asian/Pacific Islander. The death rate is higher in men than in women at 59 and 41 percent respectively. Residents aged 65 plus lead the number of deaths by age at 71 percent, followed by residents 55–64 at 16 percent; residents 45–54 at eight percent; residents 20–44 at five percent; and residents less than 20 years of age with zero percent.<sup>51</sup>

Vaccination is one of many preventative measures to avoid contracting COVID-19. Arizona has a vaccination rate of 70 percent with 5,029,341 residents receiving at least one dose as of March 16, 2022.<sup>52</sup>

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<sup>50</sup> <https://www.azdhs.gov/covid19/data/index.php#hospitalization>. COVID-19. Data. Hospitalization. Accessed March 22, 2022.

<sup>51</sup> <https://www.azdhs.gov/covid19/data/index.php#deaths>. COVID-19. Data. COVID-19 Deaths. Accessed March 22, 2022.

<sup>52</sup> <https://www.azdhs.gov/covid19/data/index.php#vaccine-admin> COVID-19. Data. COVID-19 Vaccination. Accessed March 22, 2022.







# Overview of AHCCCS

## 2. Overview of AHCCCS

### Arizona’s Medicaid Program

Arizona was the last state to implement a traditional Medicaid program, establishing AHCCCS in October 1982,<sup>53</sup> but the first state to create a mandatory managed care model, meaning that with the exception of the American Indian/Alaskan Native population, all Medicaid enrollees must be enrolled in a managed care organization (MCO), including dual eligible and long-term care members.<sup>54</sup> AHCCCS is an \$18 billion integrated managed care modeled Medicaid program covering more than 2 million lives. Medicaid recipients qualify based on income.<sup>55</sup> Approximately 88 percent of Arizona’s Medicaid population receives services through a Medicaid MCO.<sup>56</sup>

The AHCCCS care delivery system consists of several different programs based on population, which include: Fee-for-Service (FFS), Regional Behavioral Health Authorities (RBHAs), AHCCCS Complete Care, Arizona Long-Term Care System (ALTCS) elderly and physical disability, ALTCS Developmentally Disabled, and Arizona Department of Child Safety (DCS), Comprehensive Health Plan (DCS-CHP). Most AHCCCS members are enrolled in health plans that provide physical, behavioral, and Children’s Rehabilitative Services under a single plan as seen in *Figure 3*. For American Indian Medicaid members who have not enrolled in a managed care health plan, they have the option to enroll in the American Indian Health Program (AIHP), which is a FFS program administered by the Division of FSS Management (DFSM).<sup>57</sup>

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<sup>53</sup> <https://www.healthinsurance.org/medicaid/arizona/>

<sup>54</sup> <https://www.azahcccs.gov/AHCCCS/Downloads/What%20is%20AHCCCS%20Managed%20Care.pdf#:~:text=How%20many%20managed%20health%20care%20plans%20does%20AHCCCS,like%20to%20participate%20in%20upon%20enrollment%20in%20AHCCCS.>

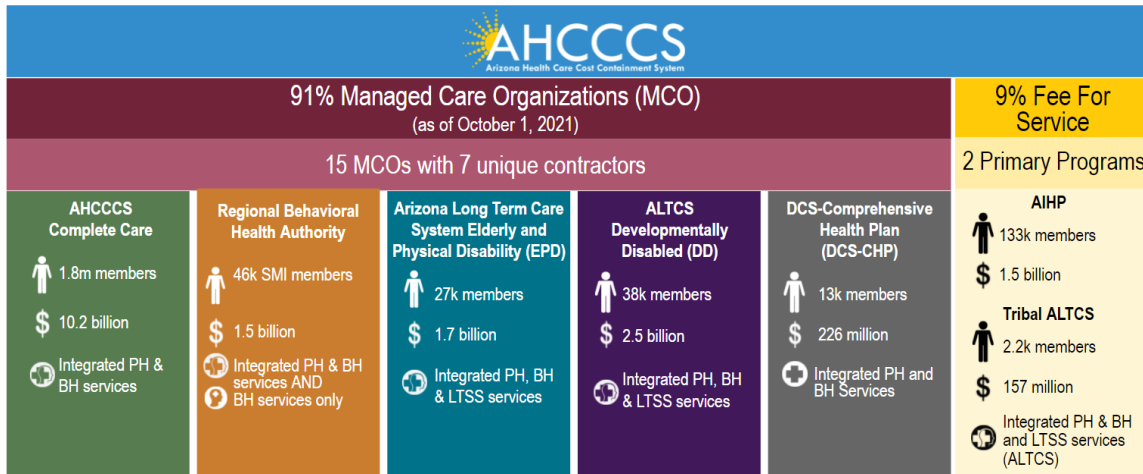
<sup>55</sup> [azahcccs.gov/shared/Downloads/AHCCCSAtaGlanceNov2020.pdf](https://www.azahcccs.gov/shared/Downloads/AHCCCSAtaGlanceNov2020.pdf). AHCCCS @ A GLANCE November 2020. Accessed August 1, 2021.

<sup>56</sup> AHCCCS in Process Slides August 2021.

<sup>57</sup> <https://www.azahcccs.gov/AHCCCS/Downloads/ACC/ACCAmericanIndianFAQ.pdf>



Figure 3: 2021–2022 AHCCCS System Overview as of October 2021<sup>58</sup>



Nearly all of the AHCCCS programs have transitioned to an integrated health plan model for physical health and mental health services in order to foster greater access and to improve health outcomes. Prior to this change, most AHCCCS members received their behavioral health services through a separate RBHA, which coordinated the delivery of mental health services per geographic region for AHCCCS members. Additional information regarding AHCCCS’ integrated health care system and efforts to improve care coordination may be found on the AHCCCS website ([Building an Integrated Health Care System \(azahcccs.gov\)](http://www.azahcccs.gov)).

*Medicaid Expansion*

In January 2014, Arizona opted to expand its Medicaid program. Coverage was extended to include individuals up to 133 percent of the federal poverty level, which is currently \$34,248 for a family of four. Due to Medicaid expansion, as of July 2019, individuals enrolled in Medicaid increased by 464,000.<sup>59</sup>

Arizona accepted federal funding to expand Medicaid in 2014, and as a result, the state’s rate of uninsured dropped from 17.1 percent in 2013 to 10 percent in 2016.<sup>60</sup> The state continued to see significant changes in the uninsured rate between 2018 and 2019 with a year increase of seven percent.<sup>61</sup> As of May 1, 2021, there were 2,217,132 residents (about 30 percent according to recent population estimates) enrolled in AHCCCS’ programs, and those numbers have been growing steadily.<sup>62</sup>

<sup>58</sup> AHCCCS In process Slides August 2021.

<sup>59</sup> <https://www.azleg.gov/jlbc/psaxsmedicaid.pdf> Accessed August 2, 2021.

<sup>60</sup> Expansion of Medicaid Eligibility. AHCCCS. Program Summary Document.

<sup>61</sup> Americas Health Rankings. 2020 Annual Report.

<sup>62</sup> AHCCCS Population Highlights. May 2021.



The state enrolled 16,991 new members between April 1 and May 1, 2021 alone, which was attributed to the Families First Coronavirus Response Act.<sup>63</sup>

### *Regional Behavioral Health Authorities*

Historically, behavioral health care was considered a separate benefit and managed by RBHAs. The overall purpose of RBHAs is to provide mental health case management services. Individuals with Serious Mental Illness (SMI) designation often had multiple health plans, and to better navigate the health care system RBHAs managed the delivery of both physical services and behavioral health services.<sup>64</sup> The RBHAs have played an integral role in providing the following services:<sup>65</sup>

- Integrated physical and behavioral health services for members with an SMI designation,
- Behavioral health services for members in the custody of the Arizona Department of Child Safety and enrolled in the Arizona Department of Child Safety/Comprehensive Medical and Dental Program (DCS/CMDP),
- Crisis services including telephone, community-based mobile, and facility-based stabilization, and
- Substance Abuse and Mental Health Services Administration (SAMHSA) grants and other Non-Title XIX/XXI funded services including housing.

In April 2021, AHCCCS integrated health care for children in foster care placing their physical, dental and behavioral health care under a single health plan.<sup>66</sup> Most recently, starting October 1, 2021, the Arizona Behavioral Health Corporation administers the AHCCCS Housing Program to provide permanent supportive housing and support programs for members with mental health issues who are experiencing homelessness. Along with these changes, the majority of the behavioral health services have shifted to the AHCCCS Complete Care integrated model which combines physical, dental, and behavioral health care under a single plan.

AHCCCS collected stakeholder feedback on suggested changes for the RBHA delivery system through the means of community forms and surveys.<sup>67</sup> On October 1, 2022, one AHCCCS Complete Care (ACC) health plan in each geographic service area (GSA) now has its provision of services expanded to include individuals that have an SMI designation.<sup>68</sup> This form of expansion of services to one ACC health plan in each GSA enables members with an SMI designation to have a more integrated health plan; thereby, making the provision of care seamless and more effective.

<sup>63</sup> AHCCCS Population Highlights. May 2021.

<sup>64</sup> <https://www.azahcccs.gov/AHCCCS/Initiatives/CareCoordination/behavioralhealth.html> Behavioral Health. Accessed September 23, 2021.

<sup>65</sup> Ibid.

<sup>66</sup> Ibid.

<sup>67</sup> Ibid.

<sup>68</sup> Ibid.



### *ACC Integration*

In October 2018, AHCCCS implemented the ACC integrated model of care for health plans. The ACC integrated model of care combines physical and behavioral health services under one chosen Medicaid MCO.<sup>69</sup> The ACC is described as an integrated health system, which allows for better coordination amongst providers within a single network. Some of the goals of the ACC integrated model are to improve health outcomes, improve member experience, and cost containment.

### *Medicaid FFS*

The DFSM within AHCCCS serves as the official health plan for Arizona’s FFS Medicaid members which serves over 128,000 members.<sup>70</sup> The majority of the FFS enrollees are members of the American Indian and Alaskan Native Populations.

The covered FFS programs and populations consists of the following:

- AIHP,
- American Indian Medical Home (AIMH),
- Tribal Regional Behavioral Health Authorities (TRBHA),
- Tribal ALTCS Program,
- Federal Emergency Services,
- FFS Regular,
- FFS Temporary,
- FFS Prior Quarter,
- Hospital Presumptive Eligibility,
- School Based Claiming,
- Pharmacy Benefit Manager (PBM), and
- Arizona Department of Corrections (ADOC).

### *Medicaid Long-Term Services and Supports*

Long-Term Services and Supports (LTSS) are both institutional care and home and community-based services (HCBS) for a diverse group of Medicaid members who often have complex conditions and high needs, making these services among the most expensive of Medicaid programs.<sup>71</sup> ALTCS is administered through several program contractors. The program contractors’ work with care providers, pharmacies,

<sup>69</sup> <https://www.azahcccs.gov/AHCCCS/Initiatives/AHCCCSCompleteCare/> AHCCCS Complete Care: The Future of Integrated Healthcare. Accessed September 22, 2021.

<sup>70</sup> AHCCCS In process Slides August 2021.

<sup>71</sup> <https://www.macpac.gov/topics/long-term-services-and-supports/>. Medicaid Long Term Services and Supports Annual Expenditures Report. Federal Fiscal years 2017 and 2018. January 7, 2021. Accessed August 20, 2021.



facilities and more to provide care for members.<sup>72</sup> Each ALTCS program member is assigned a case manager to coordinate their care.<sup>73</sup>

Arizona’s LTSS Medicaid expenditures in 2018 were the lowest in the nation at 18 percent. During the same year, Medicaid HCBS expenditures exceeded 75 percent of Medicaid LTSS.<sup>74</sup> Total Medicaid LTSS institutional expenditures increased by 10,342,792 million from 2017 to 2018. Total Medicaid HCBS expenditures increased by 163,917,295 million from 2017 to 2018. Additionally, total Medicaid expenditures increased by 308,372,097 million from 2017 to 2018.<sup>75</sup> The data from the Medicaid LTSS Annual Expenditures report from Federal Fiscal Years 2017 and 2018 indicate a trend of LTSS institutional spending decreasing and HCBS spending increasing.

### AHCCCS Agency Strategic Plan

AHCCCS currently has four overarching goals to guide its direction throughout fiscal year 2022. These strategies began in the year 2017 and were developed as a five-year strategy plan. Development of these four goals stem from the need to create a sustainable program that is manageable and does not overshadow in costs other key policy priorities such as public safety.<sup>76</sup>

Goals include the following:<sup>77</sup>

- **Goal 1. AHCCCS must pursue and implement long-term strategies that bend the cost curve while improving member health outcomes.**
- **Goal 2. AHCCCS must pursue continuous quality improvement.**
- **Goal 3. AHCCCS must reduce fragmentation driving towards an integrated sustainable healthcare system.**
- **Goal 4. AHCCCS must maintain core organizational capacity, infrastructure, and workforce planning that effectively serves AHCCCS operations.**

*Strategy One: Pursue and implement long-term strategies that bend the cost curve while improving member health outcomes*

Value-based purchasing is one policy strategy that helps healthcare delivery systems become sustainable.<sup>78</sup> The goal of value-based purchasing is to provide incentives for high-quality care while

<sup>72</sup> <https://www.azahcccs.gov/Members/AlreadyCovered/coveredservices.html> Covered Medical Services. Accessed September 23, 2021.

<sup>73</sup> Ibid.

<sup>74</sup> <https://www.macpac.gov/topics/long-term-services-and-supports/>. Medicaid Long Term Services and supports Annual Expenditures Report. Federal Fiscal years 2017 and 2018. January 7, 2021. Accessed August 20, 2021.

<sup>75</sup> Ibid.

<sup>76</sup> [https://www.azahcccs.gov/AHCCCS/Downloads/Plans/StrategicPlan\\_18-23.pdf](https://www.azahcccs.gov/AHCCCS/Downloads/Plans/StrategicPlan_18-23.pdf) AHCCCS Strategic Plan State Fiscal Years 2018–2023. September 24, 2021.

<sup>77</sup> [https://www.azahcccs.gov/AHCCCS/Downloads/Plans/FY2022\\_2-Page\\_StrategicPlan.pdf](https://www.azahcccs.gov/AHCCCS/Downloads/Plans/FY2022_2-Page_StrategicPlan.pdf) AHCCCS Fiscal Year 2022 Strategic Plan 2-Pager. Accessed September 23, 2021.

<sup>78</sup> [https://www.azahcccs.gov/AHCCCS/Downloads/Plans/StrategicPlan\\_18-23.pdf](https://www.azahcccs.gov/AHCCCS/Downloads/Plans/StrategicPlan_18-23.pdf) AHCCCS Strategic Plan State Fiscal Years 2018–2023. September 24, 2021.



keeping costs affordable. There are multiple approaches to value-based purchasing and AHCCCS has been able to achieve 77 percent of AHCCCS health plan spending in an alternative payment model.<sup>79</sup> Furthermore, from December 2019 to December 2020, telehealth services utilization increased by 172 percent which has helped to support strategy one of bending the cost curve while improving member health outcomes. For fiscal year 2022 the annual objectives that AHCCCS has planned to address strategy one include the following:<sup>80</sup>

- To increase school safety, AHCCCS' initiative is to partner with MCOs and providers to co-locate services on-campus and expand school-based claiming programs which provide reimbursements for the cost of Medicaid services provided to eligible students.
- To reduce health disparities, the annual initiative consists of increasing member enrollment in the American Indian Medical Home Program, which supports primary care case management.

*Strategy Two: Pursue continuous quality improvement*

Quality improvement is an integral component of AHCCCS as demonstrated by the continual review of national standards, regional trends, experiences and partner collaborations.<sup>81</sup> Some accomplishments made towards continuous quality improvement include the development of AHCCCS' Electronic Visit Verification (EVV) system that went live on January 2021 and the Arizona Provider Enrollment Portal that went live on August 2020. For Fiscal Year 2022, the plan to address strategy two includes the following objectives:<sup>82</sup>

- **Increase use of AHCCCS' automated provider enrollment platform.** Ongoing training and education will be offered to providers regarding how to use the automated platform.
- **Ensure seamless experience for individuals applying for AHCCCS benefits.** Focused oversight of the new contractor will be provided for AHCCCS' enrollment and eligibility system.
- **Address the behavioral health needs of uninsured and underinsured children.** AHCCCS will partner with MCOs and schools to develop referral policies and encourage use of the claims identifier and uniform referral and reporting methodology. They will also partner with the Arizona Department of Education to conduct outreach to additional schools for participation in programming.
- **Standardize treatment planning and placement for individuals with substance use disorders.** AHCCCS will offer Differential Adjustment Payment (DAP) Program incentive funding to

<sup>79</sup> [https://www.azahcccs.gov/AHCCCS/Downloads/Plans/FY2022\\_2-Page\\_StrategicPlan.pdf](https://www.azahcccs.gov/AHCCCS/Downloads/Plans/FY2022_2-Page_StrategicPlan.pdf) AHCCCS Fiscal Year 2022 Strategic Plan 2-Pager. Accessed September 23, 2021.

<sup>80</sup> Ibid.

<sup>81</sup> [https://www.azahcccs.gov/AHCCCS/Downloads/Plans/StrategicPlan\\_18-23.pdf](https://www.azahcccs.gov/AHCCCS/Downloads/Plans/StrategicPlan_18-23.pdf) AHCCCS Strategic Plan State Fiscal Years 2018–2023. September 24, 2021.

<sup>82</sup> [https://www.azahcccs.gov/AHCCCS/Downloads/Plans/FY2022\\_2-Page\\_StrategicPlan.pdf](https://www.azahcccs.gov/AHCCCS/Downloads/Plans/FY2022_2-Page_StrategicPlan.pdf) AHCCCS Fiscal Year 2022 Strategic Plan 2-Pager. Accessed September 23, 2021.



providers who integrate their Electronic Health Record (EHR) system with the American Society of Addiction Medicine continuum software.

*Strategy Three: Reduce fragmentation driving toward an integrated sustainable healthcare system*

AHCCCS recognizes that system design is critical in building a robust health care system.<sup>83</sup> The state has begun implementation of a closed-loop referral system (CLRS) to improve the process of referrals between clinicians and social services and reduce fragmentation.<sup>84</sup> For Fiscal Year 2022, the objectives to continue to reduce fragmentation in the healthcare system include:<sup>85</sup>

- **Improve AHCCCS member connectivity to critical social services.** AHCCCS will partner with its HIE, Contexture, to promote availability of the CLRS.
- **Provide a comprehensive resource for accessing treatment for opioid use disorder.** AHCCCS will continue to promote the availability of the treatment locator to interested parties.

*Strategy Four: Maintain core organizational capacity, infrastructure, and workforce planning that effectively serve AHCCCS operations*

In order to be successful and provide an effective care delivery system, it is important for AHCCCS to have a strong organizational foundation.<sup>86</sup> For Fiscal Year 2021, AHCCCS received an employee engagement score of 85 percent indicating that a majority of the employees believe that they have the tools needed to do their jobs. The objectives to address strategy four in Fiscal Year 2022 include:

- **Maximize use of remote work options.** AHCCCS will maintain organizational policies that support remote work options and offer ongoing training on how to work effectively in a remote work setting.
- **Prepare for anticipated staff retirements/departures.** To address departures, AHCCCS will develop a succession planning template and process.

### AHCCCS Whole Person Care Initiative (WPCI)

Starting in 2019, the Arizona AHCCCS WPCI was implemented to focus on SDOH. Arizona’s WPCI addresses social risk factors and encourages continued community partnerships to improve the health of Arizonans.<sup>87</sup> Through the WPCI, AHCCCS is able to enhance service delivery of Medicaid covered services and supports not available under the Arizona Medicaid program. The current priorities of WPCI include:<sup>88</sup>

<sup>83</sup> [https://www.azahcccs.gov/AHCCCS/Downloads/Plans/StrategicPlan\\_18-23.pdf](https://www.azahcccs.gov/AHCCCS/Downloads/Plans/StrategicPlan_18-23.pdf) AHCCCS Strategic Plan State Fiscal Years 2018–2023. September 24, 2021.

<sup>84</sup> [https://www.azahcccs.gov/AHCCCS/Downloads/Plans/FY2022\\_2-Page\\_StrategicPlan.pdf](https://www.azahcccs.gov/AHCCCS/Downloads/Plans/FY2022_2-Page_StrategicPlan.pdf) AHCCCS Fiscal Year 2022 Strategic Plan 2-Pager. Accessed September 23, 2021.

<sup>85</sup> Ibid.

<sup>86</sup> [https://www.azahcccs.gov/AHCCCS/Downloads/Plans/StrategicPlan\\_18-23.pdf](https://www.azahcccs.gov/AHCCCS/Downloads/Plans/StrategicPlan_18-23.pdf) AHCCCS Strategic Plan State Fiscal Years 2018–2023. September 24, 2021.

<sup>87</sup> <https://www.azahcccs.gov/AHCCCS/Initiatives/AHCCCSWPCI/> AHCCCS Whole Person Care Initiative (WPCI). Accessed September 23, 2021.

<sup>88</sup> Ibid.





- Providing support for transitional housing, particularly for members being discharged from an inpatient behavioral health facility, individuals experiencing chronic homelessness, and individuals transitioning from correctional facilities with limited resources to reduce recidivism,
- Exploring ways to leverage existing non-medical transportation services to support a member’s access to community-based services such as access to healthy food and employment services,
- Utilizing the existing service array to model service delivery aimed at reducing social isolation for members utilizing the ALTCS including consideration of a peer workforce to provide the services, and
- Partnering with the Arizona HIE, Contexture, to establish a single statewide CLRS enabling health care providers to more easily screen and refer members to community-based social services organizations to address social risk factors of health.

### AHCCCS 1115 Waiver

Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that can assist in promoting the objectives of the Medicaid program.<sup>89</sup> On September 30, 2016, CMS approved Arizona’s 1115 Waiver request to modernize the Medicaid program and continue many of the existing authorities that allows AHCCCS to maintain its unique and successful managed care model. The waiver also includes use of HCBS for members with long-term care needs and other innovations that make AHCCCS one of the most cost-effective Medicaid programs in the nation. On September 30, 2021, CMS granted a one-year extension to the existing 1115 Waiver. Subsequently, AHCCCS has requested a five-year renewal of Arizona’s Demonstration project which, if approved, would enable the program to continue through September, 2027. Highlights of the 1115 renewal include:

- Mandatory managed care,
- HCBS for individuals in the ALTCS,
- Administrative simplifications that reduce the inefficiencies in eligibility determination,
- Integrated health plans for AHCCCS members,
- Payments to providers participating in the TI Program including an expanded program, and
- Waiver of Prior Quarter Coverage for specific populations.

In addition to renewing current waiver and expenditure authorities, AHCCCS is seeking to implement the following:

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<sup>89</sup> Medicaid.gov About Section 1115 Demonstrations. Available at: <https://www.medicaid.gov/medicaid/section-1115-demonstrations/about-section-1115-demonstrations/index.html>



- Authority to allow for verbal consent in lieu of written signature for up to 30 days for all care and treatment documentation for ALTCS members when included in the member's record and when identity can be reliably established,
- Authority to reimburse traditional healing services provided in, at, or as part of services offered by facilities and clinics operated by the Indian Health Service (IHS), a tribe or tribal organization, or an Urban Indian health program, and
- Authority to reimburse IHS and Tribal 638 facilities to cover the cost of adult dental services that are eligible for 100 percent federal financial participation, that are in excess of the \$1,000 emergency dental limit for adult members in Arizona's State Plan and \$1,000 dental limit for individuals age 21 or older enrolled in the ALTCS program.

With the conclusion of HITECH funding on September 30, 2021, all state Medicaid agencies will need to be more collaborative with HIEs in order to meet the requirements of 1115 demonstrations. This may include the state tracking HIE utilization and collaborating with organizations to ensure data strategies are integrated and supportive of a unified vision. AHCCCS continues its partnership with Contexture to support agency priorities, including the AHCCCS' 1115 waiver.

### Other AHCCCS Priorities - Integrated Health Care System

One of AHCCCS' strategic priorities is to reduce fragmentation within the health care system and move toward an integrated, sustainable system.<sup>90</sup> Benefits of an integrated health system include improving health outcomes and better management of limited resources.<sup>91</sup> AHCCCS developed multiple initiatives to drive towards an integrated health system including:<sup>92</sup>

- **Integrating Services for ALTCS Department of Economic Security, Division of Developmental Disabilities (DES/DDD) Members.** Beginning October 1, 2019, the behavioral health service responsibility for DDD members transitioned from RBHAs to a DDD integrated health plan.<sup>93</sup>
- **Integrating Behavioral and Physical Health for Persons with an SMI designation.** On October 1, 2022, one ACC health plan in each GSA will have their provision of services expanded to include individuals that have an SMI designation.<sup>94</sup>
- **Simplifying the System of Care for Children with Special Health Care Needs: Children's Rehabilitative Services (CRS).** Beginning October 8, 2019, members that qualify for CRS and are not enrolled with DES/DDD can enroll in AHCCCS Complete Care.<sup>95</sup>

<sup>90</sup> [https://www.azahcccs.gov/AHCCCS/Downloads/Plans/FY2022\\_2-Page\\_StrategicPlan.pdf](https://www.azahcccs.gov/AHCCCS/Downloads/Plans/FY2022_2-Page_StrategicPlan.pdf) AHCCCS Fiscal Year 2022 Strategic Plan 2-pager. September 23, 2021.

<sup>91</sup> <https://www.azahcccs.gov/AHCCCS/Initiatives/CareCoordination/> Building an Integrated Health Care System. September 23, 2021.

<sup>92</sup> Ibid.

<sup>93</sup> Ibid.

<sup>94</sup> <https://www.azahcccs.gov/AHCCCS/Initiatives/CareCoordination/behavioralhealth.html> Behavioral Health. September 23, 2021.

<sup>95</sup> <https://www.azahcccs.gov/AHCCCS/Initiatives/CareCoordination/CRS.html> What is a Children's Rehabilitative Services (CRS) Designation?. September 23, 2021.



- **Justice System Transitions.** In partnership with state and county governments, AHCCCS supports the effective transition of individuals exiting the criminal justice system. In collaboration with the ADOC, AHCCCS engages in a data exchange that enables AHCCCS to suspend an individual's Medicaid eligibility instead of eliminating their coverage upon incarceration.<sup>96</sup>

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<sup>96</sup> <https://www.azahcccs.gov/AHCCCS/Initiatives/CareCoordination/> Building an Integrated Health Care System. September 23, 2021.





# Improving Health Through Health Information Technology

## 3. Improving Health through Health Information Technology

The main goals of health IT adoption are to achieve improved health and health care quality, safety, and communication among all members of the care team while decreasing costs and increasing value.<sup>97</sup> Over the past decade, there has been substantial investment of both public and private funds to increase the adoption of electronic health records (EHRs) in both physician practices and hospitals across the country. Adoption and interoperability of health IT systems continues to be a primary focus for The Office of the National Coordinator for Health Information Technology (ONC), which is located within the Office of the Secretary for the U.S. Department of Health and Human Services.<sup>98</sup> The following section presents information regarding existing federal health IT related initiatives, programs, and guidance as well as describing health IT and its role in transforming and coordinating care.

### 3.1. Health IT Federal Guidance and Vision

#### ONC Vision and 2025 Roadmap

Interoperable health IT is a key ingredient in transforming health care. An interoperable health IT ecosystem allows users across organizations to access relevant data. A “learning health system” allows individuals, care providers, communities, and researchers to use an array of health IT products and services to exchange information, which enables stakeholders in the health care system to continuously learn. Aside from improving health care, the learning health system will theoretically lower health care costs, improve population health, empower consumers, and encourage innovation. The 10-year vision from ONC describes the benefits of interoperable health IT infrastructure as “all individuals, their families, and care providers should be able to send, receive, find, and use health information in a manner that is appropriate, secure, timely, and reliable.”<sup>99</sup>

ONC depicts the many stakeholders in the health IT ecosystem including patients, health care practices, broad populations, and the general public at large as indicated in *Figure 4*.<sup>100</sup>

<sup>97</sup> The Office of the National Coordinator. Health IT Enabled Quality Improvement. A Vision to Achieve Better Health and Health Care. Available at: <https://www.healthit.gov/sites/default/files/HITEnabledQualityImprovement-111214.pdf>

<sup>98</sup> ONC Health IT Presentation: CMS HITECH All States Webinar. February 24, 2021.

<sup>99</sup> Connecting Health and Care for the Nation: A Ten Year Vision to Achieve Interoperable Health IT Infrastructure, PAGE 2 [A Ten Year Vision to Achieve Interoperable Health IT Infrastructure](https://www.healthit.gov/sites/default/files/ONC10yearInteroperabilityConceptPaper.pdf) <https://www.healthit.gov/sites/default/files/ONC10yearInteroperabilityConceptPaper.pdf> 2014.

<sup>100</sup> *Ibid.*



Figure 4. Health IT Ecosystem Stakeholders



The learning health system includes more stakeholders than those in the clinical care setting; it may include state and local health departments, emergency response and public safety, hospitals, diagnostic labs, researchers, community-based social service agencies, and advocacy organizations. The learning health system emphasizes collaboration where data and findings are shared, with the common goal of improved medical practice and patient care. A learning health system leverages technology; for example, telecommunications, to improve access to care across clinical and non-clinical settings.<sup>101</sup>

### Trusted Exchange Framework and Common Agreement

In January, 2022 the ONC announced a major milestone beginning a new era of electronic HIE in the US.<sup>102</sup> The milestone has two major components. The first is the Trusted Exchange Framework, which establishes a set of non-binding principles to facilitate data sharing among health information networks. ONC is addressing an HIE challenge: many organizations belong to multiple health information networks, and most health information networks do not share data with each other. The second component is the Common Agreement, which operationalizes an easier way of sharing data across the US and provides easier ways for individuals and organizations to securely connect.<sup>103</sup> ONC recognizes that trusted exchange must be simplified in order to scale to nationwide interoperability.<sup>104</sup>

There are benefits of the Trusted Exchange Framework and Common Agreement (TEFCA) across stakeholder groups as illustrated below in *Figure 5*.

<sup>101</sup> <https://www.healthit.gov/sites/default/files/hie-interoperability/nationwide-interoperability-roadmap-final-version-1.0.pdf> (2016) and <https://sites.duke.edu/rethinkingclinicaltrials/learning-healthcare-systems/>

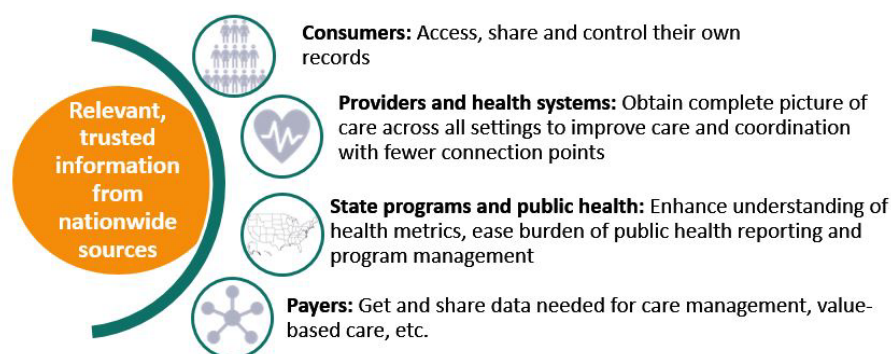
<sup>102</sup> <https://www.healthit.gov/buzz-blog/interoperability/321tefca-is-go-for-launch> Accessed March 14, 2022.

<sup>103</sup> Ibid. Accessed March 14, 2022.

<sup>104</sup> ONC TEFCA Update from the RCE, #178, August 12, 2021. See <https://rce.sequoiaproject.org/wp-content/uploads/2021/08/178.pptx>

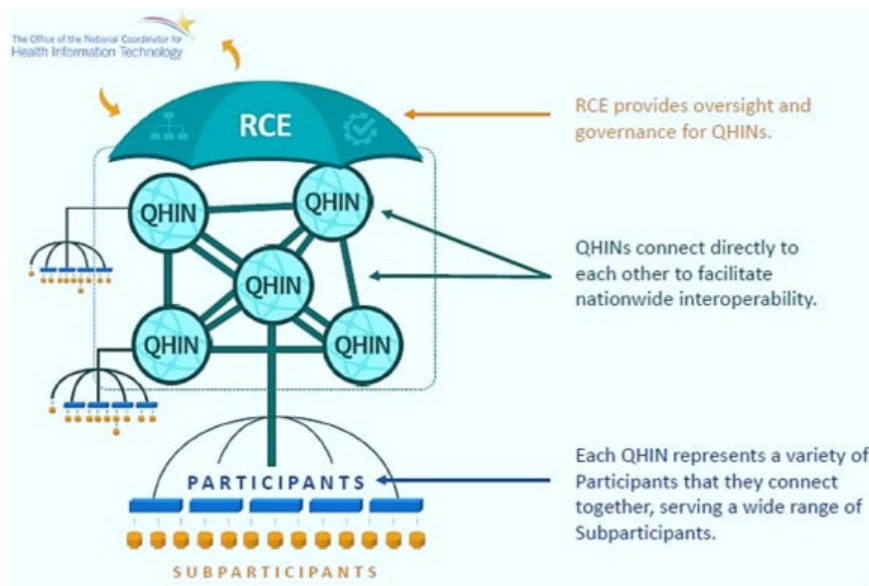


Figure 5: Benefits of TEFCA<sup>105</sup>



In the near future, health information networks will be able to apply to become Qualified Health Information Networks (QHINs) in the nationwide health information exchange.<sup>106</sup> The recognized coordinating entity (RCE), the Sequoia Project, will begin designating QHINS in 2022. QHINs can have various structures and serve as connectivity brokers (Figure 6).<sup>107</sup>

Figure 6: Sharing Among QHINs and Participants



The information that QHINs share is governed by terms and conditions in the Common Agreement. QHINs agree to comply with the QHIN technical framework, which is an implementation guide that

<sup>105</sup> ONC TEFCA Update from the RCE, #178, August 12, 2021. See <https://rce.sequoiaproject.org/wp-content/uploads/2021/08/178.pptx>

<sup>106</sup> <https://www.healthit.gov/buzz-blog/health-it/tefca-will-be-live-in-2022>

<sup>107</sup> [https://www.healthit.gov/sites/default/files/tefca\\_qa\\_webinar\\_1.19.pdf](https://www.healthit.gov/sites/default/files/tefca_qa_webinar_1.19.pdf)



specifies technical requirements. Consistent with the philosophy of building on what works, the technical and functional requirements described in the technical framework reflect many of the technologies and standards used for network-based exchange today, including those used by many community, state, and nationwide exchange networks.<sup>108</sup> The current minimum expectation for information exchanged under TEFCA is the U.S. Core Data for Interoperability (USCDI), although future additions may include population-level data exchange and Fast Healthcare Interoperability Resources (FHIR®) based exchange in the future.<sup>109</sup>

In August 2021, Health Current, Arizona’s HIE, became part of a regional organization named Contexture, which oversees the health information needs of 1,800 healthcare organizations in Colorado and Arizona. Contexture is a national leader in interoperability<sup>110</sup> and is currently evaluating how best to participate in the new TEFCA framework to meet the needs of its participants and stakeholders. Meanwhile ONC recommends that states follow the work of the RCE and if eligible, apply for QHIN designation when available. Achieving QHIN designation is a multi-step process<sup>111</sup> as illustrated in *Figure 7*. When the QHIN application package is finalized, it will be available through the REC.<sup>112</sup>

Figure 7: QHIN Designation Timeline<sup>113</sup>



An ONC effort parallel to TEFCA is an online survey for feedback on health interoperability outcomes. ONC asked for measurable and achievable yet aspirational outcomes to be reached by or before 2030. ONC examples were: “Because of interoperability, faxes are no longer used in clinical care before/by 2030,” and “Because of interoperability of health data, before or by 2030, everyone that is part of a care team will have accurate, up-to-date clinical information prior to providing care.” An “overwhelming”

<sup>108</sup> <https://rce.sequoiaproject.org/ghin-technical-framework-feedback/> Accessed March 14, 2022.

<sup>109</sup> ONC TEFCA Update from the RCE, #178, August 12, 2021. See <https://rce.sequoiaproject.org/wp-content/uploads/2021/08/178.pptx>

<sup>110</sup> <https://healthcurrent.org/corhio-health-current-contexture/>

<sup>111</sup> <https://rce.sequoiaproject.org/participate/> Accessed March 14, 2022.

<sup>112</sup> *Ibid* Accessed March 14, 2022.

<sup>113</sup> <https://rce.sequoiaproject.org/participate/> Accessed March 15, 2022.





number of survey responses were received and ONC created a synthesized set of outcome statements<sup>114</sup> reflecting collective sentiment for public review.<sup>115</sup>

### Interoperability and Patient Access Final Rules

On May 1, 2020, CMS released the Interoperability and Patient Access final rule. The purpose of the final rule is to increase patients' access to their personal health data and increase interoperability of the data between payers and agencies across the healthcare system. The final rule specifically impacts CMS-regulated payers and agencies including all Medicare Advantage organizations, all Medicaid and CHIP FFS programs, all types of Medicaid managed care plans (e.g., MCOs, prepaid inpatient health plan, and prepaid ambulatory health plan, as well as CHIP managed care entities, and Qualified Health Plans (QHPs) insurers on the federally-facilitated exchanges (FfEs). Each entity is required to implement an application programming interface (API) to allow patient information to be shared readily between patients and their health care providers and health plans. APIs are a set of commands, functions, protocols, or tools published by one software developer that enable other software developers to create programs (e.g., applications or "apps") that can interact with that company's software without needing to know the internal workings, all while maintaining consumer privacy data standards.<sup>116</sup> The main requirements of the Interoperability and Patient Access final rule include the following:

- Implement standards-based APIs that make claims, encounter, and clinical data available to patients through third-party apps of their choice within one business day of adjudication or receipt of encounter data,
- Leverage the API to make up-to-date provider directory information publically available, and
- Increase the frequency of data exchange with CMS to improve the daily dual-eligible member experience by April 1, 2022. MCOs must allow for standards-based sharing of clinical data with other payers at the patient's request by January 1, 2022.

Increasing a patient's access to their health information is a key benefit in addition to improved health outcomes due to providers and payers having comprehensive access to patient health information. One of the key goals of the final rule is to liberate health information and encourage patients to be informed about their healthcare.<sup>117</sup> To ensure patient information is protected during the exchange of information, CMS and ONC adopted the use of Health Level 7® (HL7) FHIR Release 4.0.1 as the standard to support data exchange through APIs.<sup>118</sup> As of July 2021, the two policies that are now in effect from the final rule include the requirements for hospitals with certain EHR capabilities to send admission, discharge, and transfer (ADT) notifications to other providers and the requirements for certain payers to

<sup>114</sup> <https://www.healthit.gov/topic/interoperability/health-interoperability-outcomes-2030> Accessed March 14, 2022.

<sup>115</sup> <https://www.healthit.gov/buzz-blog/interoperability/what-we-heard-health-interoperability-outcomes-2030> Accessed March 14, 2022.

<sup>116</sup> <https://www.federalregister.gov/d/2020-05050/p-116> CMS Final Rule. Accessed September 24, 2021

<sup>117</sup> <https://www.cms.gov/newsroom/fact-sheets/interoperability-and-patient-access-fact-sheet> Interoperability and Patient Access Fact Sheet. Accessed September 28, 2021.

<sup>118</sup> Ibid.



support Patient Access and Provider Directory APIs.<sup>119</sup> A recent update from CMS was published on September 15, 2021 stating that CMS will not take enforcement action against certain payers for the payer-to-payer data exchange final rule until future rulemaking is finalized.<sup>120</sup>

*Proposed and Future Rules Related to the Interoperability and Patient Access Final Rule*

On December 18, 2020, CMS published a new proposed rule: Reducing Provider and Patient Burden by Improving Prior Authorization Processes, and Promoting Patients’ Electronic Access to Health Information (CMS-9123-P). The proposed rule builds upon the policies and framework of the final rule. The purpose of the proposed rule is to improve the electronic exchange of health care data, continue the push toward interoperability, reduce burden in the health care market, and streamline processes related to prior authorization.<sup>121</sup> Prior authorization refers to the process where providers must request approval from payers before medical services or items are rendered to the patient. The proposed rule impacts Medicaid and CHIP managed care plans, state Medicaid and CHIP FFS programs, and QHPs issuers on the FFEs. Through the proposed rule, patients will have increased access to their health care information and the electronic exchange of health information between payers, providers, and patients will be improved.<sup>122</sup> The proposed rule consists of five proposals that are scheduled to take effect January 1, 2023, and include the following:<sup>123</sup>

- **Patient Access API.** To expand the established patient access API by including information about the patient’s pending and active prior authorization decisions and require impacted payers to establish, implement and maintain a process for third-party application developers to attest to privacy provisions prior to receiving patient data. Impacted payers must also report quarterly metrics to CMS regarding the use of the patient access API,
- **Provider Access API.** To require impacted payers to build and maintain a provider access API for payer-to-provider data sharing of claims and encounter data (emitting cost data), certain clinical data and pending and active prior authorization decisions,
- **Documentation and Prior Authorization Burden Reduction through APIs.** To reduce some of the burden of prior authorization and improve the patient experience, multiple polices are proposed to make the prior authorization process more efficient,
- **Payer-to-Payer Data Exchange on FHIR.** To increase data flow among payers and improve a patient’s access to their health information, a set of proposals were formed. Some of the policies include payer-to-payer data exchange at enrollment and the encouragement of payers

<sup>119</sup> <https://www.cms.gov/Regulations-and-Guidance/Guidance/Interoperability/index> Policies and Technology for Interoperability and Burden Reduction. Accessed September 28, 2021.

<sup>120</sup> Ibid.

<sup>121</sup> <https://www.cms.gov/newsroom/fact-sheets/reducing-provider-and-patient-burden-improving-prior-authorization-processes-and-promoting-patients> Reducing Provider and Patient Burden by Improving Prior Authorization Processes, and Promoting Patients’ Electronic Access to Health Information CMS-9123-P: Fact Sheet. Accessed September 28, 2021.

<sup>122</sup> Ibid.

<sup>123</sup> Ibid.



to use information from previous payers about a patient when making new prior authorization determinations, and

- **Adoption of Health IT standards and Implementation Specifications.** The ONC proposes to adopt standard implementation specifications for health care operations. This proposal ensures a cohesive approach is met to adopt all interoperability standards in a consistent manner and in one location for HHS use. A specified implementation guide will be identified to support implementation of the proposed APIs to ensure full interoperability of the APIs and reduce implementation burden.

### 3.2. SDOH Trends

SDOH are conditions in the places where people live, learn, work, and play that affect a wide range of health, functioning, and quality-of-life risks and outcomes. Safe housing, health care access, education quality, community, and economic stability are all considered SDOH.<sup>124</sup> In recent years, public health and nonprofit organizations have paid increasing attention to addressing SDOH. In fact, SDOH are a focus of CMS’s *Healthy People 2030*. The newly formed National Alliance to Impact the Social Determinants of Health presented President Biden’s transition team with several recommendations to impact SDOH.<sup>125</sup> The Biden Administration’s American Rescue Plan (APR) directly targets SDOH and other health disparities by expanding access to health insurance and implementing community-based programs.<sup>126</sup>

As influential factors in health, many medical providers are screening for and addressing SDOH. Ideally, EHRs include an SDOH screening tool which staff teams utilize to screen patients and document SDOH, and a crosswalk connects SDOH and diagnostic codes, yet, as the 2021 AHCCCS eScan data indicate, SDOH assessments are mainly conducted manually outside of the EHR. Caring for patients with unmet SDOH needs can be challenging, given that patients are referred to resources that are frequently outside the medical setting.<sup>127</sup> Further, needed resources, such as housing, may not be readily available in the community.

To assure patient needs are met, health care providers need a streamlined process to follow-up on referrals that can be easily integrated into the workflow. A closed-loop referral system (CLRS) is a feature of care coordination in which the referring provider gets confirmation from the receiving provider that services were obtained or the referral completed. In the past, it was common for specialists or community organizations to fax confirmation of a patient visit; however, faxing is time-consuming, inefficient, and can exclude valuable data. The goal of a CLRS is to assure patient-centric and timely services. A number of software platforms can be used to implement a CLRS and may be

<sup>124</sup> <https://health.gov/healthypeople/objectives-and-data/social-determinants-health>

<sup>125</sup> <https://www.hfma.org/topics/financial-sustainability/article/sdoh--an-emerging-population-health-priority.html>

<sup>126</sup> The White House. American Rescue Plan. Available at: <https://www.whitehouse.gov/american-rescue-plan/>

<sup>127</sup> <https://www.healthaffairs.org/doi/10.1377/hblog20190311.823116/full/>



interoperable with EHRs. CLRS can help improve the coordination between health care and community service providers and improve overall health outcomes.

CMS supports states addressing beneficiaries' SDOH through appropriate Medicaid and CHIP programs, which were described in a letter to state health officials in January 2021. CMS identifies the programs as 1905(a) state plan authority, HCBS options, section 1115 demonstrations, section 1945 health homes, some managed care programs, and the program of all-inclusive care for the elderly. CMS anticipates that strategies to address SDOH can be effective tools to lower the cost of health care, improve health outcomes, and increase the cost-effectiveness of health care services.<sup>128</sup>

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<sup>128</sup> CMS SHO# 21-001, Opportunities in Medicaid and CHIP to Address Social Determinants of Health.





# Current Health IT Landscape in Arizona

## 4. Current Health IT Landscape in Arizona

Dramatic advancements have been made in digitizing the health care delivery system during the past decade. In 2011, CMS established the Medicare and Medicaid EHR Incentive Programs (now known as the Promoting Interoperability, or PI, Program) to encourage Eligible Providers (EPs), eligible hospitals (EHs), and CAHs to adopt, implement, upgrade, and demonstrate meaningful use of certified electronic health record technology (CEHRT).<sup>129</sup> This section provides an overview of the health IT landscape of Arizona, highlighting the environmental scans (eScans) conducted to date; progress made by the Arizona Medicaid Promoting Interoperability program from its inception in 2011 to closure in 2021; advancements in health information exchange and efforts lead by Contexture; the collaborative relationship between AHCCCS and ADHS, and AHCCCS led healthcare redesign efforts such as the Whole Person Care Initiative, the TI Program, and DAP program.

### 4.1. Environmental Scans

#### Previous eScans

In an effort to understand progress of EHR adoption and other key measures of provider and hospital HIE utilization, CMS suggested states conduct eScans throughout the course of the Promoting Interoperability Program. eScans were also used to inform and update the SMHP, and assess use of and opportunities for HITECH funding. In Arizona, eScans were conducted throughout the course of the PI Program by the ASU Center for Health Information & Research (CHiR). Since 2007, CHiR has distributed surveys to providers to gain an understanding of providers' use of EHRs and HIE methods.

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<sup>129</sup> <https://www.cms.gov/regulations-and-guidance/legislation/ehrincentiveprograms>



**2021 AHCCCS eScan Overview**

AHCCCS utilized a multi-pronged approach to eScan engagement in 2021, including a community-based survey and small group interviews beginning in January 2021 and concluding in April 2021. Interviews were conducted with community and state representatives from a variety of areas including PI Program Eligible Providers, TI Program Eligible Providers, DAP Participants, Academia, Care Coordination Partners Professional Healthcare Organizations, Associations, Community-Based Organizations, and State of Arizona Government Agencies. The community-based survey was distributed to more than 800 contacts, including providers and practice managers.

*Focus Areas*

The eScan included six key areas of focus, including information regarding EHR adoption, PI program participation, HIE utilization, TI program participation, demographics, and focus on SDOH.

*Data Sources*

Survey questions from previous ASU CHiR surveys were utilized in the development of the 2021 AHCCCS survey to enable analysis of trends in EHR and HIE adoption over time and in accordance with CMS requirements. Other data sources used to inform trends over time include national sources of data from the ONC, CDC, American Hospital Association and the National Cancer Institute of Health Information National Trends Survey.

*Key Highlights*

Key highlights from the Arizona 2021 eScan are depicted in *Figure 8*.

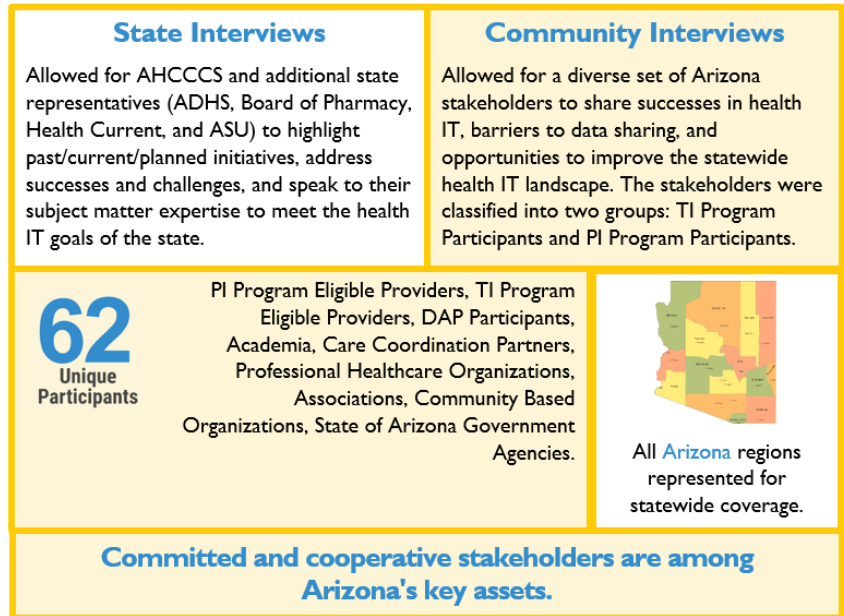
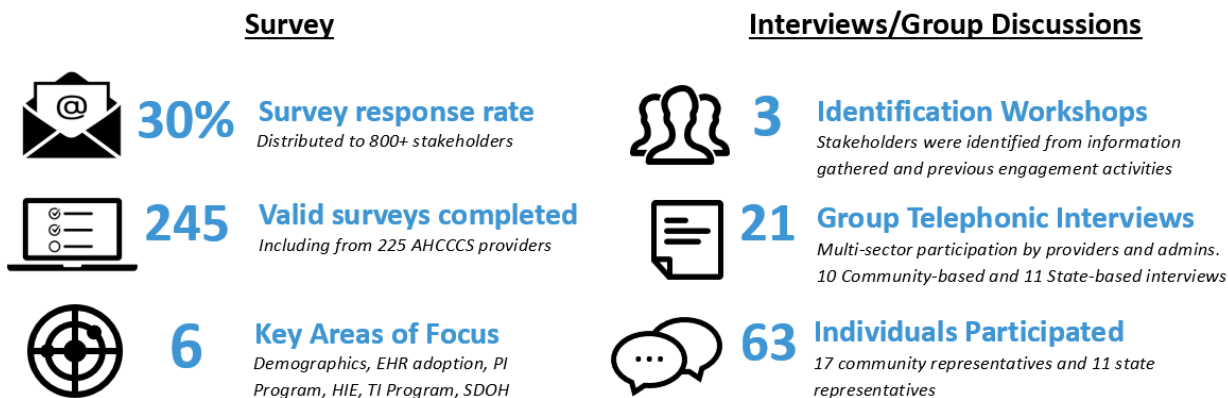


Figure 8: Arizona 2021 eScan Highlights



*Note: The survey was designed with branching logic to ask only relevant questions to each respondent, which reduced the burden of the respondent. After all results were compiled the data was reviewed for duplicate entries and invalid results. The 2021 AHCCCS survey was distributed to PI Program participants via MSLC and distributed by Health Current to their distribution list*

Perspectives and findings were provided by key stakeholder groups, including PI Program Eligible Providers, TI Program Eligible Providers, DAP Participants, Academia, Care Coordination Partners, Professional Healthcare Organizations, Associations, Community-Based Organizations, State of Arizona Government Agencies, and 2021 eScan survey respondents. The following sections summarize stakeholder perspectives by topic area: EHR adoption and utilization, HIE and interoperability, HIE incentive programs and integrated care, and SDOH and whole person care. Results from the eScan were used to inform the state’s overall health IT strategy and future direction, which were summarized in the final SMHP. For more detailed stakeholder findings, please refer to the 2021 AHCCCS eScan document.

## 4.2. Promoting Interoperability Program

### AHCCCS Medicaid PI Program

The Medicaid PI Program provided incentive payments to EPs and EHs as they demonstrated adoption, implementation, upgrading, or meaningful use of certified EHR technology. The incentive program was designed to support providers in this period of health IT transition and promote the use of EHRs in meaningful ways to help improve the quality, safety, and efficiency of patient health care. The AHCCCS Medicaid PI Program started in 2011 and has made a significant impact on EHR adoption within the state. Throughout the entire program, 7,795 payments were made to EPs and 248 payments to EHs. In total, \$296,428,977 has been distributed to participating providers and hospitals to adopt, implement, upgrade or demonstrate meaningful use of CEHRT. Participation of the program has ended as of September 30, 2021, but AHCCCS is still in the process of completing final payments and conducting appeals.





*Arizona Eligible Providers*

At the conclusion of the program, 7,795 EP payments were completed, including 254 payments to certified nurse midwives, 375 to dentists, 1,360 to nurse practitioners, 5,796 to physicians and 10 to physician assistants (*Table 1*).

Table 1. Provider Types Paid

| AHCCCS Provider Types Paid* Based on Program Year |              |              |              |              |            |              |            |            |           |          |          |              |
|---|--------------|--------------|--------------|--------------|------------|--------------|------------|------------|-----------|----------|----------|--------------|
| Provider Type                                     | 2011         | 2012         | 2013         | 2014         | 2015       | 2016         | 2017       | 2018       | 2019      | 2020     | 2021     | Count        |
| CERTIFIED NURSE - MIDWIFE                         | 53           | 30           | 29           | 35           | 11         | 41           | 31         | 22         | 2         | 0        | 0        | 254          |
| DENTIST   | 74           | 44           | 56           | 42           | 47         | 77           | 16         | 18         | 1         | 0        | 0        | 375          |
| MD-PHYSICIANS                                     | 1,018        | 1,118        | 902          | 756          | 523        | 777          | 385        | 256        | 61        | 0        | 0        | 5,796        |
| PHYSICIAN ASSISTANT                               | 4            | 5            | 1            | 0            | 0          | 0            | 0          | 0          | 0         | 0        | 0        | 10           |
| REGISTERED NURSE PRACTITIONERS                    | 178          | 167          | 215          | 187          | 129        | 295          | 114        | 67         | 8         | 0        | 0        | 1,360        |
| <b>Count Total by Calendar Year</b>               | <b>1,327</b> | <b>1,364</b> | <b>1,203</b> | <b>1,020</b> | <b>710</b> | <b>1,190</b> | <b>546</b> | <b>363</b> | <b>72</b> | <b>0</b> | <b>0</b> | <b>7,795</b> |

Data source: AHCCCS Pre-pay Team, Payment Report, October 2021

\*This includes all payments processed by AHCCCS including any payments that were subsequently recouped.

*Arizona Eligible Hospitals*

As shown in *Table 2*, 75 Arizona hospitals participated in the program. Since 2011, 58 acute care hospitals, three children’s hospitals and 14 CAHs have received a payment. Seven of these hospitals are designated as IHS/638. Seven EHs did not participate in the program.

Table 2: Arizona Promoting Interoperability Incentive Program Hospitals by Type

**AHCCCS Eligible Hospitals for PI Program Paid by Hospital Type**

| Hospital Type                       | IHS/638  | Non-IHS/638 | Count     |
|-------------------------------------|----------|-------------|-----------|
| Acute Hospital                      | 5        | 53          | 58        |
| Children’s Hospital                 | 0        | 3           | 3         |
| Critical Access Hospital            | 2        | 12          | 14        |
| <b>Count Total by Calendar Year</b> | <b>7</b> | <b>68</b>   | <b>75</b> |

*EHR Adoption and Utilization Stakeholder Perspectives*

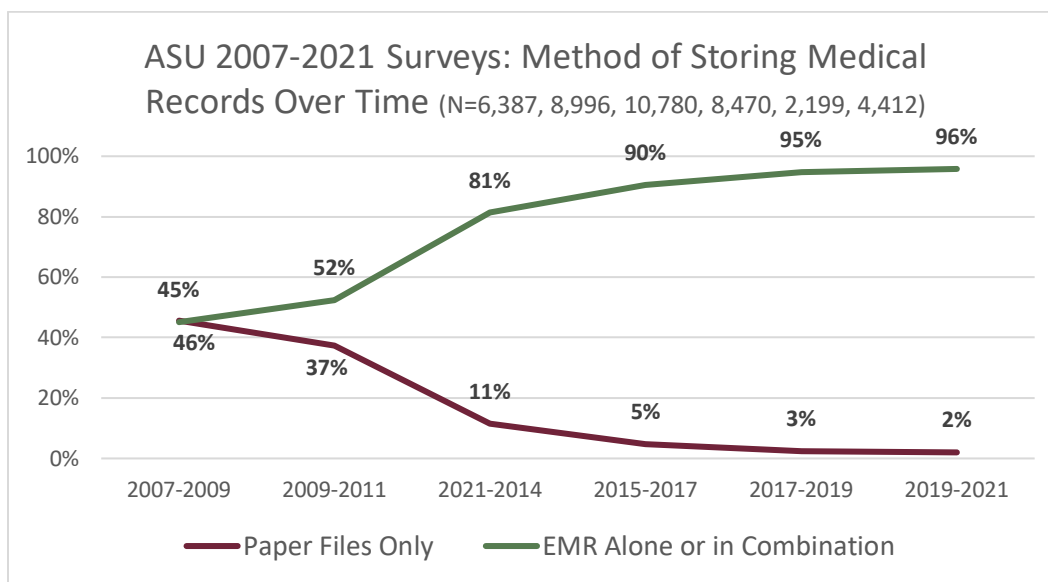
EHR and electronic medical record (EMR) are two different terms. EMR are the digital form of medical paper charts while an EHR contains greater functionality, including the ability to exchange data with other providers and analyze data. EHRs also allow patients greater access to and control of their health care.



Stakeholders overall described a high rate of EHR adoption, or use of effective homegrown systems, to maintain records. An overwhelming majority of community stakeholders utilize an EHR product and reported improved care coordination as a result. The 2021 eScan survey data show that 92 percent of respondents have an EHR. ASU CHiR data suggests a 96 percent rate of EHR adoption among Medical Doctors and Doctors of Osteopathy in the recent 2019–2020 survey.

Electronic medical record (EMR) use for Arizona physicians have increased and is now consistent with national trends. EMR use has grown from 52 percent in years 2009–2011 to 81 percent in 2012–2014 to 90 percent in 2015–2017 to 95 percent in 2017–2019 to 96.2 percent in 2020–2021 as seen in *Figure 9*.<sup>130</sup>

Figure 9: ASU 2007-2-21 Surveys: Method of Storing Medical Records

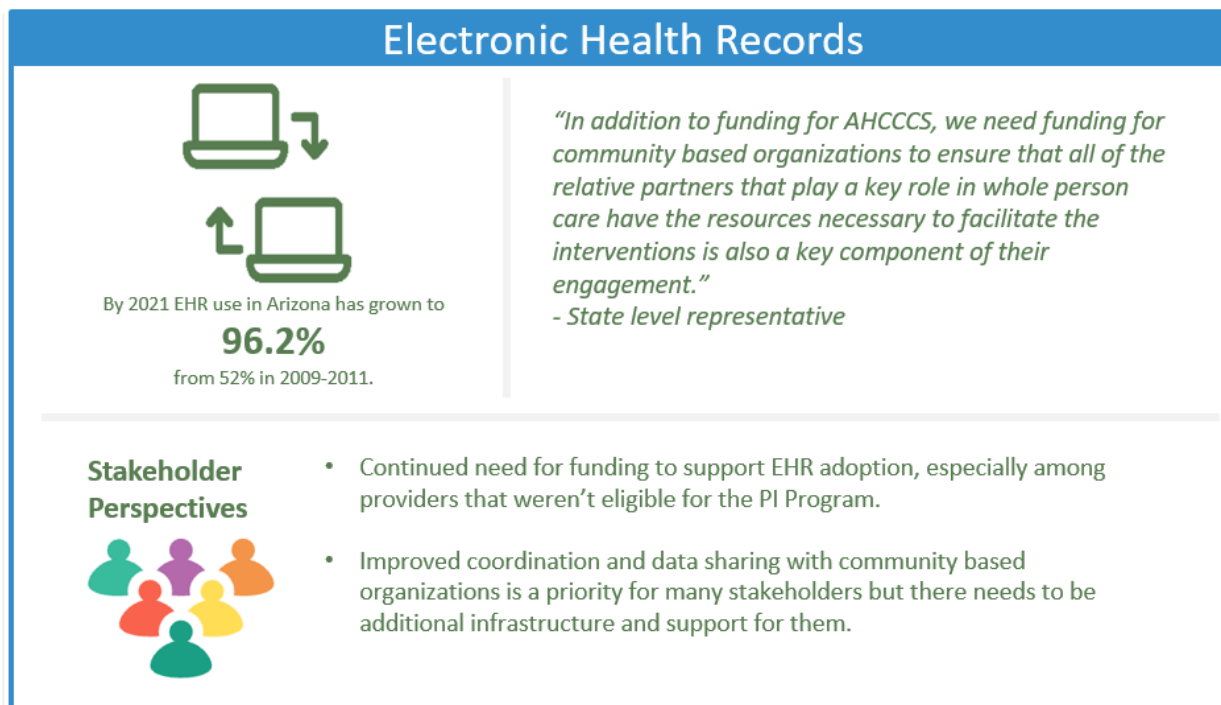


While there have been funding opportunities at both the state and federal levels for health IT adoption for some provider types, there is a continued need for enhanced federal funding to support health IT adoption among provider types ineligible for participation in federal initiatives such as the PI programs. AHCCCS recognizes this need and is committed to investing in programs to support stakeholders stated needs through the development of the Targeted Investment and Differential Adjusted Payment programs as described in Section 4.3. Several community-level providers pointed to provider types that were ineligible for incentive programs that are in need of health IT improvements and the ability to exchange data electronically, namely specialty and behavioral health facilities. *Figure 10* summarizes eScan findings related to EHRs.

<sup>130</sup> Arizona State University Survey Data, 2009–2021.



Figure 10: Arizona 2021 eScan Highlights: Electronic Health Records



### 4.3. HIE Environment

#### Contexture

AHCCCS is focusing its efforts on strengthening the partnership with its HIE, Health Current, which became part of a regional organization, Contexture, in 2021. Contexture is a collaboration between the Colorado Regional Health Information Exchange (CORHIO) and Health Current. The new umbrella organization provides the opportunity to bring together the best parts of both organizations to create an entity that can even better serve the healthcare ecosystems in both Arizona and Colorado. The goals of the combined organization are to:<sup>131</sup>

- Increase innovation and expertise,
- Expand data types and data sets available to both organizations,
- Drive greater impact in the communities and with the provider, state, and public health partners in each state,

<sup>131</sup> Contexture Strategic Plan for HIE-Enabled Medicaid & Public Health Priorities December 2021.




- Meet the interoperability needs of key stakeholders, and
- Support other HIEs to lessen administration burdens, coordinate technology, and improve return on investment.

Contexture functions as a network-of-networks. It has direct connections with hospitals, health plans, community health centers, providers, Accountable Care Organizations (ACOs), Integrated Delivery Networks, clinically integrated networks, other HIEs, and connects to the eHealth Exchange in order to access data from federal partners including CMS, Veterans Affairs, the Social Security Administration, the Department Of Defense, and other out-of-state HIEs.


*Contexture Services*

Contexture offers a variety of HIE services to provide comprehensive patient information for HIE participants. *Table 3* highlights the seven key services offered, including the following.<sup>132</sup>









Contexture has implemented a SDOH CLRS with no fees for community providers to support integrated physical and behavioral health.

Table 3. Contexture Services

| Contexture Services   |  |
|---|--|
|  | <p><b>Alerts</b></p> <ul style="list-style-type: none"> <li>• <b>Inpatient Alerts.</b> Alert the organization that a specific patient/member has been admitted to or discharged from an inpatient facility.</li> <li>• <b>Emergency Department (ED) Alerts.</b> Alert the organization that a specific patient/member has been registered at or discharged from an emergency department.</li> <li>• <b>Ambulatory Alerts.</b> Alert the organization that a specific patient/member has been registered at an ambulatory facility or practice.</li> <li>• <b>Clinical Results Alerts.</b> Alert the organization when a specified type of clinical result or document has been received by the HIE for a specific patient/member. The actual result or document is attached to the Alert.</li> <li>• <b>Patient Centered Data Home (PCDH) Alerts.</b> Alert the organization that a specific patient/member has been admitted to or discharged from an inpatient facility or has been registered at or discharged from an emergency department outside of Arizona.</li> <li>• <b>COVID-19 Lab Results.</b> Arizona HIE participants can receive real-time COVID-19 Alerts for any patient on their patient panel.</li> <li>• <b>Mental Illness Hospitalization Alerts.</b> Notifications for admissions, ADTs of patients from level-1 psychiatric hospitals.</li> </ul> |

<sup>132</sup> <https://healthcurrent.org/hie/benefits-services/> HIE Services. Accessed September 28, 2021.



| Contexture Services   |   |
|---|---|
|    | <p><b>Direct Email</b></p> <ul style="list-style-type: none"> <li>Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliant, secure email account that provides the means for registered users to exchange patient PHI with other Direct Trust-certified email accounts.</li> </ul>   |
|    | <p><b>Portal</b></p> <ul style="list-style-type: none"> <li>Secure web-based access that allows selected patient/member data to be viewed online.</li> </ul>  |
|    | <p><b>Data Exchange</b></p> <ul style="list-style-type: none"> <li><b>Unidirectional Exchange.</b> Electronic interface between patient tracking systems and the HIE with information flowing in only one direction.</li> <li><b>Bidirectional Exchange.</b> Electronic interfaces between patient tracking systems and the HIE with information flowing in both directions.</li> </ul>   |
|   | <p><b>Clinical Summary</b></p> <ul style="list-style-type: none"> <li><b>Automated Clinical Summary.</b> In response to an alert, comprehensive continuity of care document (CCD) containing up to 90 days of the patient’s most recent clinical and encounter information is returned to the treating organization.</li> <li><b>Query/Response Clinical Summary.</b> In response to the receipt of a standard compliant query, a comprehensive CCD containing up to 90 days of the patient’s most recent clinical and encounter information is pushed back to the requesting organization.</li> <li><b>PCDH Clinical Summary.</b> This summary pushes a comprehensive CCD containing up to 90 days of the patient’s most recent clinical and encounter information to requesting organization, including out-of-state information, as the result of a PCDH Alert.</li> </ul> |
|  | <p><b>Controlled Substances Program</b></p> <ul style="list-style-type: none"> <li>In August 2017, Contexture partnered with the Arizona State Controlled Substances Prescription Monitoring Program (PMP). Contexture participants can access Arizona’s PMP through the Contexture platform.</li> </ul>  |
|  | <p><b>SDOH Closed-Loop Referral System</b></p> <ul style="list-style-type: none"> <li>In 2021, as part of the WPCI strategy, AHCCCS partnered with Contexture to develop a technology solution that can support providers, health plans, community-based organizations (CBOs) and community stakeholders in meeting the health care and social-economic needs of Arizonans.</li> </ul>  |



### Contexture Services

- Contexture procured the Unite Us (formerly NowPow)<sup>133</sup> personalized community referral platform through a competitive bid process. Unite Us supports whole person care across whole communities. The referrals are highly matched and filtered, making it easy to connect people to the right community resources so everyone can stay well, meet basic needs, manage an illness, and care for others. Additionally, the Unite Us population health solution provides deep community resource and referral insights to support process improvement, network health and quality, and care access and experience.

#### *Contexture Technical Infrastructure and Capabilities*

Contexture has a variety of technical features that enable it to seamlessly transfer patient information. In order to store all patient information and data transactions, Contexture has a clinical data repository. The HIE contains a Master Person Index (MPI) which allows each patient in the Contexture system to have a unique identifier.<sup>134</sup> Mirth Connect is the integration engine that Contexture uses to manage query-response interactions with eHealth Exchange and to distribute its alerts and notifications.<sup>135</sup> The integration engine also has the ability to edit, transform, and map data to various national standard codes and formats.<sup>136</sup>

#### *Contexture HIE Governance*

The Contexture board is comprised of 20 organizational representatives, which includes the Director of AHCCCS. Contexture serves as the community statewide governance entity for health IT and HIE within Arizona. The Contexture board members are recruited from Arizona and Colorado and oversee all functions of the non-profit organization. *Figure 11* shows the governance structure of Contexture.

<sup>133</sup> <https://uniteus.com/>

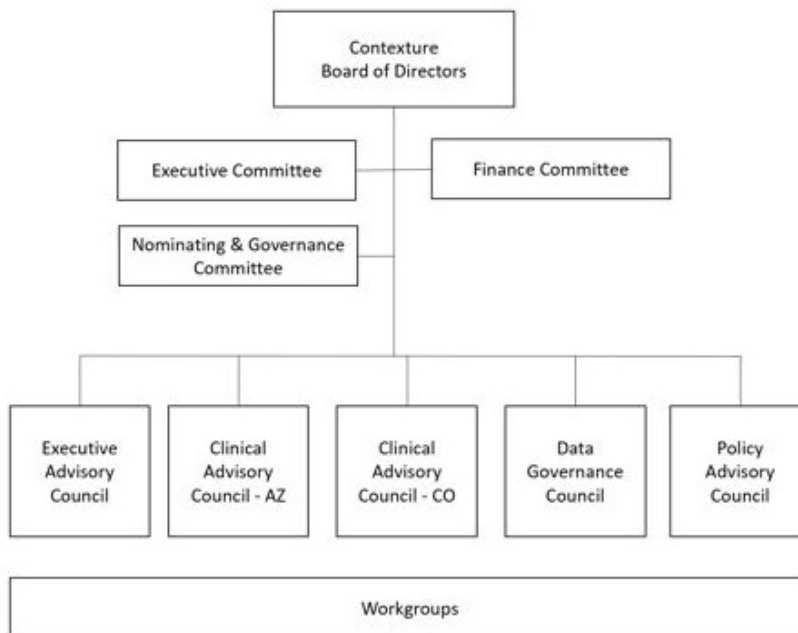
<sup>134</sup> <https://healthcurrent.org/hie/benefits-services/> HIE Services. Accessed September 28, 2021.

<sup>135</sup> *Ibid.*

<sup>136</sup> *Ibid.*



Figure 11: Contexture Governance Structure



Data Source: Contexture September 2021

The board and staff are involved in health IT and HIE activities including recruitment of HIE participants, supporting the annual education and outreach conference hosted by Contexture, and oversight of the funding for education programs and the HIE by approving an annual budget.

*Contexture Funding*

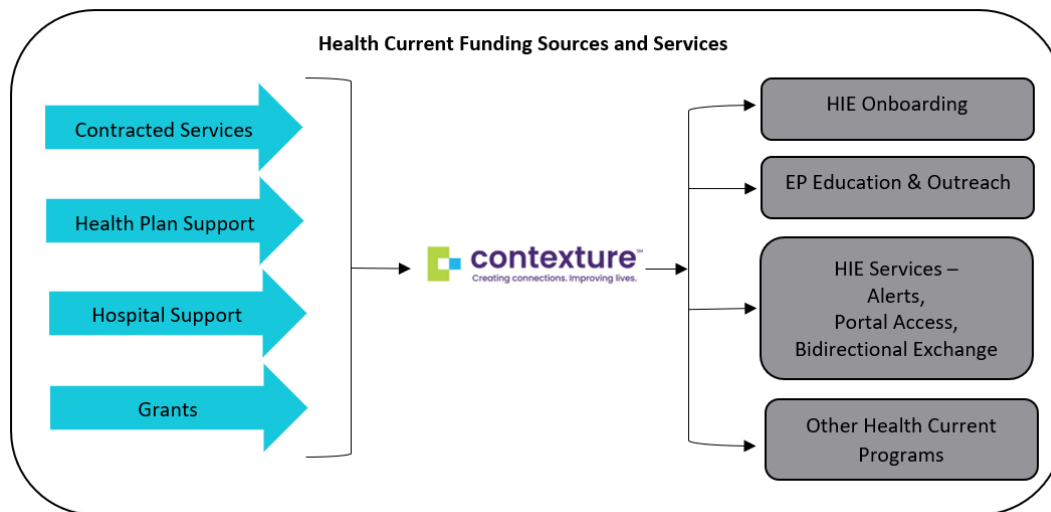
AHCCCS added a contract requirement to the MCO Acute Care plans requiring them to participate with Contexture. It is expected that the Medicaid MCOs will be able to improve their care coordination abilities by getting access to real time clinical data that is available at the HIE. Health Plans and Hospitals each pay 50 percent of the ongoing operational fees, which are offset by any grants, or other funding Contexture receives. Contexture receives revenue through multiple funding streams which helps ensure its sustainability. *Figure 12* illustrates a variety of Contexture funding sources and services/programs they are implementing to support member needs.



Contexture updated its fee structure in 2015, eliminating on-boarding fees to community providers, which has resulted in an increase in HIE participants.



Figure 12: Contexture Community Funding and Services (2020)<sup>137</sup>



Data Source: Contexture September 2022

### Contexture Strategic Plan 2020–2022

In March 2020, Contexture published its strategic plan and shared the updated four pillars of success, which include the following (Figure 14):<sup>138</sup>

- **Data Integration.** Acquiring more complete information and working closely with HIE participants and their workflow processes to ensure integration with more complete patient information to improve care delivery,
- **Data Acquisition.** Continuing to add new data sources such as new types of organizations, claims data and medication fill history data,
- **Data Quality.** Normalizing and standardizing shared data, including utilizing accepted data coding to make data more meaningful, comprehensive and actionable, and
- **Data Management.** Delivering data in meaningful, valuable ways to accomplish effective care coordination, quality improvement, predictive risk modeling and management, population health analysis, and more.

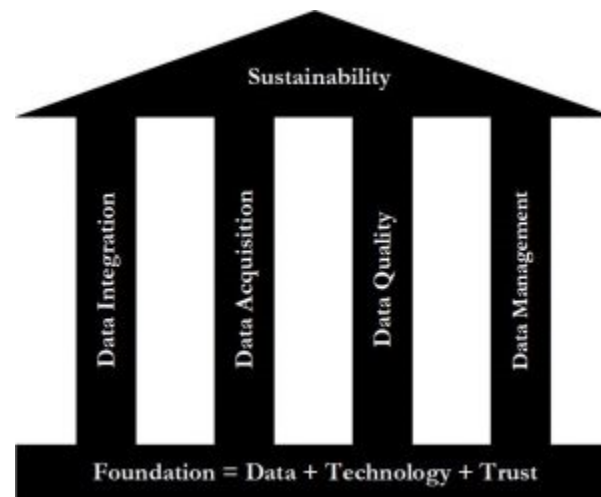
<sup>137</sup> <https://healthcurrent.org/about-us/health-current-strategic-plan/> Health Current Strategic Plan. Accessed September 28, 2021.

<sup>138</sup> [https://healthcurrent.org/wp-content/uploads/HC\\_Webinar\\_3YearStrategicPlan\\_02252020\\_FINAL.pdf](https://healthcurrent.org/wp-content/uploads/HC_Webinar_3YearStrategicPlan_02252020_FINAL.pdf) Arizona’s Health IT Future: The Health Current Three-Year Strategic Plan, 2020-2022. Accessed September 28, 2021.





Figure 13: 2020–2022 Contexture Strategic Business Plan 4 Pillars of Success<sup>139</sup>



For the 2020–2022 strategic plan, Contexture seeks to bundle HIE services into service packages customized by participant categories (FQHC, post-acute, behavioral health, etc.), continue to collect data to close gaps, customize data identification and delivery when searching for participant-specified data, and assemble comprehensive patient records.<sup>140</sup>

#### *2021 Contexture Strategic Plan for HIE-Enabled Medicaid and Public Health Priorities*

As part of the merger, Contexture developed this strategic plan in collaboration with AHCCCS and ADHS. The intent of the plan is to ensure that the HIE best supports the goals and objectives of Medicaid and public health. This effort included 36 interviews across 33 different organizations representing a cross-section of the Arizona healthcare system, as well as experts from other state agencies and HIEs in the nation. These discussions helped to identify 190 potential use cases for the HIE to support the goals of the healthcare system, with most benefitting both Medicaid and public health. Contexture is collaborating with AHCCCS, ADHS, and the community to define their strategic plan, especially related to:

- COVID-19,
- Securing other public health data feeds,
- Better integration of health information,
- Data analytics,

<sup>139</sup> [https://healthcurrent.org/wp-content/uploads/HC\\_Webinar\\_3YearStrategicPlan\\_02252020\\_FINAL.pdf](https://healthcurrent.org/wp-content/uploads/HC_Webinar_3YearStrategicPlan_02252020_FINAL.pdf) Arizona’s Health IT Future: The Health Current Three-Year Strategic Plan, 2020-2022. Accessed September 28, 2021.

<sup>140</sup> Ibid.




- Care coordination and alerts, and
- MPI.

**HIE Adoption and Utilization**

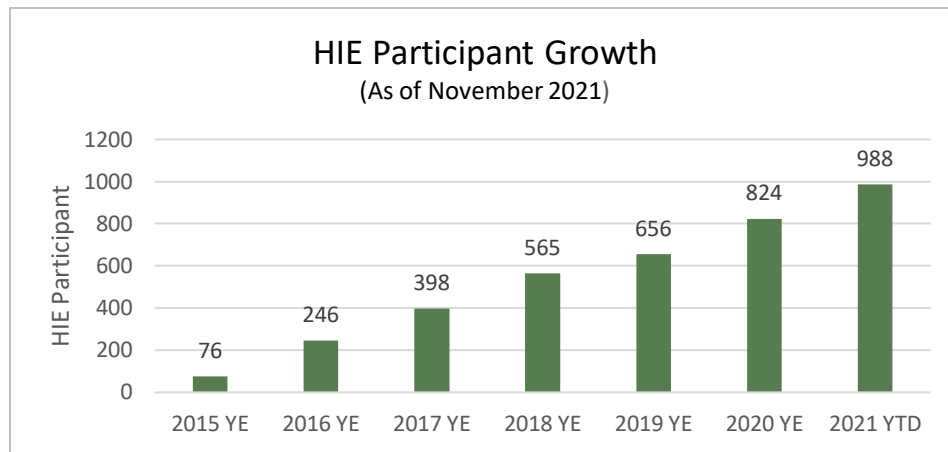
*HIE Statistics*

Contexture has seen significant growth from 2015. As of November 2021, there are 988 organizations with a signed participation agreement in place as seen in *Figure 14*. This represents over 1,000 percent growth from 2015 to 2021. *Table 4* lists the current total participants by type.<sup>141</sup>



Contexture has seen over 1000 percent growth from 2015–2021.

Figure 14: Contexture: HIE Participant Growth



Data Source: Contexture November 19, 2021

Table 4. HIE Participants

| Participant Type                        | 2022       |
|---|------------|
| ACOs and Clinically Integrated Networks | 16         |
| Behavioral Health Providers             | 127        |
| Community Providers                     | 434        |
| Emergency Medical Services              | 28         |
| FQHCs and Rural Health Clinics          | 31         |
| Health Plans                            | 17         |
| Hospitals and Health Systems            | 61         |
| Labs, Imaging Centers, and Pharmacies   | 20         |
| Long Term and Post-Acute Care           | 255        |
| State and Local Government              | 10         |
| <b>Total</b>                            | <b>999</b> |

Data Source: Health Current Website March 2022

<sup>141</sup> Health Current Participants. Available at: <https://healthcurrent.org/hie/the-network-participants/>. Accessed March 22, 2022.



Table 5 displays the transaction volume, which represents the transactions received by Contexture within the past 12 months (as of September 2021). Millions of transactions are processed monthly for the more than 10 million Contexture patients with clinical data in the system.

Table 5: Past 12 Month Transaction Volume – Contexture (HIE) as of September 2021

| Past 12 Month Transaction Volume- Contexture (HIE) as of September, 2021 |                |
|--|----------------|
| Transaction Type   | Past 12 Months |
| Real-time Alerts Delivered   | 10,800,000     |
| Patients Accessed Via Portal   | 608,000        |
| HL7 Transactions Received  | 28,000,000     |
| CCDs Received  | 1,900,000      |

Data Source: Contexture September 2021

Table 6 highlights the most used method that providers used to exchange information with other providers at different health organizations according to survey data. As shown, providers mainly used the HIE exchange for sharing information regarding prescription “e-prescribing,” lab results, and reminders for interventions.

Table 6: Arizona State University (ASU) Survey Results: Method of Exchange of Information with Other Organizations, 2019-2021<sup>142</sup>

| ASU Survey Results: Method of Exchange of Information with Other Organizations (2019-2021)<br>(N= 3975; W=24214) |     |       |       |       |      |       |                  |       |
|--|-----|-------|-------|-------|------|-------|------------------|-------|
| EMR Functions  | Fax |       | Email |       | HIE  |       | All of The Above |       |
| Patient Care Summary   | 545 | 21.8% | 75    | 3.0%  | 921  | 35.6% | 1021             | 39.3% |
| Prescription “e-prescribing”   | 239 | 8.6%  | 145   | 5.7%  | 1607 | 64.8% | 576              | 20.7% |
| Lab Results  | 5   | 7.0%  | 1     | 2.1%  | 43   | 64.5% | 22               | 26.3% |
| Reminders for Interventions  | 75  | 4.0%  | 141   | 10.1% | 955  | 60.7% | 428              | 25.0% |
| Radiology Results  | 7   | 12.4% | 0     | 0%    | 36   | 55.2% | 20               | 32.2% |
| Image Results  | 4   | 15.1% | 2     | 4.1%  | 24   | 48.8% | 15               | 31.9% |
| Public Health Reports  | 253 | 14.7% | 69    | 4.5%  | 738  | 47.7% | 541              | 32.9% |

Data Source: ASU Survey Data September 2021

<sup>142</sup> Physician Use of Electronic Medical Records and Exchange of Electronic Health Data, 2019–2021 (Arizona State University). Accessed October 19, 2021.



*HIE and Interoperability Stakeholder Perspectives*

According to stakeholders, access to health information has made much progress in the past few years, especially due to additional services offered by Contexture.

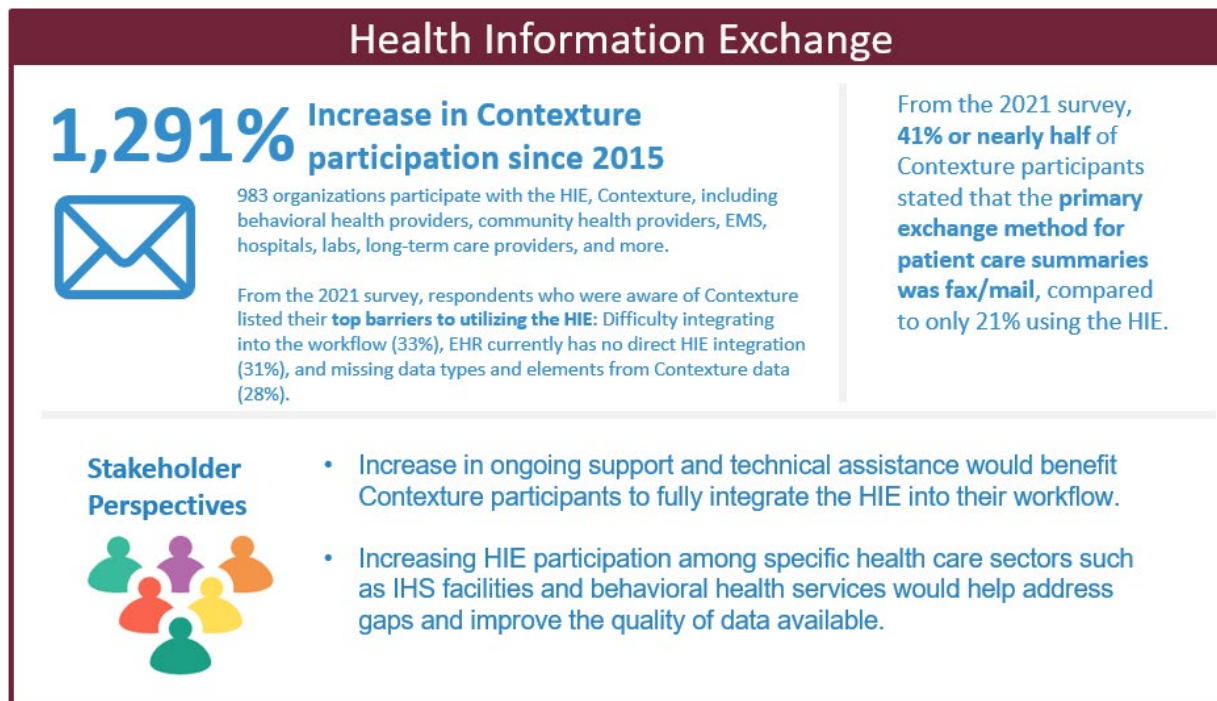
Survey results indicate the top barriers to utilizing the HIE include difficulty integrating into workflow; EHR/EMR currently has no direct HIE integration; and missing data types and elements from Contexture data. Other barriers cited included: not enough Contexture users so the information available is not as valuable, insufficient resources, and lack of customized solutions from Contexture.

There is a strong community desire to continue to incentivize Contexture participation to increase the volume of clinical data available to providers and for use in population health management.

Interviewees spoke about the need for additional data from community-level organizations and cited barriers such as use of multiple-IT systems or non-interoperable systems, and manual processes within workflows.

Stakeholders indicated fax and U.S. mail are still widely used for patient health information sharing even among Contexture participants but state programs to increase HIE adoption and utilization do make a difference. Forty-one percent of Contexture participants use fax or U.S. Mail to exchange patient care summaries compared to 22 percent of TI Program participants using fax or U.S. Mail. *Figure 15* shows highlights from the eScan related to HIE.

Figure 15: Arizona 2021 eScan Highlights: Health Information Exchange



## HIE Incentive Programs

### *TI Program*

AHCCCS received approval from CMS on December 31, 2016 to launch a TI Program to transform health care through integration of behavioral health and physical health providers.<sup>143</sup> The TI Program provides financial incentives to eligible AHCCCS providers to develop systems for integrated care.<sup>144</sup> In accordance with 42 CFR 438.6(c) and the 1115 Waiver, managed care plans will provide financial incentives to eligible Medicaid providers who meet certain benchmarks for integrating and coordinating physical and behavioral health care for Medicaid beneficiaries. AHCCCS will incorporate these payments into the actuarially-sound capitation rates.

The TI Core Components for each of the eligible provider types includes the need to connect and share clinical data using Contexture and adopting health IT in order to produce high-risk registries and perform population health analytics on a provider’s panel of members. Providers receive payments based on their completion of milestones that include adopting screenings, hiring care managers, performing “warm handoffs,” following opioid use guidelines<sup>145</sup>, and participating in bidirectional health information exchange with Contexture.

As part of the recent 1115 Waiver renewal, the TI Program has been extended for another year through September 30, 2022. As part of the “Year 6” extension there is up to \$50 million dollars in funding available. Requirements for “Year 6” payments remain the same. As of June 30, 2021, the number of sites participating in the TI Program are listed below.

- 153 adult behavioral health,
- 163 adult primary care,
- 117 pediatric behavioral health,
- 91 pediatric primary care,
- 21 hospital, and
- 13 justice co-located clinics.

On June 30, 2021, AHCCCS officially released its renewal proposal for the TI Program titled the TI Program Renewal 2.0, part of its full 1115 waiver renewal package. The proposal aligns with AHCCCS’ goal to transform the Medicaid delivery system into an integrated whole person care structure.<sup>146</sup> The following information presented below derives directly from the renewal proposal and highlights its key goals and objectives.<sup>147</sup> The three top goals of the renewal proposal includes sustaining the current TI

<sup>143</sup> <https://www.azahcccs.gov/PlansProviders/TargetedInvestments/>

<sup>144</sup> Ibid.

<sup>145</sup> [https://www.azahcccs.gov/Resources/Downloads/ti2/TI20CONCEPTPAPER\\_FINAL.pdf](https://www.azahcccs.gov/Resources/Downloads/ti2/TI20CONCEPTPAPER_FINAL.pdf) Accessed March 22, 2022.

<sup>146</sup> AHCCCS Targeted Investments Program Renewal Request. Accessed October 20, 2021.

<sup>147</sup> Ibid.



program participants care integration achievements, expanding the programs integrated care systems to new providers, and improving the program’s requirements to include a greater focus on health equity through enhanced social risk screenings and interventions. Since social inequities play a critical role in health outcomes, the TI renewal proposal places emphasis on addressing such issues.

If approved, in part or in full, the next five-year waiver will run from October 1, 2022 through September 30, 2027 and total of \$250 million. Within the expanded program, there will be an additional focus on SDOH screening, adverse childhood event screening and intervention, telehealth, data sharing and best practices for substance use disorder treatment, and trauma informed care. Specific goals of the renewed program include:

- Sustain TI participants’ point of care integration achievements,
- Expand the opportunity to implement the program’s integrated care systems to new providers that did not participate in the original program, and
- Improve the program requirements to more comprehensively address health equity by providing whole person care through enhanced social risk screening and intervention with milestone updates that reflect developments since the advent of the original TI Program.

The structure for the TI 2.0 Program will be aligned to the original program but with two distinct cohorts:

- “Extension” cohort will include current ambulatory TI Program providers.
- “Expansion” cohort will consist of interested AHCCCS-enrolled primary care practices, behavioral health providers, and integrated clinics that did not participate in the original TI program.

#### *Differential Adjustment Payment Program*

The AHCCCS DAP serves as an incentive program to providers that have committed to supporting specified actions that improve patient care experience, member health and reduce the cost of care.<sup>148</sup>

To receive incentives, providers must participate in the HIE and meet specified milestones relating to their provider type. The type of providers that AHCCCS implements DAP rates for include the following:

- Hospitals subject to the all patient refined diagnosis related groups reimbursement, excluding CAHs,
- CAHs,
- Other hospitals and inpatient facilities,
- IHS and 638 tribally owned and/or operated facilities,

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<sup>148</sup> <https://healthcurrent.org/programs/ahcccs-programs/differential-adjusted-payment-dap-program/> DAP Program and Health Information Exchange. Accessed September 29, 2021.



- Nursing facilities,
- Integrated clinics,
- Behavioral health outpatient clinics,
- Behavioral health outpatient clinics and integrated clinics,
- Physicians, physician assistants, and registered nurse practitioners,
- Behavioral health providers,
- Dental providers, and
- HCBS providers.<sup>149</sup>

### *HIE Onboarding Program*

Through HITECH funding, AHCCCS and Contexture provided an HIE Onboarding Program to support the participation of eligible AHCCCS hospitals and providers in statewide health information exchange. The program provided support and recognition of the costs the eligible HIE participant incurred to complete bidirectional HIE connectivity. The program ended in September 2021, with the conclusion of HITECH funding.

With the conclusion of HITECH, Contexture has been working to develop a continuation of the HIE Onboarding Program. The new program, Data Supplier Incentive Program, is currently in development as of December 2021 and will focus on growing and deepening the HIE clinical dataset itself, so that more data is available to all organizations participating in the HIE. The program will require submission of minimum data elements in alignment with the DAP program to ensure consistency of standards. Only health care organizations that are already submitting clinical data to the HIE or receiving a payment under the old HIE Onboarding Program are ineligible for the Data Supplier Program. The program will be funded through available resources and no new additional dollars from AHCCCS.



### *HIE Incentive Programs and Integrated Care Stakeholder Perspectives*

Improving access to mental health services is critical to integrated care and overall health outcomes. Stakeholders provided positive feedback on Arizona's many efforts to encourage and improve integrated care across the state, including the TI Program. It was noted that integrated care records have improved care across primary care, behavioral health, and specialty care centers by providing a

<sup>149</sup> <https://www.azahcccs.gov/AHCCCS/Downloads/PublicNotices/rates/DAPFinalNoticeCYE2022.pdf> AHCCCS Differential Adjusted Payment (DAP) Activity. Accessed September 29, 2021.

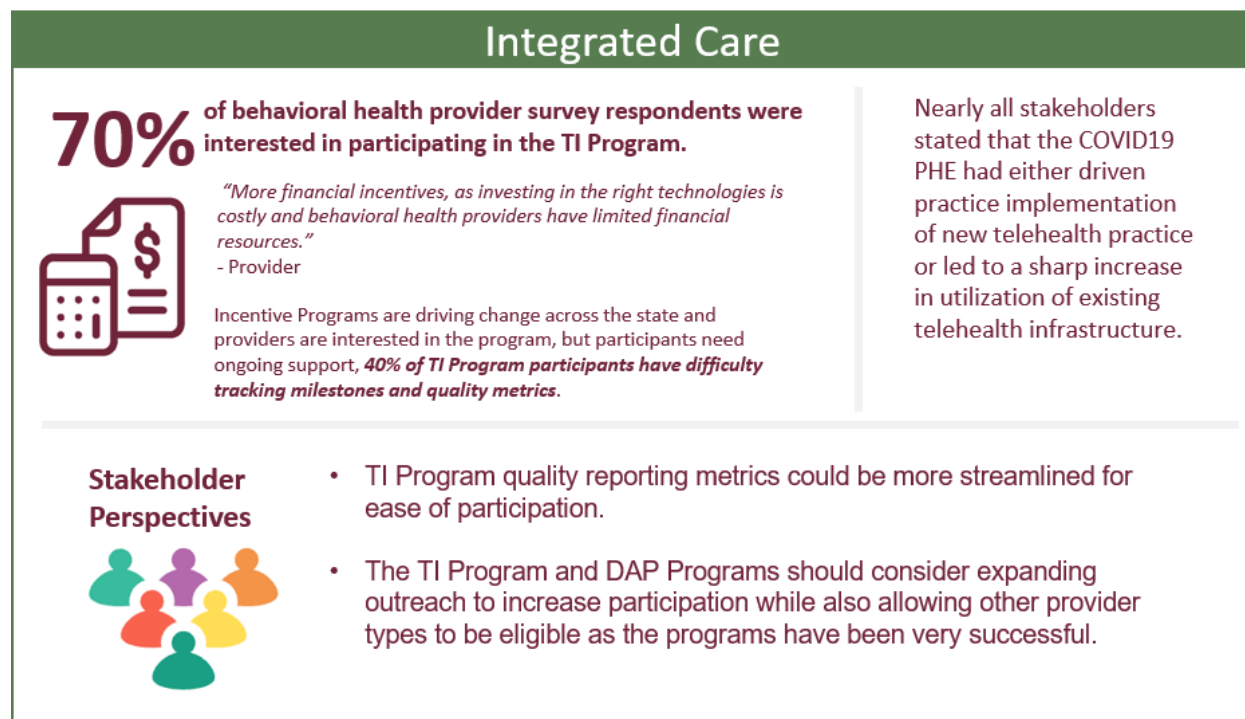


fuller clinical story. Access to this more complete clinical information enables a global view of the medical record and ensures timely care delivery. An overall finding was that behavioral health practices have limited funds and increased administrative burdens.

Data limitations for behavioral health providers present a barrier to the overall implementation of integrated care and care coordination. Providers and state representatives reported a number of challenges: confidentiality issues, lack of data sharing, and lack of health IT infrastructure to share between primary care and behavioral health. Stakeholders reported that behavioral health records are often not accessible due to more stringent requirements regarding confidentiality of data. Observations indicate that most care coordination services utilize manual work methods to accomplish both broad and targeted responsibilities. Many behavioral health facilities and practices have limited financial resources to invest in efficiency platforms and data sharing infrastructure.

Telehealth has been well-received by providers as a tool to support better-integrated care. Telehealth use surged during the pandemic. Providers want to continue to use telehealth, but need additional data sharing and infrastructure to support virtual visits. *Figure 16* shows highlights from the eScan related to integrated care.

Figure 16: Arizona 2021 eScan Highlights: Integrated Care





## SDOH

### *Closed-Loop Referral System*

As part of the WPCI strategy, AHCCCS partnered with Contexture to implement technologies to support providers, health plans, and CBOs addressing the social service needs of Arizonans. Contexture developed WPCI organized focus groups and workgroups to evaluate partnerships and request for proposal candidates for the planned statewide SDOH and CLRS.

In February 2021, it was announced that AHCCCS, Contexture, and 2-1-1 Arizona partnered to implement a statewide SDOH CLRS.<sup>150</sup> The CLRS enables health care and community-service providers to connect on a single statewide technology platform to seamlessly improve and track the referral process between health and social services. Contexture contracted with the vendor Unite Us for the CLRS.<sup>151</sup> Aside from streamlining the referral process and confirming when social services are delivered, the CLRS will provide a statewide solution to facilitate screening for social risk factors.

The CLRS integrates with EHRs, HIEs, patient and member portals, and care/case management systems ensuring referrals are part of the routine workflow for all types of users.<sup>152</sup> The features of the CLRS include:

- Evidence-based personalization that automatically maps needs to services with matching algorithms and filters results by critical access factors like COVID-19 operating status, location, language, documents needed, and eligibility requirements,
- Data collection and validation of service data to provide critical resource information,
- Referral management to ensure that referrals are shared, tracked, and coordinated,
- Coordination of SDOH including basic needs as well as needs of acute chronic conditions, ranging from food insecurity and substance use, to cancer supports,
- Functional workflows that are embedded and integrated into operating systems to provide ease-of-use into a primary platform,
- Outcome data to monitor workflows and measure success beyond whole person care to optimize the care delivery process, and
- Integration for single sign-on to enable sharing of demographics, screening responses, and activity data, which reduces duplication and ensures up-to-date records.

The CLRS originally launched in October 2021 with a goal of adding 10 providers per month. Onboarding was temporarily paused when the original vendor was acquired by Unite Us and Contexture

<sup>150</sup> <https://nowpow.com/press/health-current-selects-nowpow-as-technology-partner-to-implement-a-statewide-social-determinants-of-health-closed-loop-referral-system-in-arizona/>

<sup>151</sup> <https://polsky.uchicago.edu/2021/09/23/uchicago-spinout-nowpow-acquired-by-unite-us/>

<sup>152</sup> The NowPow Platform. Now Pow. Available at: <https://www.nowpow.com/nowpow-platform/#section-1>



renegotiated its contract. By December 2022 the target is to have 116 providers live and utilizing the CLRS. Both Contexture and AHCCCS are tracking the participation and utilization of these services.

### *AHCCCS Health Equity Committee*

Health equity is defined as “the attainment of the highest level of health for all people; achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities.”<sup>153</sup> AHCCCS established a Health Equity Committee in July 2020. The purpose of the Health Equity Committee is to gather and analyze information on health disparities in Arizona and develop strategies to promote health equity for AHCCCS members.<sup>154</sup> The responsibilities of the committee consist of managing health equity considerations for policy, data, health plan oversight and managing health care innovation strategies.<sup>155</sup> To identify health disparities among AHCCCS eligible individuals and members, the committee uses AHCCCS utilization and quality improvement data, which aids in the development of policies and strategies to improve health equity.<sup>156</sup> The goals of the Health Equity Committee include the following:<sup>157</sup>

- Understand health disparities among AHCCCS members,
- Effectuate policy changes and support the implementation of strategies for positive improvement where known disparities exist, creating opportunities for the more equitable provision of services and supports,
- Raise the visibility of AHCCCS’ commitment to health equity and the strategies in place to ensure the equitable provision of services and supports,
- Improve health outcomes for AHCCCS members, and
- Identify challenges and barriers that AHCCCS members have in accessing covered services.

### *SDOH and Whole Person Care Stakeholder Perspectives*

Arizona’s WPCI was created to address social risk factors and encourage continued community partnerships to improve the health of Arizonans. AHCCCS recognizes these issues are complex and works to continue to provide housing, employment, non-emergency transportation, and community-based services to address SDOH. As part of the WPCI strategy, AHCCCS partnered with Contexture to implement technologies such as the CLRS to support providers, health plans, and CBOs addressing the social service needs of Arizonans. As part of the 2021 AHCCCS eScan survey, respondents voiced widespread support for a statewide CLRS and increased SDOH data sharing and a desire for more educational resources and training around what services are reimbursable related to SDOH. A barrier

<sup>153</sup> <https://health.gov/our-work/national-health-initiatives/healthy-people/healthy-people-2030/questions-answers#g9> Healthy People 2030. Accessed September 29, 2021.

<sup>154</sup> <https://www.azahcccs.gov/AHCCCS/Initiatives/HEC/> Health Equity Committee. Accessed September 29, 2021.

<sup>155</sup> Ibid.

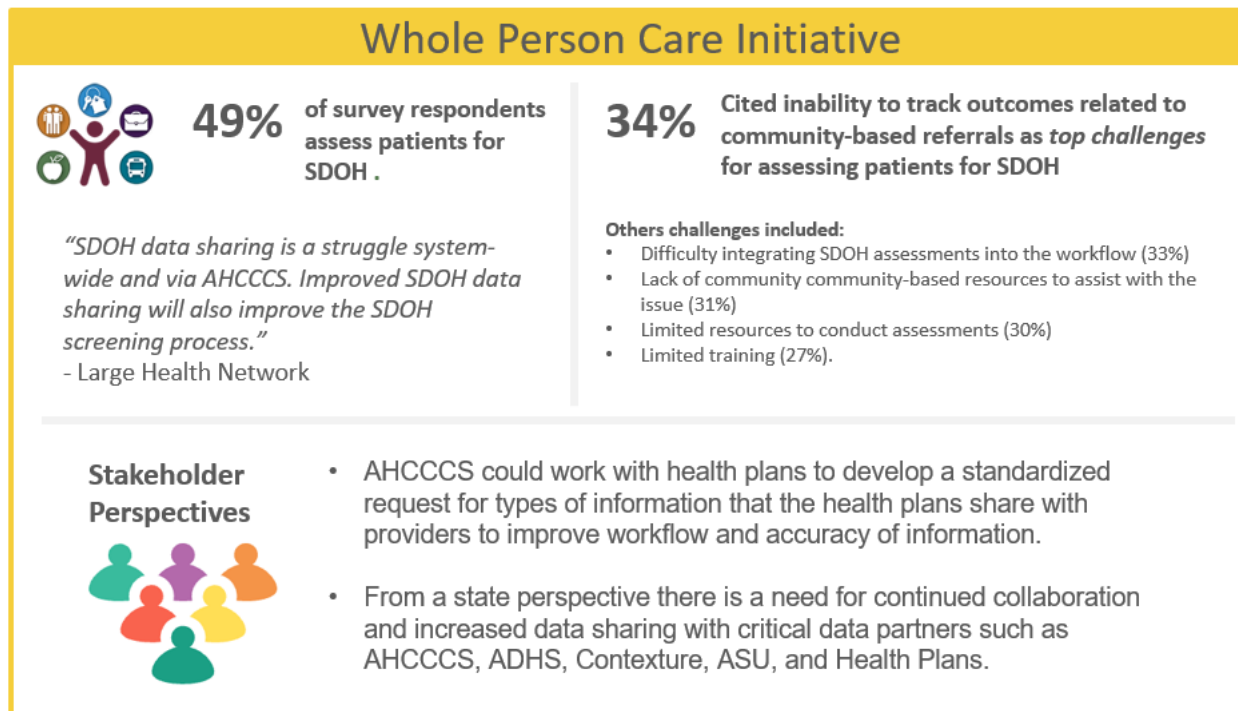
<sup>156</sup> Ibid.

<sup>157</sup> Ibid.



consistently expressed pertained to the challenge of integration of SDOH assessments into existing clinical workflows. *Figure 17* shows highlights from the eScan related to the whole person care initiative.

Figure 17: Arizona 2021 eScan Highlights: Whole Person Care Initiative



## 4.4. Public Health Environment

### Arizona Health Improvement Plan

ADHS released the five-year roadmap, the 2021–2025 AzHIP, during the summer of 2021.<sup>158</sup> This plan builds upon the results of the 2016–2020 AzHIP, which outlined 13 health priorities and four cross cutting issues including access to care, built environment, school health, and worksite wellness. The 2021–2025 AzHIP consists of five priorities which are health equity, mental well-being, health in all policies or SDOH, rural and urban underserved health, and pandemic recovery or resiliency.<sup>159</sup>

<sup>158</sup> AzHIP 2021-2025.

<sup>159</sup> Ibid.



### Strengthening the Technical Advancement and Readiness of Public Health via Health Information Exchange (STAR HIE) Program

In 2020, Contexture was one of five original recipients of a STAR HIE agreement, designed to strengthen and expand the ability of HIEs to support public health agencies in their response to public health emergencies and pandemics such as COVID-19. The two-year project had two main objectives:<sup>160</sup>

- **To improve the timeliness, accuracy, and completeness of hospital reporting of key COVID-19 healthcare data, including but not limited to facility hospitalization metrics, personal protective equipment (PPE) inventories, and ventilator inventory and utilization.** With this information, ADHS can direct healthcare resources to facilities, providers, and geographic regions in greatest need. Given the disproportionate impact of COVID-19 on racial and ethnic minority communities, including tribal communities, this ability to equitably distribute potentially life-saving resources is a key component towards addressing COVID-19–related health disparities and improving health equity.
- **To reduce hospital and health system burden related to state and federal reporting requirements, by utilizing the HIE as a data intermediary.** Hospitals spend significant staff resources daily to complete manual reporting when such reporting can be automated utilizing the HIE infrastructure. Given the significant strain that the pandemic is having on healthcare providers, particularly on hospitals, the burden reduction created by effective utilization of the HIE will have lasting impacts on the healthcare community and public health system both in the short-term and beyond the pandemic.

In 2022, Contexture receive approval to modify the scope of the grant award to convene and lead an Arizona Master Person Index (AzMPI) Planning Collaborative. This project will strengthen existing HIE infrastructure so that public health agencies can better access, share, and use health information. The objectives in the final year of the STAR HIE Program are to work with AHCCCS and ADHS to complete the planning activities necessary to proceed with implementation of this critical infrastructure. Activities include the development of a use case inventory, business requirements, data sharing model/agreements, implementation project plan, and a financial sustainability plan.

### Prescription Monitoring Program

The Arizona State Board of Pharmacy oversees the Controlled Substances PMP for the State. The PMP serves as a central repository for all scheduled II, III, IV, and V controlled substances dispensed in Arizona. Prescribers and pharmacists who are able to prescribe or dispense scheduled II, III, IV, and V controlled substances have access to the PMP online database in order to review dispensed controlled substance information for patients.<sup>161</sup> The PMP program was developed from the 2007 Arizona

<sup>160</sup> <https://www.healthit.gov/topic/star-hie-program#:~:text=The%20STAR%20HIE%20Program%20is%20a%20%245%20million,and%20pandemics%20such%20as%20Coronavirus%20Disease%202019%20%28COVID%E2%80%9119%29>

<sup>161</sup> <https://pharmacypmp.az.gov/about-us/about-cspmp> About the CSPMP. Accessed October 12, 2021.



legislation (A.R.S. Title 36, Chapter 28) which has since been amended to expand the requirements for all prescribers and dispensers.

## 4.5. AHCCCS IT Environment

### *Integrated Medicaid IT Environment 2024 Vision*

AHCCCS seeks to support an integrated Medicaid IT environment. Shown in *Figure 18*, the anticipated long term Medicaid IT environment will include AHCCCS contracting with MCOs and RBHAs to use the HIE for care coordination and clinical quality analysis.<sup>162</sup> The State Medicaid Agency (SMA) IT system will support the AHCCCS long term goals and objectives of reducing costs, improving care coordination and improving health care outcomes.<sup>163</sup> As part of the 2024 Medicaid IT environment vision, AHCCCS seeks for public health registries to connect to the HIE, enabling providers to view and update patient registry data (*Figure 18*).

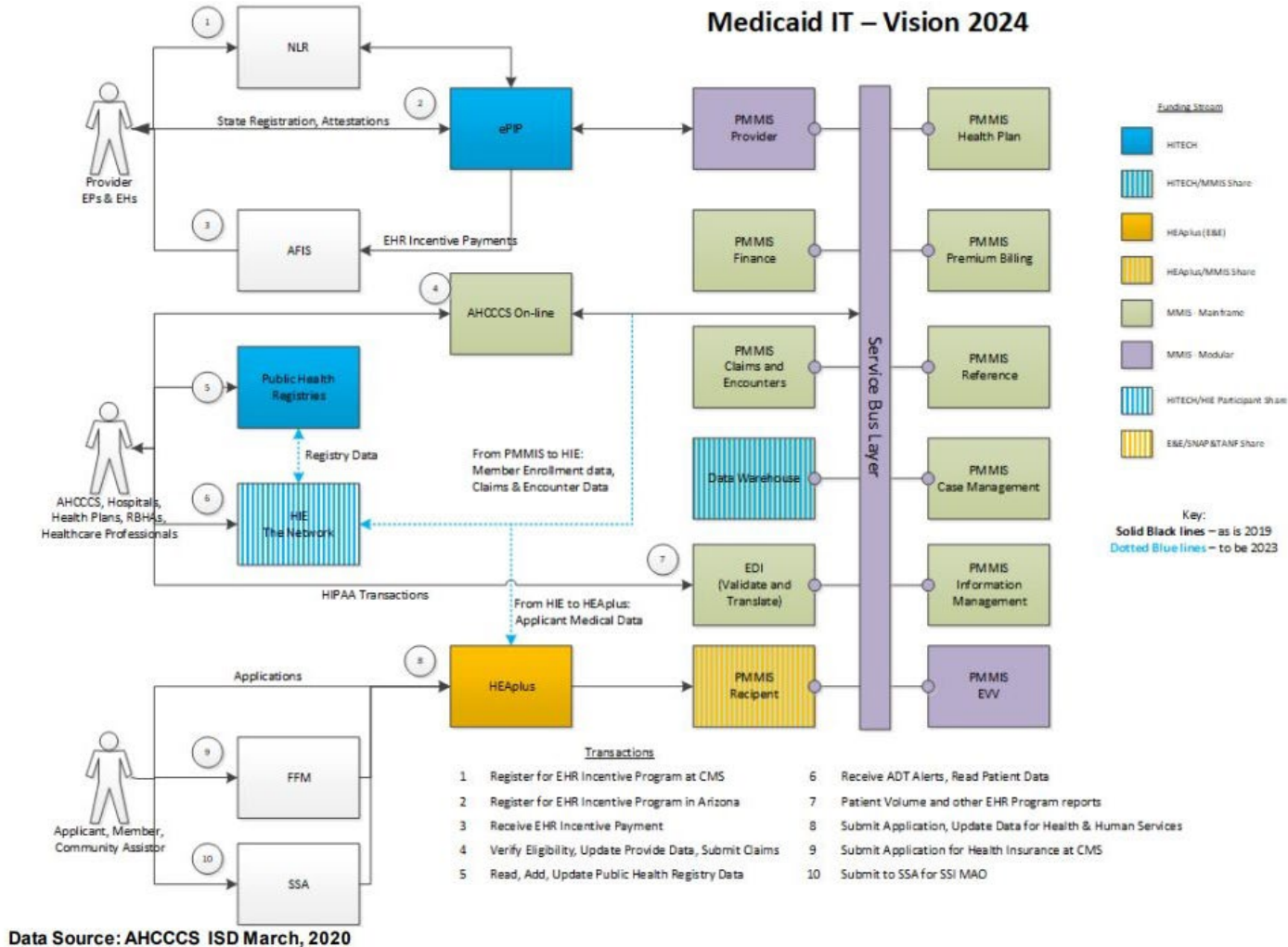
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<sup>162</sup> [https://www.azahcccs.gov/AHCCCS/Downloads/Plans/2020\\_AZ\\_SMHP\\_Version\\_10\\_0\\_FINAL\\_07082020.pdf](https://www.azahcccs.gov/AHCCCS/Downloads/Plans/2020_AZ_SMHP_Version_10_0_FINAL_07082020.pdf) Arizona State Medicaid Health Information Technology Plan. Accessed October 13, 2021.

<sup>163</sup> *Ibid.*



Figure 18: Integrated Medicaid IT Environment- Future Plans (2024)



### AHCCCS IT Plan Update

The SFY 2023 AHCCCS IT plan is structured to offer new and improved technologies to provide additional opportunities for staff and improve overall work processes. According to the published SFY 2023 AHCCCS IT plan, information regarding systems improvement and IT governance are key objectives which highlight AHCCCS' increased momentum to improve overall work processes. These goals include:<sup>164</sup>

- **Goal #1:** Modernize agency business functions,
- **Goal #2:** Business applications enhancements,
- **Goal #3:** Protect agency systems and data,
- **Goal #4:** AHCCCS IT governance plan, and
- **Goal #5:** Develop and maintain agency workforce.

One of the critical next steps is to develop a roadmap for the pre-paid Medicaid management information system (PPMIS). AHCCCS plans to develop a strategy to replace the PPMIS system with a newer system since the current PPMIS system utilizes outdated technology from the 1980s. AHCCCS is currently in the process of developing a Medicaid Enterprise System (MES) modernization roadmap.

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<sup>164</sup> SYF 2023 AHCCCS IT Plan. Accessed November 12, 2021.





# AHCCCS Health IT Strategy



## 5. AHCCCS Health IT Strategy

The 2022–2026 AHCCCS Health IT Strategy document builds upon previous Arizona roadmap efforts and will help guide future priorities, goals, and projects.

### 5.1. Previous Arizona Health IT Roadmaps

#### 2006 Health IT Roadmap 1.0

In 2006 Arizona develop its first health IT and HIE roadmap known as the *Arizona Health-e Connection Roadmap* (Roadmap 1.0). The formation of the 2006 health IT/HIE roadmap derived from the 2005 gubernatorial executive order to increase HIT usage and data exchange. The intended goal for data exchange was for more data to be exchanged among payers, healthcare providers, health care consumers, researchers and government agencies as appropriate.<sup>165</sup> The 2006 roadmap consisted of a variety of initiatives for health IT/HIE improvement that shed light on stakeholder engagement, governance, business and finance of the initiatives, privacy security and legal ramifications, and technology development.

One of the first major initiatives from the health IT/HIE roadmap launched in 2007 was the Arizona Health-e Connection (AzHeC). The AzHeC was a state wide public-private partnership with the purpose of advancing the adoption and improvement of health IT/HIE in Arizona. AzHeC had multiple roles such as providing education and clearinghouse for health IT information, researching and developing health IT policies for advocacy and supporting provider usage of health IT and HIE. One of the largest impacts that AzHeC had was assisting over 3,000 providers in the state with adopting EHRs through its federally-funded Regional Extension Center. The framework for the 2006 roadmap also helped form the Health Information Network of Arizona (HINAz) which was a collaboration between health entities in the state, which facilitated the exchange of health information for participating organizations. HINAz offered secure sharing of health information, improved care coordination, and improved quality and safety. In 2016, HINAz merged AzHEC, which was later named Health Current and is currently known as Contexture, Arizona’s official HIE. *Table 7* shows the initiatives developed in 2006.

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<sup>165</sup> [https://healthcurrent.org/wp-content/uploads/2016/03/arizona\\_health\\_it\\_roadmap\\_2.pdf](https://healthcurrent.org/wp-content/uploads/2016/03/arizona_health_it_roadmap_2.pdf) Arizona’s Health IT Roadmap 2.0. Accessed October 14, 2021.



Table 7: 2006 Health IT Roadmap 1.0 Initiatives<sup>166</sup>

| 2006 Health IT Roadmap 1.0 Initiatives |  |
|--|--|
| Domain                                 | Key Initiatives  |
| Stakeholder Engagement                 | <ul style="list-style-type: none"> <li>Engage a broad range of stakeholders to determine priorities for needed capabilities through the Clinical Task Group,</li> <li>Develop a Marketing Plan to maintain project momentum and generate enthusiasm, with associated presentations,</li> <li>Develop and distribute a quarterly newsletter,</li> <li>Develop an Education Plan, including development of materials to help communities and regions get started,</li> <li>Market and educate the health care community about Health-e Connection, and</li> <li>Encourage health IT/HIE Adoption.</li> </ul> |
| Governance                             | <ul style="list-style-type: none"> <li>Establish the Health-e Connection organization complete,</li> <li>Develop a shared vision statement, guiding principles, and operations of a complete statewide collaborative,</li> <li>Coordinate with current Arizona health IT initiatives ongoing, and</li> <li>Develop a participation structure to develop consensus about the overall ongoing technical approach.</li> </ul>   |
| Business and Finance                   | <ul style="list-style-type: none"> <li>Develop a statewide strategic and business plan,</li> <li>Identify and establish additional sources of funding,</li> <li>Identify and establish baseline measures for Health-e Connection outcomes, and</li> <li>Obtain Health-e Connection outcome measurements.</li> </ul>  |
| Privacy Security and Legal             | <ul style="list-style-type: none"> <li>Develop model participation agreements,</li> <li>Identify examples of best practices from other regions, and</li> <li>Identify specific legal actions required, including whether statutory or regulatory amendments are needed.</li> </ul>   |
| Technology                             | <ul style="list-style-type: none"> <li>Develop Arizona’s statewide web portal with security infrastructure components,</li> <li>Pilot a basic patient health summary,</li> <li>Establish a health IT adoption plan,</li> <li>Implement statewide patient locator,</li> <li>Implement secure messaging,</li> <li>Develop a provider directory, MPI, and begin data transformation, and</li> <li>Enhance public health functions.</li> </ul>   |

<sup>166</sup> [https://healthcurrent.org/wp-content/uploads/2016/03/arizona\\_health\\_it\\_roadmap\\_2.pdf](https://healthcurrent.org/wp-content/uploads/2016/03/arizona_health_it_roadmap_2.pdf) Arizona’s Health IT Roadmap 2.0. Accessed October 14, 2021.



### 2014 Health IT Roadmap 2.0

The Arizona Health IT Roadmap 2.0 was published in 2014 and built upon the foundation of initiatives and work accomplished from the 2006 HIT Roadmap 1.0. The vision for the Arizona HIT Roadmap 2.0 was for Arizonans to experience an improved quality of health enabled by robust health information technology and exchange.<sup>167</sup> Three strategies that were identified as important in order to have successful progress towards the adoption and advancement of health IT/HIE in the state included the following:

- Continued support of physicians and other providers in their adoption and use of technology,
- Accelerated and expanded the secure sharing of health information among health care providers, and
- Continued coordination of health care stakeholders to develop strategies that meet evolving health IT and HIE business needs.

The initiatives set forth in the Roadmap 2.0 took into consideration stakeholder feedback in order to ensure the initiatives created a landscape for collaboration on Arizona’s health IT/HIE plan. More than 300 stakeholders participated in the development of the Roadmap 2.0. Stakeholder sentiments were collected through avenues such as workshops, surveys, and public meetings. A variety of stakeholders were include such as health care providers, health care ancillary providers, health care payers, government agencies, and health technology organizations. There were 19 initiatives developed, as shown in *Table 8*. During the design of the initiatives, multiple funding streams were considered in order to provide flexibility regarding the manner the initiatives would be carried out.

Table 8: 2014 Health IT Roadmap 1.0 Initiatives<sup>168</sup>

| 2014 Health IT Roadmap 2.0 Initiatives   |  |
|--|--|
| Domain                                   | Key Initiatives  |
| Stakeholder Engagement and Participation | <ul style="list-style-type: none"> <li>• Stakeholder Engagement and Collaboration, and</li> <li>• Stakeholder Information and Education.</li> </ul>  |
| Governance, Policy and Planning          | <ul style="list-style-type: none"> <li>• Statewide governance of HIE,</li> <li>• Interoperability and content standards agreement and adherence,</li> <li>• Statewide unique patient identifier,</li> <li>• Incentives to support continued expansion of health IT/HIE,</li> <li>• Collaboration and support for broadband access,</li> <li>• Influence health IT and HIE vendors, and</li> <li>• Statewide vision and framework for HIE.</li> </ul> |

<sup>167</sup> [https://healthcurrent.org/wp-content/uploads/2016/03/arizona\\_health\\_it\\_roadmap\\_2.pdf](https://healthcurrent.org/wp-content/uploads/2016/03/arizona_health_it_roadmap_2.pdf) Arizona’s Health IT Roadmap 2.0. Accessed October 14, 2021.

<sup>168</sup> Ibid.



| 2014 Health IT Roadmap 2.0 Initiatives            |  |
|---|--|
| Domain  | Key Initiatives  |
| State Level health IT/HIE Business Infrastructure | <ul style="list-style-type: none"> <li>Health IT/HIE program information and collaboration office,</li> <li>Statewide HIE rollout, onboarding, and use, and</li> <li>Health IT/HIE assistance to providers.</li> </ul>   |
| Privacy and Security                              | <ul style="list-style-type: none"> <li>Patient consent approach.</li> </ul>  |
| Technology  | <ul style="list-style-type: none"> <li>Statewide HIE services and technical architecture description,</li> <li>HIE consent management engine,</li> <li>Statewide MPI/RLS expansion,</li> <li>Tools to support public health reporting,</li> <li>Tools and support for health care transformation: care coordination, analytics, and emerging technologies, and</li> <li>Integrated physical and behavioral health information exchange.</li> </ul> |

*Progress Made*

Since 2014, AHCCCS and the Arizona health care community has made significant progress. Critical technical, governance, privacy, security, stakeholder engagement, and financial challenges have all been addressed. Highlights of this progress include:

- Growth of EHR and HIE adoption,
- Sustainability of HIE in alignment with the four pillars of success,
- Stronger statewide HIE governance model,
- Compliance with additional federal rules, and
- Increased stakeholder engagement to improve adoption and utilization of health IT.

## 5.2. 2022–2026 AHCCCS Health IT Strategies

### AHCCCS Health IT Strategies Introduction

The Health IT Strategy creates a forward-looking plan that identifies the agency’s goals for advancing health IT adoption in order to improve care outcomes and improve the agency’s administrative efficiency, and is based upon current challenges reported from stakeholders.



### AHCCCS 2022–2026 Health IT/HIE Priorities and Goals

This strategy includes three priorities and five goals, each of which includes specific strategies and tactics aligned to a timeline. Taken together, these should not be viewed as sequential, but as interdependent with the collective purpose of advancing Arizona’s health IT and HIE infrastructure leading to a more cohesive data sharing environment and improving Medicaid beneficiary health outcomes using data-driven insights.

## Priority: Continue Health IT Collaboration

GOAL  
1

Establish cross-agency collaborations to maximize utilization of Contexture to advance interoperability across the enterprise, the state, and the community.

Strategy 1.1: AHCCCS actively participates in ongoing statewide health IT governance, operations, and business development.

Strategy 1.2: AHCCCS regularly reviews and evaluates Medicaid and state agency data access and sharing needs.

Strategy 1.3: AHCCCS coordinates with Contexture to engage community stakeholders to understand health IT opportunities and challenges.

## Priority: Create Efficiencies and Improve Healthcare Quality

GOAL  
2

Support data integration to enhance the data exchange infrastructure.

Strategy 2.1: Enhance Arizona's data sharing capabilities to advance public health infrastructure modernization.

Strategy 2.2: Extend Arizona's data sharing capabilities to enable informed clinical decision making and advance health equity.

GOAL  
3

Increase provider access to care information in a standardized format.

Strategy 3.1: Develop and deploy technology and policy infrastructure to support data sharing.

Strategy 3.2: Maximize available funding to advance the data sharing infrastructure.

Strategy 3.3: Support Contexture to incentivize HIE utilization to improve quality and address health disparities.



## Priority: Improve Data Quality and Modernization

**GOAL** Improve operations by modernizing agency technology.

**4**

**Strategy 4.1:** Assess and enhance the AHCCCS MES infrastructure and environment.

**Strategy 4.2:** Create and enhance agency dashboards for improved visibility and analytics.

**Strategy 4.3:** Improve provider performance monitoring.

**GOAL** Increase agency data access and information exchange.

**5**

**Strategy 5.1:** Utilize the HIE’s features and functions to create operational efficiencies.

**Strategy 5.2:** Employ data sharing to streamline quality reporting.

The strategies and tactics outlined within the next section aligned to the priorities and goals above. These provide AHCCCS the actionable steps to be taken over from 2022–2026 to achieve AHCCCS’ overall goal to advance health IT and HIE infrastructure across the state.

AHCCCS 2022–2026 Health IT and HIE Strategies and Tactics



## Priority: Continue Health IT Collaboration

**GOAL 1: Establish cross-agency collaborations to maximize utilization of Contexture to advance interoperability across the enterprise, the state, and the community.**

### STRATEGIES AND TACTICS

| Strategies   | Near-Term Tactics (30 Days up to 1 Year)   | Mid-Term Tactics (1–3 Years)   | Long-Term Tactics (3–5 Years) |
|--|--|--|-------------------------------|
| <p>1.1. AHCCCS actively participates in ongoing statewide health IT governance, operations, and business development</p> | <ul style="list-style-type: none"> <li>• <b>Complete New HIE Master Agreement.</b> AHCCCS requires an updated Master Agreement and business associate agreement for projects that do not apply under the HIE Participation Agreement.</li> <li>• <b>HITRUST Certification/Security Gap Assessment.</b> AHCCCS security require the HIE to achieve industry recognized security certification (Mars-E or HITRUST).</li> <li>• <b>Contexture Strategic Medicaid HIE Plan.</b> Building upon the foundation of the 2020–2022 Contexture Strategic Business Plan, with a focus on deeper strategic planning to support the use of the HIE to accomplish key state agency objectives involving interoperability and clinical data. The activity has two focus areas: AHCCCS program needs and AHCCCS business needs.</li> <li>• <b>Ad Hoc Reporting Process.</b> Developing a standard process for</li> </ul> | <ul style="list-style-type: none"> <li>• <b>Governor’s Office HIE Scorecard Measure.</b> Monthly total of organizations (not limited to Medicaid) that have signed a Contexture (HC) participation agreement.</li> </ul> |                               |



| Strategies  | Near-Term Tactics (30 Days up to 1 Year)   | Mid-Term Tactics (1–3 Years)   | Long-Term Tactics (3–5 Years)   |
|---|--|--|---|
|   | <p>how the HIE is engaged with scoping agency projects. (AT 1u)</p> <ul style="list-style-type: none"> <li>• <b>HIE Participation Agreement.</b> In order to meet AHCCCS Privacy and Security Standards and state contract requirements a new AHCCCS HIE Agreement needed to be created and executed.</li> </ul> |  |   |
| <p>1.2. AHCCCS regularly reviews and evaluates Medicaid and state agency data access and sharing needs.</p>                           | <ul style="list-style-type: none"> <li>• <b>Evaluate Data Access and Needs.</b> AHCCCS will regularly determine what data is needed to meet agency goals.</li> </ul>   | <ul style="list-style-type: none"> <li>• <b>AHCCCS Will Update the Health IT Strategy and IT Strategic Plan.</b> As more data sharing needs are identified, AHCCCS will identify new projects and priorities to pursue.</li> </ul>   |   |
| <p>1.3. AHCCCS coordinates with Contexture to engage community stakeholders to understand health IT opportunities and challenges.</p> | <ul style="list-style-type: none"> <li>• <b>AHCCCS Will Coordinate with Contexture on HIE Roadmap.</b> AHCCCS will continue to coordinate with Contexture on their HIE Roadmap update and will provide input on priority use cases.</li> </ul>   | <ul style="list-style-type: none"> <li>• <b>AHCCCS Will Leverage Contexture to Understand Stakeholders.</b> Contexture will continue stakeholder engagement activities to understand community health IT opportunities and challenges. When appropriate AHCCCS and Contexture may coordinate to address these challenges.</li> </ul> | <ul style="list-style-type: none"> <li>• <b>Continue Community Stakeholder Engagement.</b> AHCCCS will continue to leverage Contexture as an avenue to understand community health IT needs.</li> </ul> |







**Priority: Create Efficiencies and Improve Healthcare Quality**  
**GOAL 2: Support data integration to enhance the data exchange infrastructure.**

**STRATEGIES AND TACTICS**

| Strategies   | Near-Term Tactics (30 Days up to 1 Year)   | Mid-Term Tactics (1–3 Years)   | Long-Term Tactics (3–5 Years)   |
|--|--|--|---|
| <p><b>2.1.</b> Enhance Arizona's data sharing capabilities to advance public health infrastructure modernization.</p>                |  | <ul style="list-style-type: none"> <li>• <b>All Lab Results Reporting.</b> Capture reportable disease information, trigger electronic case reporting, and automate other public health reporting (pre-claims data).</li> <li>• <b>COVID-19 Lab Results Reporting.</b> Obtain COVID-19 lab results in order to understand health care utilization services post-positive results.</li> <li>• <b>Immunizations Reporting.</b></li> <li>• <b>COVID-19 Immunizations.</b></li> </ul> | <ul style="list-style-type: none"> <li>• <b>Establish single point of access for local health departments to access public health systems.</b> Deploy a single web page where log-on to all state public health systems exists in one location and expand to single sign-on capability.</li> <li>• <b>Model impacts of communicable diseases and long-term health risks for vulnerable populations.</b> Leverage data provides to the HIE to identify patterns extensible to other diseases and/or conditions.</li> </ul> |
| <p><b>2.2.</b> Extend Arizona's data sharing capabilities to enable informed clinical decision making and advance health equity.</p> | <ul style="list-style-type: none"> <li>• <b>Advanced Directives.</b> Advance Directives Education and Awareness supports provider and community awareness, education, and training initiatives related to the transition of Arizona's Advance Directives Registry from the Arizona Secretary of State's office to Contexture.</li> </ul> | <ul style="list-style-type: none"> <li>• <b>Building CBO-SDOH Network Partnerships.</b> HIO to make payments to CBOs to incentivize participation and adoption of SDOH CLRS.</li> <li>• <b>Enrich data with demographic information to support population health and health equity monitoring.</b> Enrichment of demographic data elements and</li> </ul>  | <ul style="list-style-type: none"> <li>• <b>Create maternal and child smart alerts.</b> Use alerts to identify high-risk pregnancies and ensure access to care for pregnant and post-partum women.</li> <li>• <b>Telehealth Device &amp; Procurement.</b> HIE can support purchase, set-up, and deployment</li> </ul>   |

| Strategies | Near-Term Tactics<br>(30 Days up to 1 Year)   | Mid-Term Tactics (1–3 Years)   | Long-Term Tactics (3–5 Years)                          |
|------------|---|--|--|
|            | <ul style="list-style-type: none"> <li>• <b>Create SMI Panel for Alerts.</b> Provide psychiatric inpatient ADTs to primary and behavioral health providers to support transitions of care.</li> <li>• <b>Closed Loop Referral Platform Operational.</b> Unite Us pilot underway with CBO and providers.</li> <li>• <b>Support Closed Loop Referral System to Connect Individuals to Social Services that Address SDOHs.</b> The SDOH system is a personalized statewide referral solution that is open to all providers, health plans, community service providers, and Arizonans.</li> <li>• <b>High Needs Cost DFSM Member Panel.</b> AHCCCS sent a panel of 200 HNHC members to HIE so they can send ADT member alerts.</li> <li>• <b>Expand Use of ADT Smart Alerts.</b> For use with ED Super-Utilizers, Overdoses, Lead Exposures, and Other Priorities.</li> </ul> | <p>associated analyses on population health, SDOH, and health disparities.</p> <ul style="list-style-type: none"> <li>• <b>Increase access to Part 2 data via enhanced consent management.</b> Update aspects of current Part 2 technical and consent management implementation to maximize availability of data.</li> <li>• <b>Share ADT, assessment and service plan data with LTSS providers.</b> Support person-centered planning through the exchange of health data with HCBS provider organizations.</li> <li>• <b>AIMH e-Health Exchange.</b> IHS connection to HIE through an e-Health exchange.</li> <li>• <b>Master Person Index.</b> Expand MPI to identify unique individuals across state programs.</li> </ul> | <p>of telehealth devices to providers and members.</p> |





Priority: Create Efficiencies and Improve Healthcare Quality  
GOAL 3: Increase provider access to care information in a standardized format.

STRATEGIES AND TACTICS

| Strategies  | Near-Term Tactics (30 Days up to 1 Year)   | Mid-Term Tactics (1–3 Years)   | Long-Term Tactics (3–5 Years)   |
|---|--|--|---|
| 3.1. Develop and deploy technology and policy infrastructure to support data sharing.                     |  | <ul style="list-style-type: none"> <li>• <b>CALOCUS.</b> Integrate and share data from health, SDOH, and other standard assessments.</li> <li>• <b>ASAM.</b> Integration of the ASAM Continuum Assessment into the HIE.</li> </ul> |   |
| 3.2. Maximize available funding to advance the data sharing infrastructure.                               | <ul style="list-style-type: none"> <li>• <b>American Rescue Plan Act (ARPA) – HCBS and Technology.</b> Identify opportunities to implement provisions of the ARPA to enhance, expand, and strengthen the HCBS system, consistent with the allowable activities and functions.</li> <li>• <b>ARPA – SAMHSA Mental Health Services Block Grant (MHBG) and Substance Abuse Prevention and Treatment Block Grant (SABG).</b> Potential funding to be used for IT enhancements, digital therapeutics, and broadband use.</li> </ul> |  |   |
| 3.3. Support Contexture to incentivize HIE utilization to improve quality and address health disparities. | <ul style="list-style-type: none"> <li>• <b>DAP Program.</b> DAP rates are proposed to be implemented to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist</li> </ul>   | <ul style="list-style-type: none"> <li>• <b>Measure the Contexture Data Supplier Incentive Program.</b> Contexture will track the progress of the new program and coordinate with AHCCCS on the status.</li> </ul>                 | <ul style="list-style-type: none"> <li>• <b>Targeted Investment 2.0 – HIE – TI Expansion Cohort (TI Newbies).</b> Making the HIE available to new TI participants (Expansion Cohort)</li> </ul> |



| Strategies | Near-Term Tactics<br>(30 Days up to 1 Year)   | Mid-Term Tactics (1–3 Years) | Long-Term Tactics (3–5 Years)  |
|------------|---|------------------------------|--|
|            | <p>enough providers so that care and services are available at least to the extent that such care and services are available to the general population in the geographic area.</p> <ul style="list-style-type: none"> <li>• <b>Targeted Investment Y6 – Support (Current TI Participants, including Hospitals).</b> Develop and support strategies to support HIE connectivity and implementation of new Mental Illness Hospitalization Alerts for current TI 1.0 participants to improve performance on TI measures. Continued participation in QIC as needed.</li> <li>• <b>Establish the Contexture Data Supplier Incentive Program.</b> Contexture is developing a new incentive program to offset provider HIE connectivity costs that will require submission of minimum data elements in alignment with the DAP program to ensure consistency of standards.</li> </ul> |                              | <p>for connectivity, clinical data sharing (AT 1n).</p> <ul style="list-style-type: none"> <li>• <b>Targeted Investment 2.0 – Training – TI Expansion Cohort (TI Graduates).</b> Develop and support strategies to support HIE connectivity and use of data by continuing (Extension cohort) providers under TI 2.0, to be approved by CMS under new waiver and ASU/CHIR.</li> </ul> |





**Priority: Improve Data Quality and Modernization**  
**GOAL 4: Improve operations by modernizing agency technology.**

**STRATEGIES AND TACTICS**

| Strategies  | Near-Term Tactics (30 Days up to 1 Year)  | Mid-Term Tactics (1–3 Years)  | Long-Term Tactics (3–5 Years)  |
|---|---|---|--|
| 4.1. Assess and enhance the AHCCCS MES infrastructure and environment.                                  | <ul style="list-style-type: none"> <li><b>Assess MES Infrastructure.</b> Complete a MITA SS-A and develop an MES Roadmap to improve infrastructure, align to federal requirements, and track status.</li> </ul> | <ul style="list-style-type: none"> <li><b>Improve MES Infrastructure.</b> Upon completion of the assessment, AHCCCS will begin to enhance and further modernize the existing MES infrastructure.</li> </ul>   | <ul style="list-style-type: none"> <li><b>Maintain MES Infrastructure.</b> AHCCCS will maintain and continually evaluate the MES infrastructure.</li> </ul>  |
| 4.2. Create and enhance agency dashboards for improved visibility and analytics for populations served. |   | <ul style="list-style-type: none"> <li><b>COVID-19 Vaccine Dashboard and Coordination.</b> Create internal and external data dashboards, reporting, and analytics for Medicaid and Public Health.</li> </ul>  | <ul style="list-style-type: none"> <li><b>AHCCCS Data Dashboard (Phase 2).</b> Health and human services state agencies share visibility into data across disparate Medicaid, public health, and social services.</li> </ul>   |
| 4.3. Improve provider performance monitoring.   |   | <ul style="list-style-type: none"> <li><b>Leverage Bed Capacity Reporting to Track Capacity for Crisis System, Mobile Crisis Teams.</b> Track bed capacity for acute facilities, crisis beds, track inpatient psych beds, and mobile crisis team capacity in dashboards to allow state programs receive near real-time be availability.</li> <li><b>Breast Cancer Screening and Diabetes Hemoglobin.</b> Develop pilot</li> </ul> | <ul style="list-style-type: none"> <li><b>Crisis Capacity Dashboard &amp; Crisis Data Repository.</b> HIO will support statewide crisis capacity dashboard and crisis data repository.</li> <li><b>Performance Measure.</b></li> <li><b>ePrescribing.</b></li> <li><b>Health II Quality Measures.</b> HIO can provide HIE clinical data and data analytics to support</li> </ul> |



| Strategies | Near-Term Tactics<br>(30 Days up to 1 Year) | Mid-Term Tactics (1–3 Years)  | Long-Term Tactics (3–5 Years)            |
|------------|---|---|--|
|            |   | to see if HIE is valid data source for FFS population CMS Core Measure sets to meet 2024 electronic submission CMS Core Set performance measures – Breast Cancer Screening and Diabetes Hemoglobin A1c control – for FFS members. | calculator of HEALTHII quality measures. |





GOAL 5:

## Priority: Improve Data Quality and Modernization

GOAL 5: Increase agency data access and information exchange.

### STRATEGIES AND TACTICS

| Strategies   | Near-Term Tactics<br>(30 Days up to 1 Year)   | Mid-Term Tactics (1–3 Years)   | Long-Term Tactics (3–5 Years)  |
|--|---|--|--|
| <p>5.1. Utilize HIE features and functions to create operational efficiencies.</p> | <ul style="list-style-type: none"> <li>• <b>Vaccine Appointment Support and Case Management.</b> Use vaccination data to assess the relative vulnerability of the unvaccinated population and health risk.</li> </ul> | <ul style="list-style-type: none"> <li>• <b>HN/HC for AIHP.</b> AHCCCS will send a list of 200 AIHP members to the HIO and request detailed clinical information for a research project.</li> </ul>  | <ul style="list-style-type: none"> <li>• <b>PAS Assessor Access to HIE Data for ALTCS Applicants.</b> Provide eligibility, enrollment, and assignment information to providers, ACOs, health plans, and state partners.</li> <li>• <b>AHCCCS Member Files.</b> Improve access to and use of clinical data at the practice level to measure outcomes and close gaps.</li> </ul> |
| <p>5.2. Employ the HIE to streamline quality reporting.</p>                        |   | <ul style="list-style-type: none"> <li>• <b>HIE NCQA Data Aggregator Validation Program.</b> Provide validated clinical data to be used in calculation of NCQA HEDIS and CMS Star Reporting measurements.</li> <li>• <b>NCQA HIE Certification.</b> The National Committee for Quality Assurance (NCQA) Data Aggregator Validation (DAV) program validates data aggregators such as HIEs to collect electronic data from one or more sources to share with payers and</li> </ul> |  |



| Strategies | Near-Term Tactics<br>(30 Days up to 1 Year) | Mid-Term Tactics (1–3 Years)                          | Long-Term Tactics (3–5 Years) |
|------------|---|---|-------------------------------|
|            |   | health plans for use in quality<br>measure reporting. |                               |





### AHCCCS 2022–2026 Health IT/HIE Annual Goals and Benchmarks

Below lists the proposed benchmarks for consideration to monitor achievement of annual goals. The benchmarks will be compared and assessed over time in order to track progress towards the goals. These benchmarks are subject to change.

#### **AHCCCS Health IT Goal 1: Establish cross-agency collaborations to maximize utilization of Contexture to advance interoperability across the enterprise, the state, and the community.**

- Benchmark 1.1 – Number of HIE governance board meetings and ad-hoc meetings attended by AHCCCS, ADHS, and Contexture within the year,
- Benchmark 1.2 – Date of last revision of relevant strategic documents (AHCCCS Health IT Strategy and Contexture Roadmap), and
- Benchmark 1.3 – Number of active and completed projects related to health IT, HIE, and data sharing for AHCCCS, ADHS, and Contexture.

#### **AHCCCS Health IT Goal 2: Support data integration to enhance the data exchange infrastructure.**

- Benchmark 2.1 – Number of organizations using the single point of access by registry/public health reporting tool,
- Benchmark 2.2 – Number of AHCCCS Health Equity Committee meetings held,
- Benchmark 2.3 – Number of Closed-Loop Referral System participants by organization type, and
- Benchmark 2.4 – Number of referrals completed through the Closed-Loop Referral System.

#### **AHCCCS Health IT Goal 3: Increase provider access to care information in a standardized format.**

- Benchmark 3.1 – Number of organizations with a participant agreement with Contexture by provider type,
- Benchmark 3.2 – Number of organizations actively sharing health information (within the past 90 days) with Contexture by provider type,
- Benchmark 3.3 – Number of participants of the TI Program by provider type and milestones completed,
- Benchmark 3.4 – Number of participants of the DAP Program by provider type and milestones completed, and
- Benchmark 3.5 – Number of participants of the Data Supplier Incentive Program by provider type and milestones completed.



**AHCCCS Health IT Goal 4: Improve operations by modernizing agency technology.**

- Benchmark 4.1 – Number of unique AHCCCS dashboards created to support agency operations,
- Benchmark 4.2 – Number of AHCCCS agency-wide data governance board and steward meetings held, and
- Benchmark 4.3 – Number of AHCCCS data use agreements executed and cataloged.

**AHCCCS Health IT Goal 5: Increase agency data access and information exchange.**

- Benchmark 5.1 – Number of Contexture participants who are part of an AHCCCS Health Plan, and
- Benchmark 5.2 – Date of last revision of the AHCCCS Health Plan contracts with health IT and HIE requirements updated.





# Appendix

## Appendix

### Appendix A: Acronyms

| Acronym | Term  |
|---------|---|
| ACC     | AHCCCS COMPLETE CARE                        |
| ACO     | ACCOUNTABLE CARE ORGANIZATION               |
| ALTCS   | ARIZONA LONG-TERM CARE SYSTEM               |
| ADE     | ARIZONA DEPARTMENT OF EDUCATION             |
| ADHS    | ARIZONA DEPARTMENT OF HEALTH SERVICES       |
| ADOC    | ARIZONA DEPARTMENT OF CORRECTIONS           |
| ADT     | ADMIT, DISCHARGE, AND TRANSFER              |
| AHA     | AMERICAN HOSPITAL ASSOCIATION               |
| AHCCCS  | ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM |
| AIHP    | AMERICAN INDIAN HEALTH PROGRAM              |
| AIMH    | AMERICAN INDIAN MEDICAL HOME                |
| ARPA    | AMERICAN RESCUE PLAN ACT                    |
| API     | APPLICATION PROGRAMMING INTERFACE           |
| ASU     | ARIZONA STATE UNIVERSITY                    |
| AzHeC   | ARIZONA HEALTH-E CONNECTION                 |
| AzHIP   | ARIZONA HEALTH IMPROVEMENT PLAN             |
| BH      | BEHAVIORAL HEALTH                           |
| CAH     | CRITICAL ACCESS HOSPITAL                    |
| CBO     | COMMUNITY-BASED ORGANIZATION                |
| CCD     | CONTINUITY OF CARE DOCUMENT                 |
| CDC     | CENTERS FOR DISEASE CONTROL AND PREVENTION  |



| Acronym | Term  |
|---------|---|
| CEHRT   | CERTIFIED ELECTRONIC HEALTH RECORDS TECHNOLOGY                          |
| CHC     | COMMUNITY HEALTH CENTER   |
| CHIP    | CHILDREN’S HEALTH INSURANCE PROGRAM                                     |
| CHIR    | CENTER FOR HEALTH INFORMATION & RESEARCH                                |
| CHP     | COMPRHENSIVE HEALTH PLAN  |
| CIN     | CLINICALLY INTEGRATED NETWORKS  |
| CLRS    | CLOSED LOOP REFERRAL SYSTEM   |
| CMDP    | COMPREHENSIVE MEDICAL AND DENTAL PROGRAM                                |
| CMS     | CENTERS FOR MEDICARE & MEDICAID SERVICES                                |
| CHP     | COMPREHENSIVE HEALTH PLAN   |
| CORHIO  | COLORADO REGIONAL HEALTH INFORMATION EXCHANGE                           |
| CRS     | CHILDRENS REHABILITATIVE SERVICES                                       |
| DAP     | DIFFERENTIAL ADJUSTED PAYMENT   |
| DCS     | DEPARTMENT OF CHILD SAFETY  |
| DES/DDD | DEPARTMENT OF ECONOMIC SECURITY, DIVISION OF DEVELOPMENTAL DISABILITIES |
| DFSM    | DIVISION OF FFS MANAGEMENT  |
| ED      | EMERGENCY DEPARTMENT  |
| EH      | ELIGIBLE HOSPITAL   |
| HER     | ELECTRONIC HEALTH RECORD  |
| EVV     | ELECTRONIC VISIT VERIFICATION   |
| EMR     | ELECTRONIC MEDICAL RECORD   |
| EP      | ELIGIBLE PROFESSIONALS  |
| ESCAN   | ENVIRONMENTAL SCAN  |



| Acronym            | Term   |
|--------------------|--|
| FFS                | FEE-FOR-SERVICE  |
| FHIR               | FAST HEALTHCARE INTEROPERABILITY RESOURCES                         |
| FQHC               | FEDERALLY QUALIFIED HEALTH CENTER                                  |
| GSA                | GEORGRAPHIC SERVICE AREA   |
| HCBS               | HOME AND COMMUNITY-BASED SERVICES                                  |
| HEALTH IT          | HEALTH INFORMATION TECHNOLOGY                                      |
| HEDIS              | HEALTH CARE EFFECTIVENESS DATA AND INFORMATION SET                 |
| HIE                | HEALTH INFORMATION EXCHANGE  |
| HINaz              | HEALTH INFORMATION NETWORK OF ARIZONA                              |
| HINTS              | HEALTH INFORMATION NATIONAL TRENDS SURVEY                          |
| HIPAA              | HEALTH PORTABILITY AND ACCOUNTABILITY ACT                          |
| HITECH             | HEALTH INFORMATION TECHNOLOGY FOR CLINICAL AND ECONOMIC HEALTH ACT |
| HL7                | HEALTH LEVEL 7   |
| IDN                | INTEGRATED DELIVERY NETWORK  |
| IHS                | INDIAN HEALTH SERVICE  |
| IT                 | INFORMATION TECHNOLOGY   |
| KFF                | KAISER FAMILY FOUNDATION   |
| LTSS               | LONG-TERM SERVICES AND SUPPORTS                                    |
| MACPAC             | MEDICAID AND CHIP PAYMENT AND ACCESS COMMISSION                    |
| MCOs               | MANAGED CARE ORGANIZATIONS   |
| MD                 | MEDICAL DOCTOR   |
| MU                 | MEANINGFUL USE   |
| MYERS AND STAUFFER | MYERS AND STAUFFER LC  |



| Acronym  | Term   |
|----------|--|
| ONC      | OFFICE OF THE NATIONAL COORDINATOR   |
| PCP      | PRIMARY CARE PROVIDER  |
| PMP      | PRESCRIPTION MONITORING PROGRAM  |
| PPE      | PERSONAL PROTECTIVE EQUIPMENT  |
| RHC      | RURAL HEALTH CENTER  |
| PBM      | PHARMACY BENEFIT MANAGER   |
| PI       | PROMOTING INTEROPERABILITY   |
| PPMIS    | PRE-PAID MEDICAID MANAGEMENT INFORMATION SYSTEM                                |
| QHINs    | QUALIFIED HEALTH INFORMATION NETWORKS  |
| RBHAs    | REGIONAL BEHAVIORAL HEALTH AUTHORITIES   |
| RCE      | RECOGNIZED COORDINATING ENTITY   |
| SAMHSA   | SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION                      |
| SDOH     | SOCIAL DETERMINANTS OF HEALTH  |
| SFY      | STATE FISCAL YEAR  |
| SMA      | STATE MEDICAID AGENCY  |
| SMHP     | STATE MEDICAID HEALTH IT PLAN  |
| STAR HIE | STRENGTHENING THE TECHNICAL ADVANCEMENT AND READINESS OF PUBLIC HEALTH VIA HIE |
| SUD      | SUBSTANCE USE DISORDER   |
| TEFCA    | TRUSTED EXCHANGE FRAMEWORK AND COMMON AGREEMENT                                |
| TI       | TARGETED INVESTMENT  |
| TIP      | TARGETED INVESTMENT PROGRAM  |
| TRBHA    | TRIBAL REGIONAL BEHAVIORAL HEALTH AUTHORITIES                                  |
| USCDI    | U.S. CORE DATA FOR INTEROPERABILITY  |



| Acronym | Term                       |
|---------|----------------------------|
| WPCI    | WHOLE-PERSON CENTERED CARE |

