Arizona Health Care Cost Containment System (AHCCCS)
2025 -2029 Strategic Plan (5 years-Static)

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Statewide Vision: An Arizona for everyone.

Agency Vision: To be the recognized national leader in providing high quality whole-person public health care.

Agency Mission: Helping Arizonans live healthier lives by ensuring access to quality health care across all our communities.

Agency Description: Founded in 1982, the Arizona Health Care Cost Containment System (AHCCCS) is Arizona's Medicaid program, a federal health care program jointly funded by the federal and state governments for individuals and families who qualify based on income level. Built on principles of competition and choice, AHCCCS operates under an integrated care model for its American Indian Health program (fee-for-service) and contracted managed care organizations (MCOs) (health plans) to coordinate and pay for physical and behavioral health care services delivered by approximately 100,000 health care providers to more than 1.8 million Arizonans. AHCCCS also serves as the state behavioral health authority, which includes the administration of grant funding from the Substance Abuse and Mental Health Services Administration (SAMHSA) and other sources. Arizona receives national recognition for its innovative approach to behavioral health crisis services. For example, Arizona operates 24/7 crisis call centers to respond to people in need (regardless of insurance coverage) and dispatch mobile crisis teams.

Resource Assumptions: Enter # of full-time employees (FTEs) and funding data by type (e.g. General fund (GF), appropriated funds (AF), non-appropriated funds (NAF), and federal funds (FED).

FY	FTEs	GF	AF	NAF	FED	Total
25	1274.5	$2,669,731,700	$455,300,200	$3,492,110,400	$18,496,508,400	$25,113,650,700
26	1274.5	$2,611,707,100	$621,150,200	$3,592,186,700	$18,772,322,800	$25,597,366,800
27	1322.5	$2,919,510,700	$560,100,100	$2,847,122,400	$16,633,704,500	$29,514,314,100

*Total reflects GF + AF + NAF. FED funding shown is broken out from NAF

Director's Summary: AHCCCS is committed to a two-pronged strategy of ensuring eligible Arizonans maintain healthcare coverage and are able to access high-quality whole-person health care throughout the state. Recent federal policy changes and funding cuts have created more complex eligibility processes, reduced funding for providers, and uncertainty among members and providers about the future of healthcare availability for Arizona families. Despite these headwinds, AHCCCS is committed to taking a data driven approach to ensuring qualified individuals maintain coverage and Arizonans have access to quality healthcare services. AHCCCS will do this by enhancing our closed-loop referral system, investing in rural and justice-involved healthcare initiatives, streamlining eligibility systems, offering training and technical support to providers, and enhancing systems to detect fraud, waste, and abuse.

#	Agency Five-Year Outcomes	FY	Statewide Priority	Annual Progress Towards 5-Year Outcome
1	**UPDATED FY27 Five-Year Outcome:** Increase the percentage of members with identified Health-Related Social Needs (HRSNs) whose cases are actively managed by a community-based provider/organization* to meet or exceed the national average of 61.6% by June 2029.	FY24	**Reproductive Freedom and Health Care: Accessible Healthcare**	**FY26 Annual Objective(s):** 1.1. Increase the % of resolved closed-loop referrals to 45.50% by June 30, 2026. **Target:** 45.5% **Actual:** 40.5 **5-Yr Status:** As a result of improved data accuracy and availability, the AHCCCS Whole-Person Care team has updated this 5Y outcome to shift focus from improvements to closed-loop referrals to the intended impact of this, % of those referrals being actively managed by a provider in their community. We will continue to work on improving closed-loop referrals (those being referred for and connected with a provider) to increase those accessing community-based care. *Actively managed cases are defined as having an open, documented engagement with a provider or community-based organization delivering or coordinating services.
2	**NEW FY27 5-YEAR OUTCOME** Reduce preventable (procedural) AHCCCS disenrollments due to "Failure to Complete Renewal" by 3% by June 2029.	FY27	**Reproductive Freedom and Health Care: Affordable Healthcare**	**FY26 Annual Objective(s): These relate to the previous 5Y outcome on uninsured rate.** 2.1 Increase the Medicaid enrollment rate among eligible uninsured individuals by 5% by 6/30/26. **Target:** 5% **Actual:** Data for 2025 is not yet available. 2.2 Identify top 10% of zip codes with high eligibility rates and high uninsured rates by 6/30/26. **Target:** 10% **Actual:** 10% **5-Yr Status:** Changes in federal healthcare policy have resulted in increased administrative costs and additional hurdles to accessing and maintaining Medicaid coverage. This has made the previous 5Y outcome to increase the % of eligible individuals accessing Medicaid unachievable. To promote continuous coverage for eligible individuals and reduce unnecessary loss of coverage, AHCCCS is making strategic shift toward reducing procedural disenrollments.
3	**NEW FY27 5-YEAR OUTCOME** Reduce the percentage of justice-involved AHCCCS members who have an Emergency Department visit within six months of release from 33.97% to 25.5% by June 30, 2030.	FY27	**Reproductive Freedom and Health Care: Accountable Healthcare**	**FY26 Annual Objective(s): These relate to the previous 5Y outcome on caller satisfaction.** 3.1 Increase very satisfied provider callers from 78% to 82.5% by June 30, 2026. **Target:** 82.5% **Actual:** 86.6% 3.2 Maintain member caller satisfaction at or above 85% by June 30, 2026. **Target:** 85% **Actual:** 84.4% 5-Yr Status: Due to consistent improvements in provider caller satisfaction, we are moving the previous 5Y outcome to maintenance and adding a new 5Y strategic outcome focused on reducing ER visits among justice-involved AHCCCS members. This will help reduce costly ER visits and promote access to care which helps reduce recidivism.

Outcome #	FY27 Annual Objectives	Objective Metrics	Annual Initiatives
1	1.1 Maintain or exceed 61% of cases under active management by providers and community-based organizations by 6/30/27	1.1 % of cases actively managed by providers and community-based organizations.	1.1 In order to improve access to whole-person care through strengthened engagement and follow-through in the closed-loop referral system, we will expand Provider & CBO Adoption of CommunityCares platform by conducting targeted outreach and onboarding campaigns to increase participation among providers, CBOs, and health plans.
2	2.1 Reduce preventable (procedural) AHCCCS disenrollments due to "Failure to Complete Renewal" by 1% by June 2027	2.1 % of disenrollments due to reason code "Failure to Complete Renewal"	2.1 We will increase efforts to strengthen partnerships with community organizations to provide more hands-on support and guidance during Medicaid enrollment.
3	3.1. By June 30, 2027, at least 65% of identified justice-involved members with qualifying needs will receive documented care coordination or referral prior to release.	3.1 % of identified justice-involved members with coordination prior to release.	3.1 We will update current data-sharing agreements with key carceral partners to support timely information exchange and add care coordination 3.1 We will strengthen Justice System Reach-In Implementation by developing care plans and scheduling of services within 7 days post-release. 3.1 We will strengthen Contractor Accountability and Reporting through implementation of enhanced data tracking requirements as specified in AMPM1022.
4	4.1. By January 30, 2028, at least 33% of Targeted Preventive Care (TPC) measures will meet or exceed the National Committee for Quality Assurance (NCQA) Medicaid Mean.	4.1 % of TPC measures meeting or exceeding NCQA mean	4.1 We will identify barriers to preventive care access and implement targeted strategies to improve member completion of recommended screenings and services.
5	5.1 Achieve at least 80% approval rate for all claims submitted to the prepayment review code group by June 30, 2027.	5.1 % of approved claims submitted to the prepayment review code group	5.1 We will continue monitoring of pre- and post-payment reviews to identify patterns of fraud, waste, and abuse more effectively. 5.1 We will develop and provide monthly trainings for FFS providers, focusing on those who are newly registered or are struggling to meet compliance, and will refer providers who are struggling to receive individualized Technical Assistance. This will provide providers with guidance, support, and oversight to ensure compliance and set up providers for success.

#	Agency Five-Year Outcomes	FY	Statewide Priority	Annual Progress Towards 5-Year Outcome
4	**CONTINUING FY27 Five-Year Outcome:** Increase % of Targeted Preventive Care (TPC) measures meeting or exceeding the National Committee for Quality Assurance (NCQA) Medicaid Mean from 25% to 35% by June 2029.*	FY24	**Reproductive Freedom and Health Care: Accountable Healthcare**	**FY26 Annual Objective(s):** 4.1 Increase 25% of the Targeted Preventive Care (TPC) Measures which were below the NCQA Mean in the previous reporting period by 2% **Target:** 25% **Actual:** 80% **5-Yr Status:** The % of measures meeting or exceeding the NCQA mean is currently 33.3% (CY24). The FY26 objective targeted 10 specific areas that had room for improvement. We executed improvement activities that resulted in improvement in 8 of the 10 targeted metrics. Note: *AHCCCS' performance measure results and NCQA data have a lag of about 18 months.
5	**UPDATED FY27 Five-Year Outcome:** Increase the % of claims approved for claims submitted to the prepayment review code group from 71% to 81% by June 2029.	FY25	**Reproductive Freedom and Health Care: Accountable Healthcare**	**FY26 Annual Objective(s):** 5.1. Increase the % of claims approved after prepayment review by 2 percentage points by 6/30/26 **Target:** 2% **Actual:** 7% **5-Yr Status:** To date we are averaging a 78% approval of claims after prepayment review. In FY26 AHCCCS continued to strengthen our ability to conduct targeted audits, prepayment reviews, and investigations. In FY27 we will focus specifically on claims submitted to the prepayment review code group in support of our goal to improve quality of care and reduce fraud, waste, and abuse.

Stakeholder Engagement Strategies:

Outcome 1: Internally, we will involve the Leadership, Whole Person Care, and Rates teams through meetings, progress updates, and scorecard tracking to improve coordination of care management and increase participation from providers and Community Based Organizations. Externally, we will involve Managed Care Organizations, providers, Community Based Organizations and Contexture through meetings, events, and monthly reporting to expand participation in Contexture and support the increase in actively managed cases.

Outcome 2: Internally, we will involve the Division of Member and Providers Services, the Information Systems Division, the Communications Team, and HR1 Staff through huddles, workgroups, and committees to reduce barriers and improve the renewal process. Externally, we will involve providers, Community Assistor Organizations and Managed Care Organizations through regular strategy meetings to streamline messaging, coordinate, and improve processes.

Outcome 3: Internally, we will engage the Justice, Federal Relations, Fee-for-Service Management, and Managed Care teams through workgroups to implement the waiver. Externally we will work with correction agencies, jails, health plans, and community partners on coordination, data sharing, and training, to improve care continuity.

Outcome 4: Internally, we will engage the Clinical Quality, Division of Fee-for-Service Management, Division of Business and Finance, and the Division of Managed Care teams through workgroups to set targets and coordinate with health plans. Externally, we will engage Managed Care Organizations, providers, the National Committee for Quality Assurance, the Centers for Medicare & Medicaid Services, and Community Based Organizations through reporting, training, and meetings to improve quality performance and preventive care uptake.

Outcome 5: Internally, we will involve the Office of the Inspector General and the Division of Fee-for-Service Management through meetings and data reviews to improve procedures. Externally, we will engage a vendor, the Arizona Department of Health Services, the Arizona Board of Behavioral Health Examiners, and providers through training, technical assistance and outreach to improve billing compliance.

Stakeholder Communication Strategies:

Outcome 1: Internally, we will communicate with the Leadership team, the Whole Person Care team and Contexture through quarterly performance reporting and leadership reviews. Externally, we will communicate with Community Based Organizations, Managed Care Organizations and providers through social media and community outreach events to support awareness and stakeholder buy-in and increase cases managed by Community Based Organizations.

Outcome 2: Internally, we will communicate with the Leadership team and the Division of Member and Providers Services through performance reporting and leadership reviews to ensure compliance and identify improvements. Externally, we will communicate with the Arizona Department of Economic Security, Community Partner Assistor Organizations, and Managed Care Organizations through our website, presentations, and dashboards to reduce misinformation and increase implementation accuracy.

Outcome 3: Internally ,we will communicate with the Leadership, Legislative, Communications, and Justice teams through reporting to inform staff of outcomes, and support staff in triaging issues. Externally, we will communicate with the Governor's Office, Managed Care Organizations, community stakeholders, and advocacy groups through performance reporting, data sharing, and meetings to increase transparency, promote stronger partner alignment, and improve engagement in care coordination.

Outcome 4. Internally, we will communicate with the Leadership, Data and Analytics, and Managed Care Oversight teams through reporting, performance reviews and recognition of wins, to improve issue identification and performance tracking. Externally, we will communicate with Managed Care Organizations, providers, the Centers for Medicare & Medicaid Services, the National Committee for Quality Assurance, and community partners through bulletins, dashboards and presentations to improve preventive care utilization, strengthen alignment with quality benchmarks, and enhance accountability.

Outcome 5: Internally, we will communicate with the Program Integrity, Claims, Finance, and Leadership teams through scorecard updates and prevention meetings to reduce risk and errors. Externally, we will communicate with the Centers for Medicare & Medicaid Services, the Governor's Office, legislators, and providers through our website, presentations, and reports to promote transparency, build trust, and increase participation in the training program.