

# AHCCCS STRATEGIC PLAN

## STATE FISCAL YEARS 2014-2018



June 2013  
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***Our first care is your health care***  
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

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July 1, 2013

Dear Arizonans:

I am pleased to share with you a copy of the Arizona Health Care Cost Containment System (AHCCCS) Strategic Plan for State Fiscal Years 2014-2018. Thanks to the efforts of Governor Brewer and a majority of the legislature, AHCCCS will be working to restore affordable health care coverage to 300,000 Arizonans over the next year.

The decision to restore coverage was the most important healthcare policy issue this State has faced since the inception of the AHCCCS program 30 years ago. The AHCCCS restoration is critical to low-income Arizonans who typically do not have access to affordable coverage. The AHCCCS restoration is critical to providers who have seen dramatic increases in uncompensated care. The AHCCCS restoration is critical for economic development in supporting businesses and families who cover the costs of uncompensated care through their insurance premiums.

With the completion of the coverage debate, AHCCCS has identified four Goals that are critical to sustaining and building on our success:

- 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 the systematic fragmentation that exists in healthcare delivery to develop an integrated system of healthcare.*
- Goal 4.** *AHCCCS must maintain core organizational capacity, infrastructure and workforce planning that effectively serves AHCCCS operations.*

This past year AHCCCS celebrated its 30<sup>th</sup> Anniversary. AHCCCS has served as an innovative model for delivering efficient and effective health care to Arizonans in need. The Auditor General and legislature recognized this success by recommending and extending the AHCCCS program for an additional ten years. As the program enters into its fourth decade of existence AHCCCS welcomes the opportunity to continue to be a leader and agent of change in the Arizona healthcare delivery system.

Sincerely,

Thomas J. Betlach  
Director

## TABLE OF CONTENTS

Introduction.....	4
Vision, Mission, Guiding Principles.....	4
Strategic Plan Map.....	5
AHCCCS Overview .....	6
Key Accomplishments.....	7
Environmental Scan.....	9
Strategic Goals	
Goal 1.....	23
Goal 2.....	24
Goal 3.....	25
Goal 4.....	26
Resource Assumptions.....	28

## INTRODUCTION

The AHCCCS Strategic Plan for 2014-2018 begins with statements of the AHCCCS vision and mission, and a description of the Agency's guiding principles. This is followed by an overview of the programs and populations served, a review of accomplishments during the past fiscal year, and a scan of selected environmental circumstances that impact AHCCCS operations and drive strategic planning.

The Plan identifies Six Areas of Focus for AHCCCS. These include:

1. Delivery System Alignment and Integration
2. Payment Modernization
3. Tribal Care Coordination Initiative
4. Program Integrity
5. Health Information Technology
6. AHCCCS Quality Assessment and Performance Improvement Strategy.

The Plan then concludes with a summary of Goals, Strategies and Performance Measures that will serve to focus the efforts and energy of the program over the next few years.

### **AHCCCS VISION:**

Shaping tomorrow's managed health care... from today's experience, quality, and innovation.

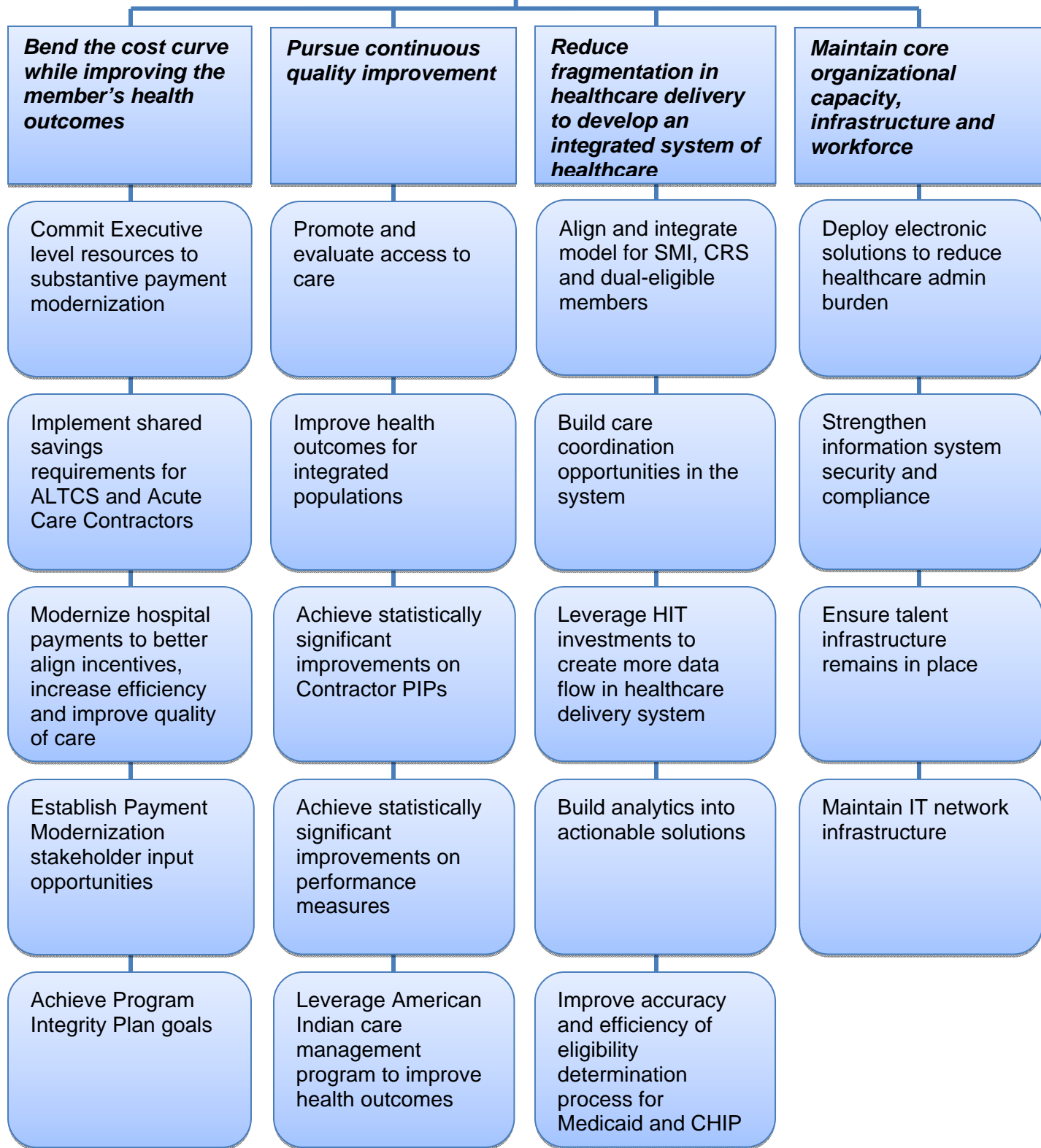
### **AHCCCS MISSION:**

Reaching across Arizona to provide comprehensive, quality health care for those in need.

### **GUIDING PRINCIPLES:**

- A Strategic Plan is the result of a collaborative process and reflects informed planning efforts by the Executive Management Team.
- AHCCCS continues to pursue multiple long-term strategies already in place that can effectively bend the cost curve including: system alignment and integration, payment modernization, tribal care coordination, program integrity, health information technology and continuous quality improvement initiatives.
- Success is only possible through the retention and recruitment of high quality staff.
- Program integrity is an essential component of all operational departments and, when supported by transparency, promotes efficiency and accountability in the management and delivery of services.
- AHCCCS must continue to engage stakeholders regarding strategic opportunities.

**Reaching Across Arizona to  
Provide Comprehensive, Quality  
Health Care for Those in Need**



## AHCCCS OVERVIEW

The Arizona Health Care Cost Containment System (AHCCCS), the State's Medicaid Agency, uses federal, state, and county funds to provide health care coverage to the State's acute and long-term care Medicaid populations, low-income groups, and small businesses. Since 1982, when it became the first statewide Medicaid managed care system in the nation, AHCCCS has operated under a federal Research and Demonstration 1115 Waiver authority that allows for the operation of a total managed care model.

AHCCCS makes prospective capitation payments to contracted health plans responsible for the delivery of care to members. The result is a managed care system that mainstreams recipients, allows them to select their providers, and encourages quality care and preventive services. Over the past two years enrollment in the program has decreased as a result of an enrollment freeze that was instituted on waiver members beginning in July 2011. Table 1 below provides a snapshot of the AHCCCS enrollment as of June 1, 2013. Over the course of FY 2013, approximately 1.8 million unique Arizonans were enrolled with the AHCCCS program.

**Table 1. AHCCCS oversees three main programs:**

Program	Number Recipients*	Percent Recipients
AHCCCS Acute Care	1,177,843	93%
Arizona Long Term Care System (ALTCS)	53,628	4%
KidsCare	43,211	3%
TOTAL	1,274,732	100%

\* As of June 1, 2012

### *AHCCCS Acute Care*

The majority of Acute Care Program recipients are children and pregnant women who qualify for the federal Medicaid Program (Title XIX). Although most AHCCCS members are required to enroll in contracted health plans, American Indians and Alaska Natives in the Acute Care Program may choose to receive services through either the contracted health plans or the American Indian Health Program, the agency's only fee-for-service program. AHCCCS also administers an emergency services only program for individuals who, except for immigration status, would qualify for full AHCCCS benefits.

### *ALTCS*

The Arizona Long Term Care System (ALTCS) provides acute care, behavioral health services, long-term care, and case management to individuals who are elderly, physically disabled, or developmentally disabled and meet the criteria for institutionalization. Whereas ALTCS members account for less than 4.0% of the AHCCCS population, they account for approximately 26.0% of the costs. The ALTCS program encourages delivery of care in alternative residential settings. As in the Acute Care Program, elderly physically disabled and developmentally disabled members of all ages receive care through contracted plans.

### *KidsCare*

The Children's Health Insurance Program (CHIP), known as KidsCare in Arizona, offers affordable insurance coverage for low income families. Children under age 19 may qualify for the program if their family's income exceeds the limit allowed for Medicaid eligibility, but is below 200% of the Federal Poverty Level (FPL). An enrollment freeze was instituted in January 2010, which has resulted in the program going from 45,820 children to 7,185 as of June 1, 2013.

However, AHCCCS has also worked with local funding partners to provide the state match funding for a limited group of new enrollees, and as a result, the KidsCare II program currently has an enrollment of 36,026 children.

#### *Additional Program Detail*

AHCCCS administers a Freedom to Work Program and a Breast and Cervical Cancer Treatment Program. These are considered Acute Care programs and included in Acute Care Program enrollment numbers.

AHCCCS engages in contracts with a number of public and private organizations that provide a variety of services:

- Behavioral health services are provided by the Arizona Department of Health Services (ADHS), Division of Behavioral Health Services (DBHS).
- Services for individuals with developmental disabilities in ALTCS are offered through the Arizona Department of Economic Security (ADES), Division of Developmental Disabilities (DDD).
- Acute health care services for children in foster care are provided by the Arizona Department of Economic Security (ADES), Comprehensive Medical and Dental Program (CMDP).
- Selected administrative services, such as eligibility determination, are performed by ADES.
- Claims payments associated with the Medicaid School Based Claiming (SBC) program are administered by a private third party administrator.

#### **KEY ACCOMPLISHMENTS**

- After months of debate, the Arizona legislature voted to adopt the Governor's Medicaid Restoration plan providing coverage for approximately 300,000 Arizonans while establishing appropriate protection against potential decreased federal participation. The proposal also includes the creation of a hospital assessment to help fund the state's costs associated with restoration.
- AHCCCS celebrated its 30<sup>th</sup> Anniversary in 2012.
- AHCCCS was ranked number one nationally among state Medicaid programs for its individuals with developmental disabilities program in the 2013 United Cerebral Palsy Report.
- Every ten years, the Legislature must review and decide whether to continue the AHCCCS program. As part of this process, the Auditor General conducted a sunset review of the program using the criteria in Arizona's sunset law and presented its findings before the Committee of Reference (COR) at the AHCCCS Sunset Review Hearing on November 13, 2012. At the hearing, the COR approved the motion to continue AHCCCS for another ten years. During the 2013 legislative session, the AHCCCS program was continued for another ten years.
- AHCCCS successfully completed a competitive procurement process for the Acute and CRS programs resulting in a decrease of 2.8% in capitation rates and no successful bid protests.
- AHCCCS made progress pursuing long-term strategies to bend the health care cost curve while improving quality outcomes and care coordination, including:





- Program Integrity - AHCCCS met the vast majority of the Program Integrity goals established in its annual plan. The Agency worked with prosecutors successfully on 25 different cases resulting in convictions - a program record. AHCCCS realized over \$979 million as a result of coordination of benefits, third party recoveries, and OIG activities, and began pursuing the ability to leverage private sector expertise on data analyses. The Arizona Auditor General found that AHCCCS had a 1.1% eligibility error rate.
  - Health Information Technology – AHCCCS has registered, validated and paid 1,572 eligible professionals and 81 eligible hospitals since the program opened in July, 2011 - the payments total over \$131 million. AHCCCS continues to serve on the Health-E Connection Board and the Health Information Network of Arizona (HINAZ) Board, and entered into agreement with HINAZ to begin using its Health Information Exchange (HIE) services.
- 10 Acute Care and DES/CMDP Contractors were in full compliance for 83.2% of the 1,237 reviewed standards.
- In response to the substantial reductions that were imposed as part of the FY 2012 and FY 2013 budgets, AHCCCS worked with stakeholders and secured approval from CMS through Waiver amendments, to establish a mechanism to leverage local funds allowing over 20,000 children to become eligible for KidsCare coverage, pay \$300 million to select hospitals and establish an ability to pay IHS and 638 facilities for uncompensated care providing critical resources to retain important healthcare infrastructure.
- AHCCCS continued to pursue an improved partnership with Arizona tribes while continuing to engage in strategies that improve the health system for tribal members. AHCCCS conducted 12 tribal consultation meetings in 2012, and created a new position in the Division of Fee for Service Management, the division that oversees the American Indian Health Program. The Tribal Health Care Coordinator is responsible for working with IHS, 638 and Urban Indian Health Centers to ensure better coordination of care and follow up for American Indian members.
- The AHCCCS 2013 employee survey indicated a strong positive feeling among staff, despite the many challenges endured by the program over the past few years. A total of 98% of staff value members of their team; 97% believe in the AHCCCS mission; 94.7% understand clearly what is expected from them; and 92.4% are proud to be an AHCCCS employee. In addition, AHCCCS has 4.7 engaged employees for every 1 disengaged employee compared to the statewide average of 1.6 engaged employees for every 1 disengaged employee.

## **ENVIRONMENTAL SCAN**

To appreciate the context in which the AHCCCS Strategic Plan was developed, it is helpful to review the environment in which Arizona health care delivery systems operate and the challenges they may face in the future. The scan that follows is not meant to exhaustively cover the multiple over-arching circumstances that impact AHCCCS operations and drive strategic planning.

## The Economy and AHCCCS Policy Decisions

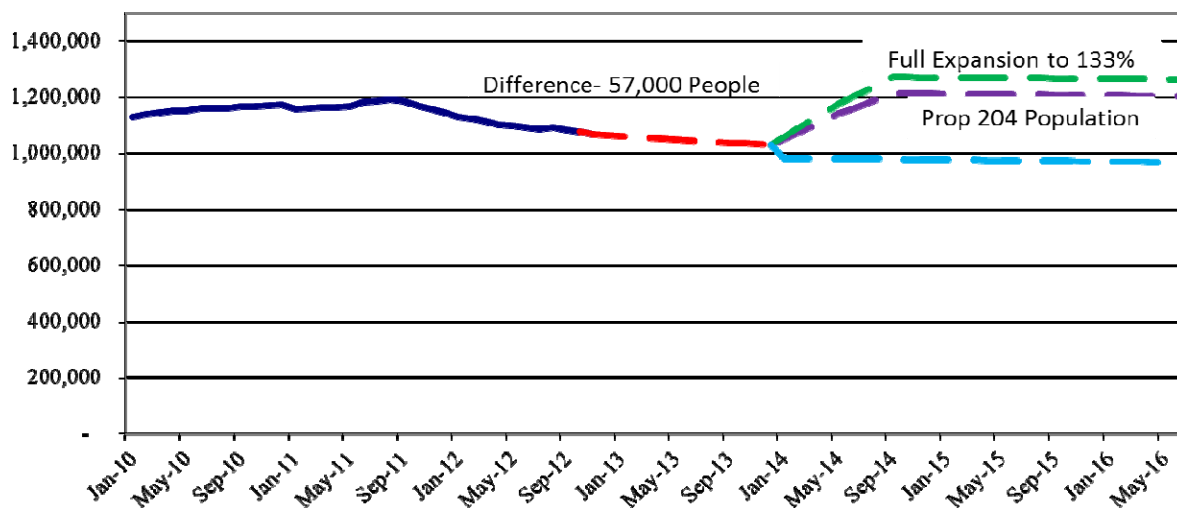
The economy in Arizona is improving with the unemployment rate dropping from a high of 10.8% in 2010 during the Great Recession to a rate of 7.9% in June 2013. In addition, due to the effective implementation of prudent budget decisions, the State budget now has a modest surplus.

The economic improvement combined with the reductions imposed within the AHCCCS budget resulted in a more stable fiscal environment over the past twelve months. However, the FY 2014 budget was dominated by the debate over Medicaid and more specifically what to do with regards to restoration of the Proposition 204 population established by voters in 2000. During her State of the State, Governor Brewer announced that she wanted to restore and expand Medicaid coverage to fulfill the will of Arizona voters, stabilize the healthcare delivery system and provide affordable coverage for low-income Arizonans.

After many months of debate, ultimately the Arizona legislature decided to move forward with the Governor's coverage proposal. Thus, over the period of 30 months the agency will have implemented the largest cuts in the history of the program and had to manage the restoration of many of those reductions.

As part of the Governor's proposal, the agency will also be responsible for implementing a hospital assessment that will cover a portion of the restoration costs. This funding strategy removes the state match obligation from the General Fund for the Proposition 204 population. In addition, a circuit breaker has been included to protect Arizona should federal support of Medicaid expansion falter. If federal funding decreases below 80% for the Prop 204 or expansion populations, Medicaid coverage and the provider assessment levied against hospitals will be terminated.

**Figure 4: Relatively Minor Tweak to Populations Already Covered by Arizona Voters**



In addition to the coverage initiative, there are several other Affordable Care Act requirements that will impact the AHCCCS budget and operations. There is an assumption that the coverage changes will create a "woodwork" effect. Those already eligible for AHCCCS, but do not

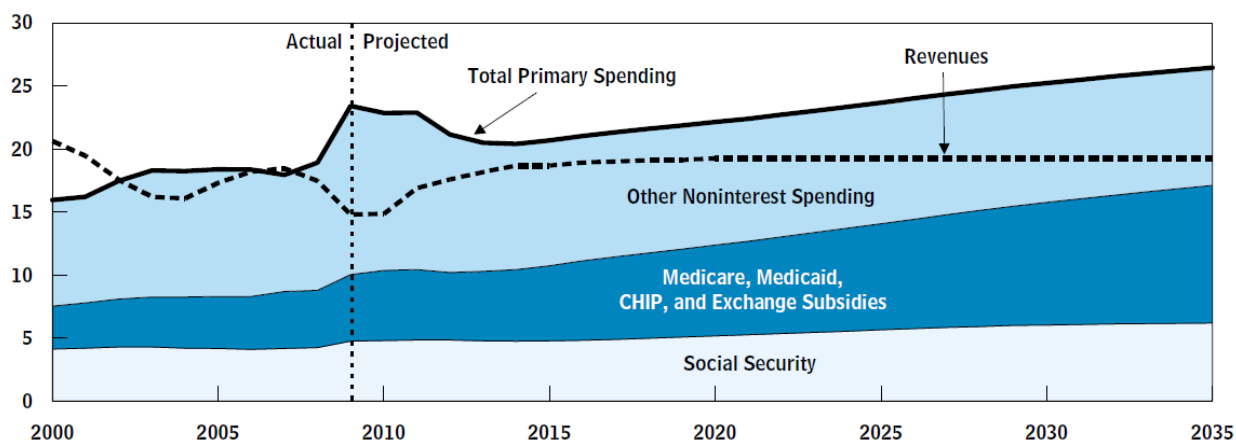
currently have Medicaid coverage will join the program. There is a 1.3% tax on insurers, including Medicaid health plans that will impact the AHCCCS budget. The ACA's modification to how AHCCCS will handle member redetermination, will likely result in members maintaining continuous coverage rather than dropping from and returning to the program. There is also a requirement to reimburse primary care physicians at Medicare rates (which are generally higher than Medicaid). The federal government will pay 100% of the necessary increases from rates in effect on July 1, 2009. However, the State has to pay state match to restore a series of provider rate cuts that were made during the recession. Finally, the agency is also working to develop a new eligibility system that was necessary to implement changes made in the ACA.

### Federal Budget

Since Medicaid is a federal-state partnership, it is important to recognize that future program success is not just dependent on state commitments but also the decisions made by federal policymakers. Given the mandates in the ACA, it is unlikely that any significant changes will be made to Medicaid over the short term. However, as depicted below in Figure 2, the demographic growth of Medicare and Medicaid begin to dominate the federal budget picture over the longer term. Based on projected growth trends, health care will be a dominant topic for policymakers during the next several decades as they look for solutions and strategies that bend the cost curve.

**Figure 2. Federal Spending**

Percent of Gross Domestic Product



Source: Congressional Budget Office, The Long-Term Budget Outlook, June 2010, revised August 2010.

## SIX AREAS OF FOCUS

The next section highlights six areas where the agency has been pursuing multi-year efforts to pursue opportunities to drive positive changes into the AHCCCS system. In order to implement or pursue these opportunities, the proper systems and workforce infrastructure must be in place.

### 1. Delivery System Alignment and Integration

The definition of a system is ***an assemblage or combination of things or parts forming a complex or unitary whole***. Unfortunately, care delivery has become increasingly fragmented, leading to coordination and communication challenges for patients and clinicians. Ultimately, this fragmentation degrades the quality of health care due to disrupted relationships, poor coordination of care and communication within and across

provider groups. In an effort to address this issue, the structure of the AHCCCS program is transforming. Integrated care delivery systems and the proper alignment of incentives efficiently improve health outcomes. Both are critical for reducing fragmentation.

*Children's Rehabilitative Services (CRS)* - Arizona's Children's Rehabilitative Services (CRS) was started in 1929 to serve children with complex health care needs who require specialized services. A list of specific conditions determines whether a child is eligible for CRS. Although CRS is part of the Arizona Medicaid program, CRS services have not been managed within the AHCCCS health plans. As a result, a child with complex health care needs was enrolled in a minimum of two separate systems of care. One for well-child and primary care, and the other for specialty care through CRS. Children with other conditions, including developmental disabilities or behavioral health needs, are sometimes enrolled in several systems of care.

This can be confusing for both families and providers. Coordinating care for CRS children became a challenge for AHCCCS, and clearly the burden placed on families has also been significant. On January 1, 2011, AHCCCS entered into an Intergovernmental Agreement with ADHS to implement an administrative simplification of the CRS program. On November 1, 2012, AHCCCS released the Notice of Request for Proposal soliciting managed care contracts beginning October 1, 2013, integrating the Acute Care and CRS programs. On January 28, 2013, AHCCCS received proposals from two offerors for the CRS program. AHCCCS awarded the contract on March 22, 2013 and it will go into effect October 1, 2013.

On January 31, 2013, CMS approved the Waiver amendment for the Acute Care and CRS Integration. The new Waiver authority allows AHCCCS to:

- Transform care for children with special healthcare needs by operating a fully integrated healthcare system that will enroll CRS-eligible children into one MCO that will manage their CRS, physical and behavioral health care needs.
- Improve care coordination for children with special healthcare needs.
- Increase the ability of the integrated CRS MCO to collect and analyze data to better assess the health needs of their members with a CRS condition from a holistic approach.
- Streamline the current fragmented health care delivery system, which has caused inefficiencies and led to challenges with care coordination for the families of CRS-eligible children.

Ultimately, the goal for the CRS integration initiative is a system that offers members a choice of plans, comparable to the Acute and Long-Term Care programs.

*Behavioral Health Services* – National data indicates that individuals with serious mental illness die 25 years earlier than the general public. In Arizona, that number is even greater. Treatable medical conditions that result from modifiable risk factors such as smoking, obesity, substance abuse, and reluctance to access medical care are often the cause of the increased mortality. A holistic approach to care is essential for this population as the mind and body cannot be separated. This means physical and mental health are not mutually exclusive constructs - the health of one impacts the health of the other. A common treatment plan that integrates care for both physical and mental health needs will positively impact overall health outcomes.

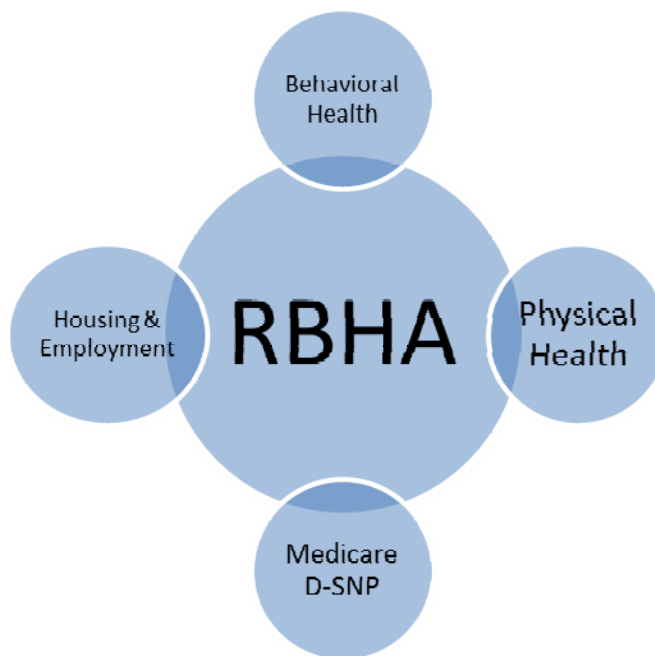
AHCCCS worked with the Arizona Department of Health Services/ Division of Behavioral Health Services (ADHS/DBHS) to create a specialty Regional Behavioral Health Authority (RBHA) model with expanded responsibility for Medicaid members determined to have a Serious Mental Illness (SMI) in Maricopa County. The integrated RBHA model will be fully

responsible for the delivery and payment of providing coordinated and integrated behavioral and physical health care for members with SMI. In addition, the RBHA is required to be a Medicare Advantage Special Needs Plan.

On January 8, 2013, ADHS received proposals from five offerors for the Acute Care and Behavioral Health Care Integration Request for Proposal targeting the SMI population in Maricopa County. On January 31, 2013, CMS approved the Waiver amendment for the Acute Care and Behavioral Health Care Integration. The new RBHA contract award is currently being protested.

The Greater Arizona (all counties except Maricopa) RBHA procurement is slated to begin with contract start dates of October 1, 2015. AHCCCS will work with DBHS to expand the SMI integration model to other counties and other behavioral health populations, such as the general mental health and substance abuse populations, as part of this procurement process. Like CRS, the ultimate goal of the SMI integration initiative is to offer members choice of RBHA plans.

**Figure 5. Integrated RBHA**



Dual Eligible Members – AHCCCS has approximately 120,000 individuals who are eligible for both Medicaid and Medicare. When the Medicare Modernization Act was implemented, AHCCCS worked with its contracted managed care organizations to pursue the establishment of Special Needs Plans (SNPs) where the member is enrolled in the same managed care organization for both Medicare and Medicaid. About one-third of the AHCCCS dual population is in an aligned plan structure.

82% of Arizona’s elderly and physically disabled population that is at risk of institutionalization is dually eligible. Avalere Health compared national data for duals enrolled in traditional Medicare fee-for-service to dual eligible members served by an AHCCCS health plan for both Medicare and Medicaid. The aligned AHCCCS duals exhibited:

- 31% lower rate of hospitalization;
- 43% lower rate of days spent in a hospital;
- 9% lower Emergency Department use; and
- 21% lower readmission rate.

AHCCCS has a goal of increasing dual alignment from 40,000 to 75,000 beneficiaries, and is pursuing various strategies in conjunction with the National Association of Medicaid Directors to achieve this goal.

AHCCCS will also work with DBHS to identify a way to expand the Dual integration model to non-SMI Dual eligible individuals, including the general mental health and substance abuse services by October 1, 2015. Expanding the model to this population so they may also receive acute and behavioral health care from one plan improves quality of care and increases efficiencies within the overall system.

## ***2. Payment Modernization***

One of the biggest challenges facing health care today is that incentives are not aligned for the providers. Even with significant managed care penetration, many providers still are reimbursed through fee-for-service mechanisms. In addition, hospital systems have large facility fixed costs and have business models built around having consumers hospitalized.

Payment modernization is a critical policy strategy for moving to a financially sustainable and value-based healthcare delivery system, which rewards high quality care provided at an affordable cost. There are many payment modernization approaches with varying degrees of breath and depth within both the Medicaid and Medicare program. Reforms include outcome based care models, aligned provider incentives, and increased patient engagement that can lead to improved health and overall program savings. Many AHCCCS stakeholders have initiatives that embrace various features of these sorts of health system reforms.

AHCCCS has had success in the past when care delivery and payment incentives are properly aligned. For example, when the ALTCS program first began, the vast majority of members resided in nursing facilities. Over time AHCCCS incentivized contractors to establish more home and community placement opportunities for members. The end result has been a tremendous shift to home and community settings that not only increases savings for the program but also more appropriately meets the needs and desires of the members.

AHCCCS remains committed to maximizing the efficiencies within our program as demonstrated by the payment modernization questions included in the last Acute Care procurement process. Health plans were required to identify how they could create greater efficiencies, alignment and integration of care at a lower cost within their own organizations.

Additionally, several payment modernization strategies have been explored and implemented at AHCCCS so our members can achieve greater health outcomes while saving taxpayer dollars as discussed below. Finally, AHCCCS will convene various groups

of community stakeholders with expertise in payment modernization. These groups will include representation from providers, health plans and healthcare leaders who will engage in focused dialogue regarding payment reform opportunities to help guide and inform our efforts.

*Shared Savings Requirements* – Beginning October 1, 2013, health plans are required to enter into shared savings arrangements equal to 5% or more of their contracted medical spend to compete for capitation withhold incentives. Additionally, ALTCS plans were required to move forward with pilot shared savings arrangements.

*Inpatient Hospital Reimbursement* – AHCCCS currently pays on an antiquated per-diem system. AHCCCS will be transitioning to an All Patient Refined Diagnostic Related Group (APR-DRG) methodology designed to reimburse per diagnosis rather than per day. Although DRGs have been used by the Centers for Medicare and Medicaid Services to reimburse hospitals for Medicare beneficiaries, the APR-DRG model is an updated reimbursement model more appropriate for the Medicaid program. Implementation will begin on October 1, 2014.

Ultimately, AHCCCS will be publishing a Payment Modernization Plan by October 1, 2013 that will lay out proposed strategies to be pursued over the next three years.

### **3. Tribal Care Coordination Initiative**

Arizona is home to over 250,000 American Indians, approximately half of whom are enrolled in AHCCCS. AHCCCS covers over 50% of all American Indian births, and more than two-thirds of all nursing facility days utilized by American Indians in Arizona. Significant health disparities exist between the American Indian and general population of Arizona. The average age of death for American Indians is 17.5 years lower than the general population, and American Indians experience higher death rates from many preventable diseases. Whereas the American Indian population accounts for less than 2% of the national population and 4% of the Arizona population, it accounts for approximately 10% of the AHCCCS population.

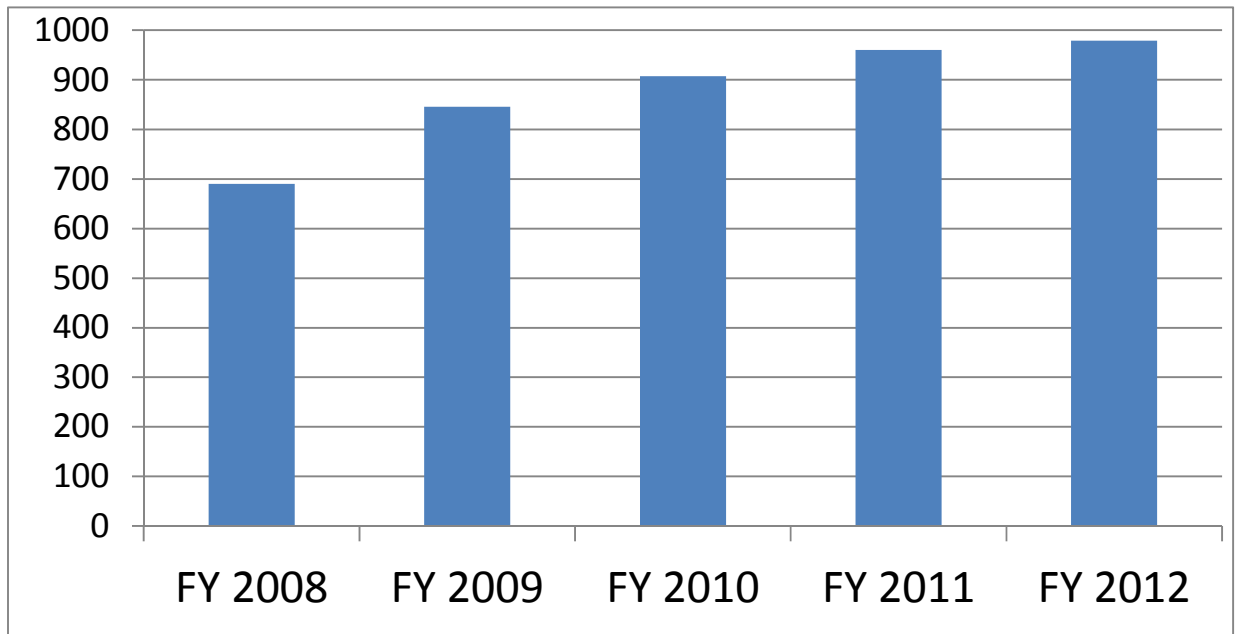
Approximately 25% of AIs are enrolled in managed care. For AIs that opt out of managed care, AHCCCS FFS is responsible for authorizing services outside of an IHS/638 facility when required. In addition, the Administration processes claims payments for American Indians who are enrolled in a contracted health plan but seek services through an Indian Health Service or Tribal facility (I/T) facilities. Historically, AHCCCS has limited its role to mainly claims adjudication. However, in 2012, AHCCCS hired a Tribal Health Care Coordinator with an emphasis on providing better care management for its FFS members. In addition to this resource, the agency has an Executive team that is working with the Care Coordinator to develop broader strategies.

AHCCCS is committed to improving the health outcomes of tribal members by identifying critical population needs and by collaborating with tribal partners to address these needs. This is accomplished through the implementation of program initiatives that support care coordination and encourage the use of medical homes. Currently, the initiative is focused on three populations: post inpatient hospital stay including newborns, diabetic and long-term care patients.

#### 4. Program Integrity

The Centers for Medicare and Medicaid Services (CMS) policy defines Medicaid Program Integrity as the "...planning, prevention, detection, and investigation/recovery activities undertaken to minimize or prevent overpayments due to Medicaid fraud, waste, or abuse." In keeping with the comprehensive nature of this definition, AHCCCS believes that Program Integrity is an important component of all operational departments.

**Figure 6. Program Integrity Avoidance and Recovery Savings (in millions)**



In State Fiscal Year (SFY) 2013, AHCCCS is expected to spend approximately \$8.4 billion providing health care coverage to over 1.2 million Arizonans through a network of over 50,000 providers. Given the size and scope of the AHCCCS program, there are program integrity risks at both the member and provider level. AHCCCS is committed to developing strategies and tools to ensure proper oversight of the limited taxpayer resources. Effective program integrity is a critical component of any long-term strategy in managing costs.

For the fourth consecutive year, AHCCCS has developed and published an agency [Program Integrity Plan](#) that lays out a series of goals and objectives that are currently being pursued. This plan is developed by an Executive-level Program Integrity Team that meets on a regular basis to review agency progress. The AHCCCS Program Integrity experts are also involved in national initiatives geared toward creating Program Integrity tools for other states to use. AHCCCS worked with the National Association of Medicaid Directors' Executive Work Group to develop a letter and white paper to CMS requesting and outlining the benefits of leveraging Medicare information/data for use by Medicaid programs. This group is also working to leverage Medicare data that can be used to pursue valuable program integrity leads.



## **5. Health Information Technology**

The State [Medicaid Health Information Technology Plan](#) (SMHP), located on the AHCCCS website, describes the Agency's historical, current, and future efforts to improve health outcomes by leveraging electronic health record deployment, adoption, and use by providers. Under the HITECH Act, CMS launched the Medicare and Medicaid EHR Incentive Programs to provide incentive payments to eligible professionals, eligible hospitals and critical access hospitals (CAHs) as they adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology. Eligible professionals can receive up to \$44,000 through the Medicare EHR Incentive Program and up to \$63,750 through the Medicaid EHR Incentive Program. States have been able to provide incentive payments for providers to use certified Electronic Health Record technology in a way that can positively impact patient care. The program provides incentive payments to eligible professionals, eligible hospitals and critical access hospitals (CAHs) as they adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology.

AHCCCS has been administering the Medicaid EHR Incentive Program since July, 2011. AHCCCS has been able to register, validate and pay 1,970 Eligible Professionals and 66 Eligible Hospitals since the program opened in July, 2011. These Medicaid payments total over \$132,665,669 million. Medicare has paid an additional 3,689 Eligible Professionals totaling \$60,689,275 and made payments to hospitals that make the total amount of Medicaid and Medicare payments made to providers in Arizona as of April 2013 \$247,815,252.

Having providers adopt and use electronic health technology like EHRs, is seen as a first step in supporting providers who need to share clinical information to improve care outcomes. The implementation and effective operation of a health information exchange (HIE) in Arizona provides opportunities for both health care and health care system efficiencies. However, it is dependent on a high level of physician penetration and use of EHRs and the HIE.

AHCCCS is supporting the development of HIE infrastructure in Arizona in several ways. AHCCCS continues to serve on the Arizona Health-e Connection Board, which is focused on policy development and outreach and education to providers. AHCCCS is also a member of the Health Information Network of Arizona (HINAZ) Board, which won a state contract to build a provider directory and operate an HIE. AHCCCS has encouraged all of its health plans to join the HIE and expects services to start sometime in CY 2013. Through the use of an approved IAPD from CMS, AHCCCS is helping to lower the cost of its high volume Medicaid providers to join the HIE.

## **6. AHCCCS Quality Assessment and Performance Improvement Strategy**

AHCCCS has built its quality structure over time by means of its adherence to Federal requirements, continual review of applicable national standards and national and/or regional trends, collaboration with partners, and its own experiences. [The Quality Strategy](#) includes both the Medicaid and CHIP programs and encompasses AHCCCS acute and long-term care Contractors, the Arizona Department of Health Services, Division of Behavioral Health Services (ADHS/DBHS), and Children's Rehabilitative Services (CRS). It also incorporates measures to improve the Agency's internal processes involving enrollee information, monitoring and evaluation.

AHCCCS regularly establishes key clinical and non-clinical areas on which to focus future quality improvement efforts. This is done through analyses of state and national trends and in consultation with other entities working to improve health care in Arizona, such as the Medicare Quality Improvement Organization (QIO), community leaders, other state agencies, and AHCCCS Contractors. In addition, AHCCCS utilizes [the Consumer Assessment of Healthcare Providers and Systems \(CAHPS\)](#). It is a survey tool created by the Agency for Healthcare Research and Quality (AHRQ) to support and promote the assessment of members' experiences with health care. The member data collected may be used to identify areas of program success and areas in need of targeted improvement.

AHCCCS also establishes performance measures based on the CMS Core Measure sets and the National Committee for Quality Assurance (NCQA) HEDIS measures as well as measures unique to Arizona's Medicaid program. Over time, the number and content of CMS measure sets has grown significantly and shifted the focus to align more with outcomes and experiences of care. AHCCCS has adopted measures from these sets that are the most relevant for the AHCCCS population, when reliable data sources exist and where the results of measurement would yield actionable opportunities to improve outcomes and member satisfaction. To support the transition to and implementation of new measures, AHCCCS continues to expand its information technology and business analytics capabilities to support expanded data source opportunities such as registries, electronic health records and health information technology as these sources are deemed reliable.

AHCCCS also establishes minimum performance standards and goals for each performance measure that are based on national standards, such as the NCQA National Medicaid means, whenever possible. Contractors are expected to achieve the minimum performance standard for performance measures. Performance measure reports may compare the Contractors' results with each other and with Medicaid and commercial health plan national averages. Contractors are expected to develop methods to continuously increase the well-being of their respective populations through the removal of barriers to care and ongoing process improvement. AHCCCS also participates in national efforts focused on developing Medicaid and CHIP Core Measures to allow comparability across States' programs.

Care coordination is an important element of ensuring quality of care and positive outcomes for AHCCCS members. Through Agency integration efforts, opportunities to improve care coordination for members in need of care and services across various domains including physical and behavioral health is less fragmented. Quality management and quality improvement initiatives focused on communication and coordination for follow-up after discharge, medication management, receipt of chronic disease recommended care and services and data sharing among the care team are anticipated to result in improved outcomes, member satisfaction and more appropriate utilization of health care services. AHCCCS monitors the effectiveness of these activities through measurement of inpatient, emergency department and re-admission rates.

CMS and other regulatory bodies utilize multiple measure sets with a series of performance measures for each set in an effort to improve program quality. This broad brush approach to quality often leads to tremendous resources being expended on measurement and reporting, rather than actual improved quality. AHCCCS utilizes a more focused strategy in an effort to move the entire system of care in Arizona down a path of continuous quality improvement. This approach includes focused intervention and activities that result in concentrated accountability as described below.

AHCCCS Contractors are expected to conduct Performance Improvement Projects (PIPs) in clinical care and non-clinical areas that are anticipated to have a favorable impact on health outcomes and member satisfaction. Utilizing financial, population, and disease-specific data and input from the Contractors, AHCCCS selects an indicator of performance improvement to be measured across Contractors. Focused PIPs may also be assigned to individual Contractors when needs are identified. For each mandated PIP, AHCCCS develops a methodology to measure performance in a standardized way across Contractors and manages data collection and analysis. In this way, AHCCCS ensures that the project is implemented by Contractors in a consistent manner and yields results that can be analyzed by individual Contractors, as well as by other stratifications and for the program overall. In addition, Contractors are required to review their data and quality measures to determine Contractor-specific Performance Improvement Projects. Table 6 below provides some history of the documented success of the PIPs completed by AHCCCS contractors.

**Table 6 – Performance Improvement Projects**

Measure	Years	Baseline %	Final %
Influenza vaccine refusal	2007-12	59.4	36.2
Report vaccines to ASIIS	2005-08	74.2	88.2
3-8 year old dental visits	2003-08	52.2	65.4
HBA1C	2001-04	60.8	79.5
Advanced Directives	2008-10	41.8	64.7
Appropriate pharmacological therapy – asthma	2006-10	81.1	96.3

The health and safety of AHCCCS members receiving covered services remains a focus for the Agency. AHCCCS utilizes a multi-Agency and Contractor approach in implementing oversight health and safety requirements. Health and safety standards, which include monitoring and oversight requirements of placement settings utilized by AHCCCS Contractors, are reviewed regularly to ensure programmatic consistency and a comprehensive approach is implemented throughout the system. Regular review and application of credentialing and organizational requirements across provider types utilized to provide care and services to AHCCCS members continues to expand opportunities to enhance the quality of care provided to AHCCCS members.

## **AGENCY SUPPORT FUNCTIONS**

If the agency is going to be successful in pursuing the Six Areas of Focus then there are a number of other important infrastructure capabilities and initiatives that must be completed over the next several years.

### Systems and Security

Looking ahead, AHCCCS needs to implement complex changes mandated by ICD-10 requirements. ICD-10 is the largest single change to transactional code sets since HIPAA

and it impacts the operation of the entire system in Arizona and across the country. On September 30, 2014 all ICD-9 codes will de-activate, and on October 1, 2014, it will be mandatory for all payers and providers to use ICD-10 codes. There is no overlap between code sets, so all payers and providers must have code sets updated by this date. The magnitude of this effort is best illustrated by the fact that the ICD-9 code set contains about 13,000 codes while the ICD-10 code set contains approximately 70,000 codes with a completely different numbering system.

System resources will continue to be a challenge and maintaining the appropriate infrastructure to manage and analyze the millions of records generated by the AHCCCS system requires appropriate investment.

The AHCCCS Information Systems Division (ISD) must be ever vigilant regarding security of our systems and information. As AHCCCS grows, developing and implementing new systems and more technology, we are faced with new security threats that have to be addressed. Security policies must be developed and maintained that meet growing state and federal requirements, and ISD staff are required to make more effort than ever before just to stay at the same threat level. The AHCCCS ISD is responsible for providing technical support to the Hawaii Medicaid program, which means ISD staff must also maintain the security of Hawaii's information as well. In addition to the AHCCCS mainframe (PMMIS), ISD will continue to keep non-mainframe systems and applications running consistently and efficiently. This includes server based applications, network infrastructure, the data warehouse, and bandwidth for communication. It is important to note that PMMIS is a very mature system. Although it is still functional, performance is slowly degrading over time and maintenance of the mainframe is becoming more challenging. AHCCCS will need to begin to explore options for replacing the mainframe application in the near future, as replacement is the long-term solution.

#### Federally Facilitated Marketplace (FFM) and Eligibility

On November 28, 2012, Governor Brewer informed the Obama administration that Arizona would not pursue the creation of a state-based Health Insurance Exchange. Arizona will participate in a FFM, as outlined in the guidelines of the Affordable Care Act. The Agency has completed planning and design for an IT infrastructure to support ACA related changes to Medicaid and Medicaid restoration and is moving forward with development of the Health-e-Arizona Plus system and an interface to the FFM in two phases.

The Health-e-Arizona Plus October 1, 2013 Phase I implementation includes: web-based eligibility system for applications, determinations, renewals, changes and health plan enrollment for all AHCCCS programs except the Arizona Long Term Care System (ALTCS). The system also includes similar functionality for SNAP, TANF, and some local health programs. Phase I includes portals for consumers, community assisters and state workers. It provides support through a variety of help and educational tools. It includes account set up, identity proofing, notices, document management, on-line appeals requests, workload management tools, and premium billing. The system integrates with federal and state data systems, call center and interactive voice response (IVR), and the SNAP and TANF electronic benefit transfer (EBT) vendor.

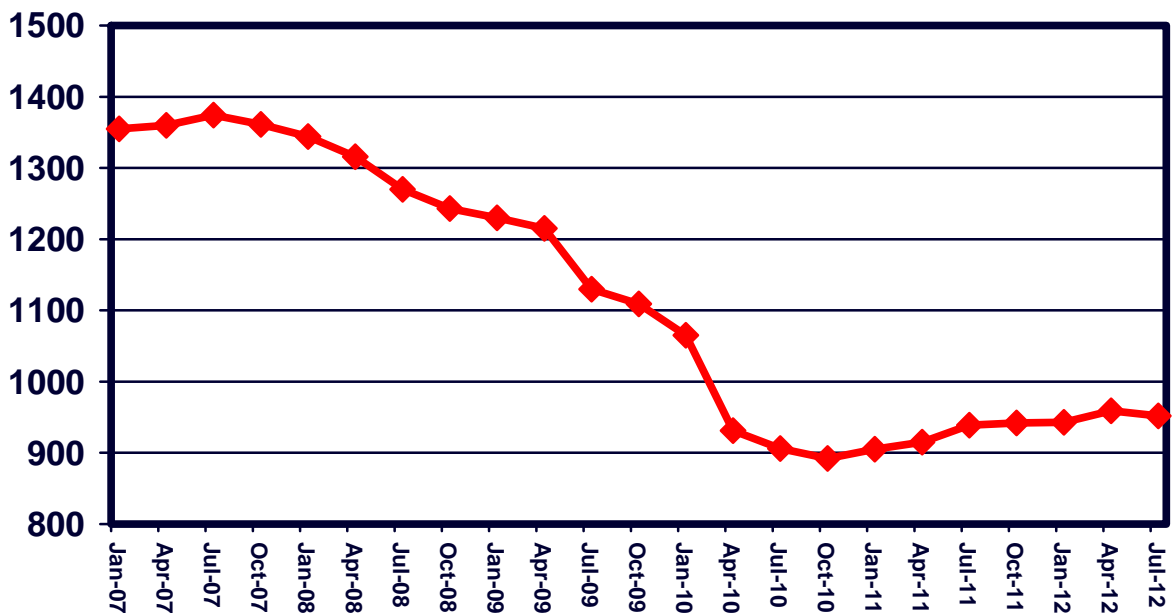
Health-e-Arizona Plus Phase II (post October 1, 2013 through December 31, 2015) includes: incorporation of remaining back-end functions in the AHCCCS and DES legacy systems. Health-e-Arizona Plus will incorporate applications, determinations, renewals, changes and health plan enrollment for ALTCS. It will include enhanced fraud detection,

appeals management, additional reports, data warehouse and coordinated notices and appeals

Workforce

As seen in Table 7, AHCCCS continues to operate with approximately one-third less staff than prior to the start of the Great Recession. Turnover rates remain in the 16% range while approximately one-third of the current AHCCCS workforce is eligible to retire during CY2013. Retirement projections predict that this number will increase each year thereafter in several key employee groups. As such, AHCCCS is faced with future prospects that will certainly test the resolve of the Division of Human Resource and Development (HRD) as well as the entire AHCCCS team as it works to acquire, develop and retain qualified staff.

**Table 7 – AHCCCS Staffing Levels**



AHCCCS is pursuing several strategies to address these challenges.

- Increasing AHCCCS’ presence in the employment marketplace for purposes of enhancing our ability to attract the most qualified applicants;
- Identifying and implementing relevant compensation strategies;
- Maintaining an environment conducive to staff engagement;
- Expanding innovative, low-cost professional development opportunities for existing employees;
- Retaining critical staff;
- Workforce and succession planning in order to ensure continuity of services and avoid leaving a significant gap in the Agency’s knowledge base; and
- Continuing to provide flexibility.
  - Over 30% of the AHCCCS workforce is Virtual Office with an even higher percentage on some variation of a flexible work schedule. This type of flexibility has proven essential to retention and assisting employees with striking a work-life balance.

The implementation of Governor Brewer’s Personnel Reform initiative in calendar year 2012 introduced significant changes to various aspects of human resources management, and has demanded substantial time and resources from HRD and Agency leadership.

Additionally, several system changes have been implemented requiring new business processes and policies be developed.

*Leveraging Data Analytics*

The availability of reliable and valid information and the capacity to make that information actionable is critical to the decision-making process. Data driven decision making is the only way for true reform to occur in the healthcare system. However, determining the most effective way to utilize data, and having the time and resources to effectively review or explore data can produce challenges. As a result, there is an increased value and emphasis being placed on data analytics. The Office of Medical Policy, Analytics and Coding (OMPAC) is responsible for the AHCCCS Data Warehouse, which provides the Agency with information that is easily accessible and reliable. The information allows the organization to gain greater insight into its operations. AHCCCS will work with internal and external data analytics experts over the next year to develop the organization's capacity as a whole to turn solid information into efficient actions. Additionally, OMPAC staff will work to determine what information is most often required so a set of standard reports based on the organization's focused areas can be developed.

## STRATEGIC GOALS

### GOAL 1.

**AHCCCS must pursue and implement long term strategies that bend the cost curve while improving member health outcomes.**

#### STRATEGY 1.1

Commit Executive level resources towards substantive system payment modernization

##### PERFORMANCE MEASURE 1.1.1

Payment Modernization Plan published by 10-1-13 with subsequent updates

#### STRATEGY 1.2

Implement and maintain shared savings requirements for all ALTCS and Acute Care Contractors excluding CRS, CMDP and the RBHA

##### PERFORMANCE MEASURE 1.2.1

Percent of medical spend in shared savings arrangement

#### STRATEGY 1.3

Modernize hospital payments to better align incentives, increase efficiency and improve the quality of care provided to members

##### PERFORMANCE MEASURE 1.3.1

Implement a DRG-based reimbursement system by 10/1/14

##### PERFORMANCE MEASURE 1.3.2

Deny payments for hospital acquired conditions and preventable surgical errors based on specific diagnosis codes beginning 10/1/14

#### STRATEGY 1.4

Establish robust Payment Modernization stakeholder input opportunities

##### PERFORMANCE MEASURE 1.4.1

Number of new strategies developed from external meetings

#### STRATEGY 1.5

Achieve the [Program Integrity Plan](#) goals that improve Third Party Liability (TPL), Coordination of Benefits (COB), and Fraud and Abuse programs

##### PERFORMANCE MEASURE 1.5.1

Percent of Program Integrity goals met

**GOAL 2.**  
**AHCCCS must pursue continuous quality improvement**

STRATEGY 2.1

Continue to promote and evaluate access to care

PERFORMANCE MEASURE 2.1.1

Percent of AHCCCS Contractors that meet the minimum contractual performance standards for Access to Care performance measures

STRATEGY 2.2

Continue to improve health outcomes for the integrated populations (CRS and SMI)

PERFORMANCE MEASURE 2.2.1

Percent of chronic care measures that achieve a statistically significant improvement for the integrated populations (CRS and SMI)

STRATEGY 2.3

Achieve statistically significant improvements on Contractor PIPs

PERFORMANCE MEASURE 2.3.1

Percent of AHCCCS Contractors that complete AHCCCS-mandated PIPs (improve and sustain performance) or demonstrate statistically significant improvement on re-measurements

STRATEGY 2.4

Achieve statistically significant improvements on quality performance measures

PERFORMANCE MEASURE 2.4.1

Percent of outcomes-focused quality performance measures (readmissions, inpatient days and emergency department utilization) that achieve a statistically significant state-wide improvement

PERFORMANCE MEASURE 2.4.2

Percent of quality performance measures for the Medicaid population that achieve a statistically significant state-wide improvement

STRATEGY 2.5

Leverage American Indian care management program to improve health outcomes

PERFORMANCE MEASURE 2.5.1

Percent of IHS and 638 facilities submitting patient data to AHCCCS

PERFORMANCE MEASURE 2.5.2

Percent of readmissions that are reduced



### **GOAL 3.**

#### **AHCCCS must reduce the systematic fragmentation that exists in healthcare delivery to develop an integrated system of healthcare**

##### STRATEGY 3.1

Align and integrate the model for individuals with Serious Mental Illness (SMI), Children's Rehabilitative Services (CRS) and Dual-eligible members

###### PERFORMANCE MEASURE 3.1.1

Percent of individuals with SMI aligned and integrated into the same plan for behavioral health and physical health services

###### PERFORMANCE MEASURE 3.1.2

Percent of CRS members aligned and integrated into the same plan for CRS conditions and acute care services

###### PERFORMANCE MEASURE 3.1.3

Percent of dual-eligible members aligned and integrated into the same plan for Medicare and Medicaid services

##### STRATEGY 3.2

Pursue Care Coordination opportunities in System

###### PERFORMANCE MEASURE 3.2.1

Percentage of service blind spots (due to system fragmentation and carve-outs) resolved with provision of encounter information to Contractors to improve care coordination activities.\*

*\*42 CFR Part 2 regulations generally prohibit the disclosure of information obtained by a federally assisted drug or alcohol abuse program. Encounter information for these services are excluded from this performance measure.*

##### STRATEGY 3.3

Leverage HIT investments to create more data flow in healthcare delivery system

###### PERFORMANCE MEASURE 3.3.1

Increase Eligible Professionals by an additional 500 providers by June 30, 2014

###### PERFORMANCE MEASURE 3.3.2

50% of Eligible Professionals that received an Adoption/Implementation/Upgrade payment will receive a Meaningful Use Stage 1 payment by June 30, 2014

###### PERFORMANCE MEASURE 3.3.3

Participate in an operational HIE by June 30, 2014

##### STRATEGY 3.4

Develop the organization's capacity to conduct and translate research and apply analytics into actionable solutions to inform, advance and drive evidence-based decision making in policy and practice

PERFORMANCE MEASURE 3.4.1

Number of workshops conducted by external experts with AHCCCS staff regarding how to apply analytics into actionable solutions

PERFORMANCE MEASURE 3.4.2

Increase number of staff who receive COGNOS training from Office of Medical Policy, Analytics and Coding

STRATEGY 3.5

Build a web-based system (Health-e-Arizona Plus) in accordance with federal timelines and requirements that improve the accuracy and efficiency of the eligibility determination process for Medicaid and CHIP

PERFORMANCE MEASURE 3.5.1

Implement Phase I of Health-e-Arizona Plus including MAGI requirements and Federally Facilitated Marketplace by mandated date of 10-1-13

PERFORMANCE MEASURE 3.5.2

Implement Phase II of Health-e-Arizona Plus including the integration of other systems such as ACE by mandated date of 12-31-15

**GOAL 4.**

**AHCCCS must maintain core organizational capacity and workforce planning that effectively serves AHCCCS operations**

STRATEGY 4.1

Pursue continued deployment of electronic solutions to reduce healthcare administrative burden

PERFORMANCE MEASURE 4.1.1

Percent of members submitting on-line applications

STRATEGY 4.2

Continue to manage workforce environment, promoting activities that support employee engagement and retention; and address potential gaps in the organization's knowledge base due to retirements and other staff departures.

PERFORMANCE MEASURE 4.2.1

Rate of employee turnover within the first year of employment

PERFORMANCE MEASURE 4.2.2

Percent of employees participating in learning and development opportunities.

PERFORMANCE MEASURE 4.2.3

Percent of positive responses from employees derived from the AHCCCS Employee Survey

PERFORMANCE MEASURE 4.2.4

Percent of employees with "meets or exceeds expectations" on performance evaluations

#### STRATEGY 4.3

Strengthen system-wide security and compliance with privacy regulations related to all information/data by evaluating, analyzing and addressing potential security risks

##### PERFORMANCE MEASURE 4.3.1

Percent of documented findings that have been remediated

##### PERFORMANCE MEASURE 4.3.2

Percent of documented findings that have been remediated by MCOs

#### STRATEGY 4.4

Maintain IT network infrastructure, including server-based applications, ensuring business continuity

##### PERFORMANCE MEASURE 4.4.1

Network system availability

##### PERFORMANCE MEASURE 4.4.2

Compliance with ICD-10 requirements by mandated date

## RESOURCE ASSUMPTIONS

Total FY2013 - FY2014	FY2013 Approp/Exp. Plan	FY2014 Exec. Rec.
Full Time Equivalent (FTE)	2,217.3	2,217.3
General Fund	1,397,607,300	1,311,915,000
Other Appropriated Fund	151,097,500	161,722,600
Non-Appropriated Fund	1,431,616,400	1,394,131,700
Federal Funds	5,931,100,900	6,572,253,800
<b>TOTAL FUNDS</b>	<b>8,911,422,100</b>	<b>9,440,023,100</b>

**Note:** Due to the significant uncertainty related to the Federal Medicaid reform, no estimates past FY14 are provided.

**Sources:**

1) FY 2013 Appropriation/Expenditure Plan from AHCCCS FY 2013 Budget Submittal. Includes all appropriated funding from JLBC FY 2013 Appropriations Report as well as non-appropriated funding based on AHCCCS estimates. Does not include any potential supplemental appropriations.

2) FY 2014 Executive Recommendation from the Agency Detail Section of the FY 2014 Executive Budget Book