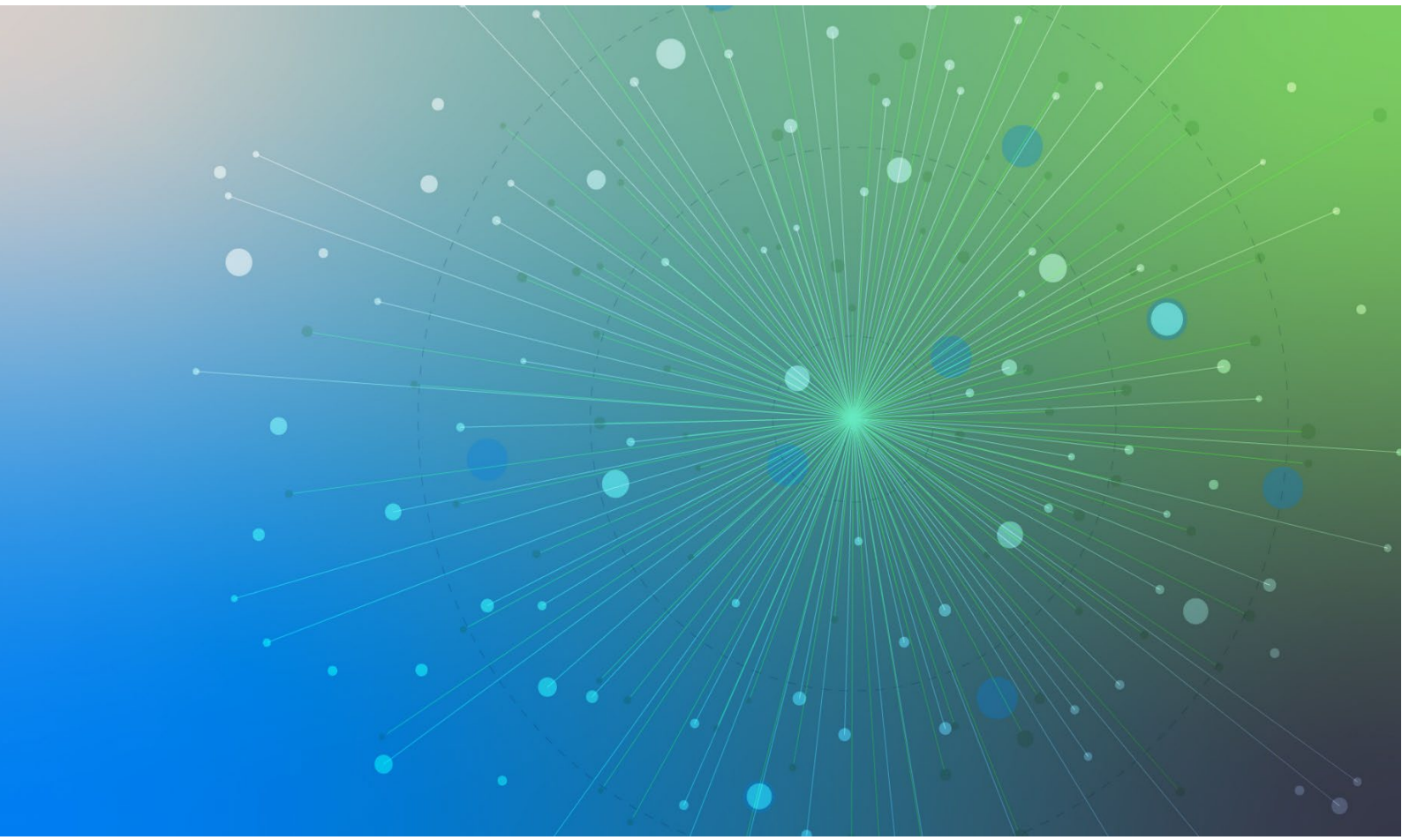
MILLIMAN REPORT

HEALTHII Quality Performance Measures Technical Guide – FFY 2026

Commissioned by the Arizona Health Care Cost Containment System

September 2025

Ben Mori, Principal & Senior Healthcare Consultant
Justin St. Andre, Senior Healthcare Consultant
Noelle Gaughen, Healthcare Policy Consultant



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Summary

BACKGROUND

The Arizona Health Care Cost Containment System (AHCCCS) engaged Milliman, Inc. (Milliman) to support quality performance measures for the "Hospital Enhanced Access Leading to Health Improvements Initiative" (**HEALTHII**) program to be developed during federal fiscal year (FFY) 2026 (the fifth year of this program). This guide provides the technical specifications and submission requirements for providers to submit historical quality performance data (generally from 2024). It also focuses on the quality measures based on **hospital self-reported data**, as measures based on Medicaid claims data will be collected directly from AHCCCS. **Please note that there are changes in the data submission process this year as described in this guide**, as this is the first year Milliman is performing the HEALTHII quality measure calculations.

In response to HB 2668 (2020),[1] AHCCCS established the Health Care Investment Fund (HCIF) that expanded the existing inpatient and outpatient hospital assessment under Arizona Final Rule R9-22-731.[2] As required under HB 2668, since October 1, 2020, HCIF has funded the non-federal share of a §438.6(c) state directed payment for hospitals under Medicaid managed care, called the **"HEALTHII" payment program**. State directed payment arrangements are a commonly used approach for states to set parameters on managed care contract expenditures that assist states in achieving their overall objectives for delivery system and payment reform, and performance improvement. These types of programs are made permissible under 42 CFR §438.6(c) and have a number of Centers for Medicare and Medicaid Services (CMS) requirements, including a requirement for annual approval by CMS.[3] Additional background regarding Arizona's HEALTHII payment program can be found on the AHCCCS website.[4] As of September 2025, the FFY 2026 HEALTHII payment program is currently under review in the CMS renewal process and is subject to federal approval.

As part of the HEALTHII payment program, AHCCCS establishes a separate quality incentive payment pool to reward hospitals for reporting on specific quality measures outlined in this guide. Hospitals that meet AHCCCS' reporting requirements are eligible for payments from this pool.

This payment arrangement is designed to advance the goals and objectives in the AHCCCS Quality Strategy, including improving performance and providing high-quality services to AHCCCS members.[5] It is also a key component to receive written approval from CMS through their annual pre-print process, which requires states to demonstrate that each state-directed payment arrangement supports at least one goal or objective in their Quality Strategy.

Currently, hospitals earn incentive payments for reporting on targeted measures ("pay for reporting"). In the future, AHCCCS may consider adding "pay-for-performance" (P4P) measures, where hospitals could earn incentive payments based on their actual performance or scores on targeted measures.

For technical questions or questions related to the submission process please contact:

AZ-HEALTHII@milliman.com

For questions related to hospital assessments or HEALTHII directed payments, including the application of the quality measure results into HEALTHII quality incentive payments, please contact AHCCCS at:

healthii-quality@azahcccs.gov

[1] https://www.azleg.gov/legtext/54leg/2R/laws/0046.pdf.
[2] State of Arizona Final Rule, Title 9. Health Services, Chapter 22. Arizona Health Care Cost Containment System – Administration, Section 731. https://www.azahcccs.gov/shared/Downloads/Reporting/UnpublishedRules/NOFER11012020.pdf.
[3] For more background see MACPAC's October 2024 Issue Brief "Directed Payments in Medicaid Managed Care." https://www.macpac.gov/publication/directed-payments-in-medicaid-managed-care/.
[4] Arizona Health Care Cost Containment System, Hospital Assessment. https://www.azahcccs.gov/PlansProviders/RatesAndBilling/HospitalAssessment.html.
[5] Arizona Health Care Cost Containment System, Quality Strategy. July 1, 2024. https://www.azahcccs.gov/PlansProviders/Downloads/QualityStrategyJuly2024Final.pdf

FFY 2026 HEALTHII MEASURES

AHCCCS selected these quality measures through multiple stakeholder sessions with hospitals and developed quality measure results over a multi-year process in coordination with its prior HEALTHII quality measure vendor.

AHCCCS' selected quality measures for collection and analysis during FFY 2026, along with the measure type and applicable provider types, are listed in Figure 1 below.

FIGURE 1: FFY 2026 HEALTHII PERFORMANCE MEASURES

MEASURE	TYPE OF MEASURE	MEASURE DESCRIPTION	MEASURE BASIS	APPLICABLE PROVIDER TYPES
AHCCCS-02	Claims based	Patient Safety Indicators 90 (PSI 90) Patient Safety and Adverse Events Composite	CBE # 0531	General Acute Care Hospitals
AHCCCS-04	Self-reported	Hours of Seclusion Use	CBE # 0641	Psychiatric Hospitals
AHCCCS-05	Self-reported	Percent of Residents Experiencing One or More Falls with Major Injury	CBE #0674	Freestanding Inpatient Rehabilitation Facilities (IRFs) & Long Term Care Hospitals (LTCHs)
AHCCCS-06	Self-reported	National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure	CBE #1717	Children's & General Acute Care Hospitals
AHCCCS-07	Claims based	30-Day Hospital-Wide All-Cause Unplanned Readmission Measure	CBE # 1789	Short Stay Hospitals
AHCCCS-12	Self-reported	Median Time from Emergency Department (ED) Arrival to ED Departure for Discharged ED Patients	CBE# 0496	Critical Access Hospitals

FFY 2026 DISCONTINUED HEALTHII MEASURES

AHCCCS has discontinued several self-reported measures for FFY 2026. These measures will not be reported by hospitals or measured by AHCCCS for purposes of the HEALTHII program. These discontinued measures are listed in Figure 2 below.

FIGURE 2: LIST OF DISCONTINUED MEASURES IN FFY 2026

MEASURE	TYPE OF MEASURE	DISCONTINUED MEASURE	MEASURE BASIS	APPLICABLE PROVIDER TYPES
AHCCCS-01	Self-reported	Influenza Vaccination Coverage Among Healthcare Personnel	CBE # 0431	All
AHCCCS-03	Self-reported	HBIPS-2 Hours of Physical Restraint Use	CBE # 0640	Psychiatric Hospitals
AHCCCS-08	Claims based	Pediatric All-Condition Readmission Measure	CBE # 2393	Freestanding Children's Hospitals
AHCCCS-09	Self-reported	Percent of LTCH Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function	CBE # 2631	LTCHs
AHCCCS-10	Claims based	Discharge to Community-Post Acute Care Measure for IRFs	CBE # 3479	IRFs
AHCCCS-11	Self-reported	Successful Implementation of Antibiotic Stewardship Program	N/A	Critical Access Hospitals

Reporting Process

SELF-REPORTED DATA SUBMISSION TEMPLATE

All participating hospitals will collect, calculate, and submit the performance metrics for the applicable self-reported performance measures via the self-reported performance measure Submission Template ("the template"). The template requires submission of aggregate numerator and denominator data only.

Please note that for this year's submission period, short-stay hospitals are not being required to submit data.

Each participating hospital should download and save a copy of the template and update it with the required data on each tab.

- The template "HEALTHII Data Submission Template FFY 2026" is available on AHCCCS' website:
  - https://www.azahcccs.gov/PlansProviders/RatesAndBilling/hospitalassessment.html
- Submit the HEALTHII Data Submission Template FFY 2026 workbook to AZ-HEALTHII@milliman.com using the following subject line:
  - *HEALTHII - [Hospital Name] - [AHCCCS Provider ID]*
  - *Example: HEALTHII – Arizona Medicaid Hospital - 123456*

SELF-REPORTED DATA LOG SUBMISSION REQUIREMENTS

All hospitals must maintain a data log showing the complete set of data inputs used to determine the resulting measure metrics. **A subset of hospitals will be selected to submit a data log subject to a secondary review process**.

Hospitals do not need to follow a specific data log format for HEALTHII measures, but the data log should include all relevant information needed to determine a measure's reported rate. The data log must be an Excel file and may use the facility's prescribed file layout. However, the layout should be clear so that AHCCCS or AHCCCS' vendor can review with minimal questions. The Excel file should contain sufficient documentation regarding which members were eligible for inclusion in the measure, whether a member experienced the measure event, and how the numerator/denominator were tallied. Facilities may use the previously provided file layout template for measure collection, but this is not required.

POST SUBMISSION EXPECTATIONS

Hospitals will receive email confirmation that their template was received and confirmed to be complete within two business days of submission. Hospitals that are selected for data log submission will be notified no later than December 1st, 2025 and will have two weeks to submit data via a secure Milliman FTP site. The notification will include instructions for using Milliman's secure FTP site. A high level timeline is listed in Figure 3 below.

All hospitals are required to retain data logs and AHCCCS reserves the right to require additional verification of any data, related documentation, and compliance with all program requirements, and to audit data from participating hospitals at any time.

FIGURE 3: HIGH LEVEL TIMELINE AND DUE DATES

Activity	Timeline
Self-Reported Data Submission Template Available	No later than Monday, October 13th, 2025
Self-Reported Data Submission Template Due to Milliman	Friday, November 21st, 2025
Hospitals notified if selected for submission of a complete data log for self-reported measures	No later than Monday, December 1st, 2025
Data log for self-reported measures due	Two weeks after request and no later than Monday, December 15th, 2025

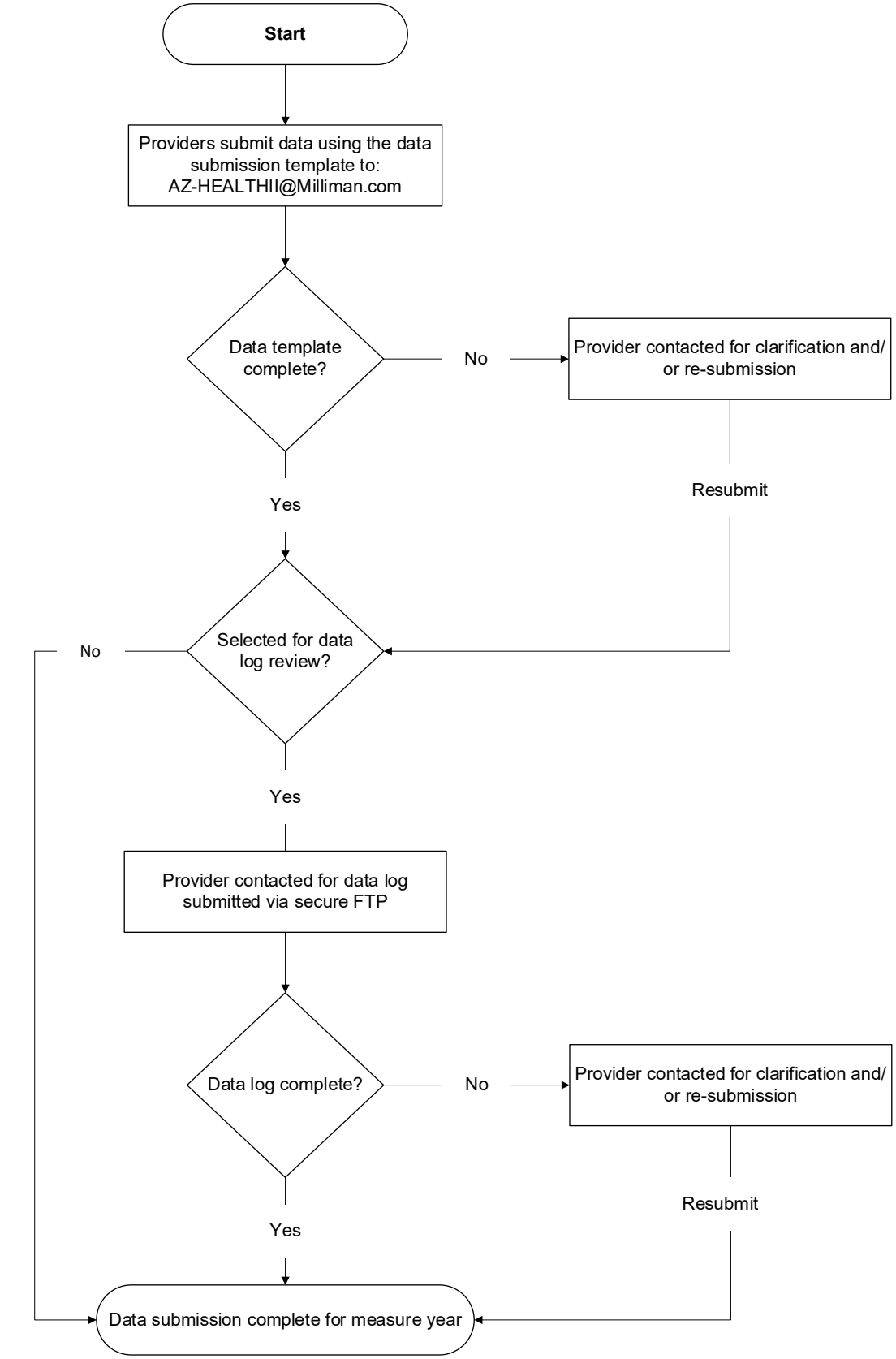
POLICIES ON SUBMISSION OF PHI

Hospitals should not include any member level information, including but not limited to protected health information (PHI) and personally identifiable information (PII), in the submitted templates. Hospitals selected to submit a completed data log will be required to submit more detailed data, which may include PHI, via a secure FTP site to be provided by Milliman.

SELF-REPORTED DATA SUBMISSION FLOWCHART

Figure 4 below is an illustration of the process for hospitals to submit self-reported data for HEALTHII FFY 2026.

FIGURE 4: SELF-REPORTED DATA SUBMISSION FLOWCHART



Technical Reporting Guidance

The Self-Reported Measure Specifications sections below describe each measure in detail, including:

- Hospital Type
- Description
- Reporting Period
- Measure Basis
- Specifications Source
- Measure Modifications
- Detailed Specifications Summary

Milliman is available to support organizations that have additional questions that are not addressed in this technical guide. Participating hospitals may contact Milliman via email at AZ-HEALTHII@milliman.com.

SELF-REPORTED MEASURE REPORTING TEMPLATE INSTRUCTIONS

The template is an Excel workbook with multiple tabs for data entry. The template also includes important attestations regarding the submission, including that the submission contains **no protected health information (PHI) and personally identifiable information (PII).** Member level data is not required for completion or submission of the template. Submissions with PHI, PII, or individual level data included in the workbooks will be identified as a privacy violation and reported through the appropriate security incident reporting channels. As such, workbooks with privacy violations will not be considered complete or valid submissions, and the hospital must resubmit to participate in the HEALTHII program.

The template is organized using the following format.

- **Instructions:** Written instructions on how to complete the template, as described in Figure 5.
- **Hospital Information:** Documentation of who submitted the data, a series of acknowledgements, hospital information, and a key for the corresponding tabs on hospital types.
- **Hospital Type:** Series of tabs organized in the following order. As described above, data will be entered in these workbook tabs.
    - Children's
    - Critical Access
    - General Acute
    - Long Term
    - Psychiatric
    - Rehabilitation

FIGURE 5: SELF-REPORTED DATA SUBMISSION INSTRUCTIONS

Instructions as Shown on the Template

Step 1: Complete "Hospital Information" Tab
Populate contact information for the appropriate person completing and submitting HEALTHII performance data and select your hospital from the drop down.

Step 2: Complete Data Entry in Corresponding Hospital Type Tab
Please enter measure-specific data as applicable for your facility.
Note: Completion of the template does not require Protected Health Information (PHI) or Personally Identifiable Information (PII). PHI and PII should not be included in the workbook or in any email transmittal to Milliman.

Step 3: Submit Data Entry Template via Email
Once all data elements have been entered and saved, please submit via email to Milliman using the program email address below. Should you have any questions, please submit using the same program email address below.

AZ-HEALTHII@milliman.com

Note: The HEALTHII program is displayed using a capital i – healthii

See additional information on submission requirements below.

Figures 5-8 outline the data entry required for each measure. Data shall be entered into the green “Numerator” and “Denominator” cells.

FIGURE 5: DATA ENTRY TAB: CHILDRENS & GENERAL ACUTE

Data Entry - Medicaid Managed Care Population Only

See 2026 HEALTHII Technical Manual for numerator and denominator calculation requirements

	CDI Events	
Numerator:		
	Admissions	
Denominator:		

Calculation

Rate:		= [CDI Events] ÷ [Admissions]

FIGURE 6: CRITICAL ACCESS

Data Entry - Medicaid Managed Care Population Only

See 2026 HEALTHII Technical Manual for calculation requirements

	Median Time (Minutes)	
Numerator:		*This is the calculated measure, matching Median Time in white box below.*
	Number of Visits	
ED Visits:		

Calculation

Median Time:	0	= [Median Time (Minutes)]

FIGURE 7: DATA ENTRY TABS: LONG TERM & REHABILITATION

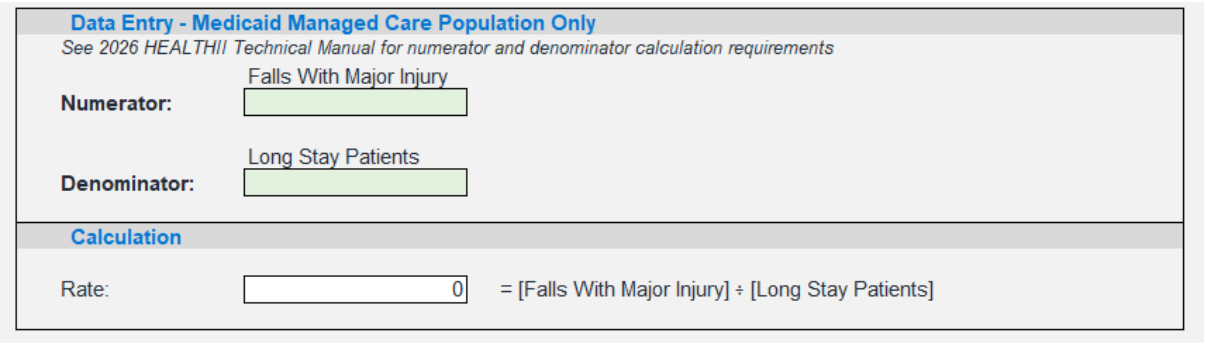
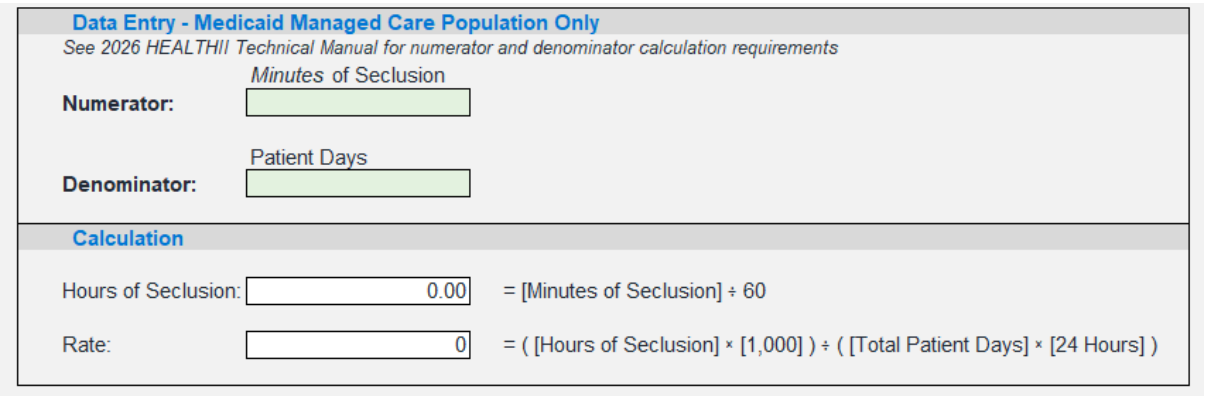


FIGURE 8: DATA ENTRY TAB: PSYCHIATRIC



SELF-REPORTED MEASURE SPECIFICATIONS

AHCCCS-04: Hours of Seclusion Use

- **Hospital Type:** Psychiatric
- **Description:** The total number of hours that all patients admitted to a hospital-based inpatient psychiatric setting were held in seclusion (Overall rate)
- **Reporting Period:** 10/01/2023 - 09/30/2024
- **Reporting Method:** Self-reported
- **Measure Basis:** CBE #0641
- **Specifications Source:** Reporting may align with The Joint Commission's specifications for the Medicare Inpatient Psychiatric Facility Quality Reporting Program, HBIPS-3a Hours of Seclusion, Overall Rate, with measure modifications as appropriate.
    - Link: Specifications Manual for Joint Commission National Quality Measures (v2024a) HBIPS-3
- **Measure Modifications:** Denominator and numerator limited to Arizona Medicaid managed care population

FIGURE 9: AHCCCS-04 DETAILED SPECIFICATIONS SUMMARY (SEE SPECIFICATIONS SOURCE FOR LOGIC)

Numerator Statement: The total number of hours that all psychiatric inpatients were held in seclusion

Numerator Basis: The numerator evaluates the number of hours of seclusion; however, the algorithm calculates the number of minutes to ensure a more accurate calculation of the measure.

Included Populations:

- Patients for whom at least one seclusion event is reported during reporting period

Excluded Populations: None

Denominator Statement: Number of psychiatric inpatient days

Denominator Basis: per 1,000 hours

Included Populations:

- All psychiatric inpatient days

Excluded Populations:

- Total leave days

AHCCCS-05: Percent of Residents Experiencing One or More Falls with Major Injury

- **Hospital Type:** Long Term and Rehabilitation Hospitals
- **Description:**
  Long Term Hospital: Percentage of patients who experience one or more falls with major injury during their stay
  Rehabilitation Hospital: The percentage of stays in which patients experience one or more falls with major injury during the stay.
- **Reporting Period:** 10/01/2023 - 09/30/2024
- **Reporting Method:** Self-reported
- **Measure Basis:** CBE #0674
- **Specifications Source:** Reporting may align with Medicare Inpatient Rehab Facility Quality Reporting and Long-Term Care Hospital Quality Reporting
  - Link: Inpatient Rehabilitation Facility Quality Reporting Program Measure Calculations and Reporting User's Manual
  - Link: Long-Term Care Hospital Quality Reporting Program Measure Calculations and Reporting User's Manual
- **Measure Modifications:** Denominator and numerator limited to Arizona Medicaid managed care population. While the CBE measure specifications define a long stay as receiving 101 or more cumulative days of care by the end of the target period, this measure is modified to include all eligible members regardless of the duration of their stay.

FIGURE 10: AHCCCS-05 DETAILED SPECIFICATIONS SUMMARY (SEE SPECIFICATIONS SOURCE FOR LOGIC) LONG TERM HOSPITALS

Numerator Numerator Total number of stays in the denominator with planned or unplanned Discharge assessment or Expired Record during the reporting period that experienced one or more falls that resulted in major injury: J1900C = [1] or [2].
Denominator The total number of stays with a planned or unplanned Discharge assessment or Expired Record (A0250 = [10, 11, 12]) in the reporting period, which do not meet the exclusion criteria.
Exclusions A stay is excluded if the number of falls with major injury was not coded: J1900C (Falls with Major Injury) = [-].

FIGURE 11: AHCCCS-05 DETAILED SPECIFICATIONS SUMMARY (SEE SPECIFICATIONS SOURCE FOR LOGIC) REHABILITATION HOSPITALS

Numerator Total number of stays in the denominator during the selected time window that experienced one or more falls that resulted in major injury: J1900C = [1] or [2].
Denominator The total number of stays with a discharge date in the measure target period, which do not meet the exclusion criteria
Exclusions An IRF stay is excluded if the number of falls with major injury was not coded at discharge: ▪ J1900C (Falls with Major Injury) = [-]

AHCCCS-06: NHSN Facility-wide Inpatient Hospital-onset Clostridium difficile [*C. difficile*] Infection (CDI) Outcome Measure

- **Hospital Type:** Children's and General Acute Hospitals
- **Description:** Hospital-onset CDI Laboratory-identified events (LabID events) among all inpatients in the facility, excluding well-baby nurseries and neonatal intensive care units (NICUs).
- **Reporting Period:** 10/01/2023 - 09/30/2024
- **Reporting Method:** Self-reported
- **Measure Basis:** CBE #1717
- **Specifications Source:** Hospitals will use their own medical record data to calculate an observed rate (no standardized infection ratio [SIR] will be calculated). Because no SIR is calculated, specifications will not align with Medicare programs.
    - Link: MDRO & CDI Protocol
- **Measure Modifications:** Denominator and numerator limited to Arizona Medicaid managed care population

FIGURE 12: AHCCCS-06 DETAILED SPECIFICATIONS SUMMARY (SEE SPECIFICATIONS SOURCE FOR LOGIC)

Numerator The number of observed hospital-onset incident CDI LabID events among all inpatients in the facility
Denominator The number of inpatient admissions to the facility
Settings Surveillance will NOT be performed in NICU, SCN, babies in Labor, Delivery, Recovery, & Post-partum (LDRP/PP) units, well-baby nurseries, or well-baby clinics. If LDRP/PP locations are being monitored, baby counts must be removed when compiling total counts for line 3 of the FacWideIN denominator submission.

AHCCCS-12: Median Time from Emergency Department (ED) Arrival to ED Departure for Discharged ED Patients

- **Hospital Type:** Critical Access Hospitals
- **Description:** Calculates the median time from ED arrival to time of departure from the ED for patients discharged alive from the ED
- **Reporting Period:** 10/01/2023 - 09/30/2024
- **Reporting Method:** Self-reported
- **Measure Basis:** CBE #0496
- **Specifications Source:** Reporting may align with the Medicare Hospital Outpatient Quality Reporting Program OP-18 Median Time from ED Arrival to ED Departure for Discharged ED Patients but limited to Arizona Medicaid managed care members.
    - Link: Hospital Outpatient Quality Reporting Specifications Manual
- **Measure Modifications:** Median time calculated based on the Arizona Medicaid managed care population only

FIGURE 13: AHCCCS-12 DETAILED SPECIFICATIONS SUMMARY (SEE SPECIFICATIONS SOURCE FOR LOGIC)

Continuous Variable Statement
Time (in minutes) from ED arrival to ED departure for patients discharged alive from the ED, from which a median time will be calculated.

Included Populations
Any ED patient from the facility's emergency department

Excluded Populations
Patients who expired in the ED

CLAIMS BASED MEASURE SPECIFICATIONS

NOTE: HOSPITALS WILL NOT SUBMIT DATA FOR CLAIMS-BASED MEASURES

Hospitals are not required to submit information for the claims-based performance measures, as those calculations are performed by Milliman on claims obtained directly from AHCCCS. After a review of the data, Milliman and AHCCCS may reach out to providers in the event that a calculation falls significantly outside of the expected results range or a data issue has been identified that impacts the results of the claims-based performance measures.

Data

Medicaid managed care encounters and enrollment files were obtained from the AHCCCS Medicaid Management Information System (MMIS). The extract consists of approved and adjudicated encounters from 10/1/2023 through 10/31/2024 based on service end date. This extract serves as the basis for claims-based quality measures and subsequent inclusion/exclusion criteria are applied at the individual measure level.

AHCCCS-02: Patient Safety Indicator (PSI) 90 Patient Safety and Adverse Events Composite

- **Hospital Type:** General Acute Care Hospitals
- **Description:** The PSI 90 composite measure summarizes patient safety across multiple indicators. Claims data extracted from the MMIS is used to calculate a PSI 90 composite score. The ten measures included in the composite measure are listed below:
    - PSI 03: Pressure Ulcer Rate
    - PSI 06: Iatrogenic Pneumothorax Rate
    - PSI 08: In-Hospital Fall-Associated Fracture Rate
    - PSI 09: Postoperative Hemorrhage or Hematoma Rate
    - PSI 10: Postoperative Acute Kidney Injury Requiring Dialysis Rate
    - PSI 11: Postoperative Respiratory Failure Rate
    - PSI 12: Perioperative Pulmonary Embolism or Deep Vein Thrombosis Rate
    - PSI 13: Postoperative Sepsis Rate
    - PSI 14: Postoperative Wound Dehiscence Rate
    - PSI 15: Abdominopelvic Accidental Puncture or Laceration Rate
- **Reporting Period:** 10/01/2023 - 09/30/2024
- **Measure Basis:** CBE #0531
- **Specifications Source:** For interested facilities, the Agency for Healthcare Research & Quality (AHRQ) provides free, downloadable software to calculate PSI 90. The software is a set of programs that run using Statistical Analysis System (SAS) by the end user. Additional information and downloads are available on the AHRQ website.[6]

  Facilities can also download PSI software via CMS. To request the free software, visit: https://cmsqualitysupport.servicenowservices.com/qnet_qa
    - Select, "Ask a Question"
    - Choose "Inpatient Claims-Based Measures" in the program list,
    - In the "Patient Safety Indicators (PSI)" Topic List category, select "PSI 90 Software"
    - Complete the form as requested and submit
    - Software is provided as a SAS program with supporting reference tables
- **Measure Modifications:** Denominator and numerator limited to Arizona Medicaid managed care population

FIGURE 14: AHCCCS-02 MEASURE DESCRIPTION

Measure Description: Measure reports a hospital level weighted average of the indicators listed in the measure description for AHCCCS Medicaid managed care admissions

[6] AHRQ Quality Indicators: https://github.com/AHRQ/AHRQ-Quality-Indicators/tree/master

AHCCCS-07: 30-Day Hospital Wide All-Cause Unplanned Readmission Measure

- **Hospital Type:** Short Stay Hospitals
- **Description:** 30-Day Hospital-Wide All-Cause Unplanned Readmission Measure (Observed rate)
- **Reporting Period: Reporting Period:** 10/01/2023 - 09/30/2024
- **Measure Basis:** CBE #1789
- **Specifications Source:** CMS Quality Payment Program – 2024 All-Cause, Unplanned Hospital-Wide Readmission Measure
    - Link: https://qpp.cms.gov/resources/document/19e89489-50dd-42c3-b363-281cc4c4c557
- **Measure Modifications:** Denominator and numerator limited to Arizona Medicaid managed care population; measure results will not be risk-adjusted

FIGURE 15: AHCCCS-07 DETAILED SPECIFICATIONS SUMMARY (SEE SPECIFICATIONS SOURCE FOR LOGIC)

Numerator Statement: Number of index admissions with one or more readmission within 30 days The outcome is 30-day readmission defined as an inpatient readmission for any cause, except for certain always planned and potentially planned admissions (e.g. transplants, maintenance chemotherapy, scheduled procedures) and exclusions (i.e. COVID-19), within 30 days from the date of discharge from an eligible index admission. If a patient has more than one readmission within 30 days after discharge from the index admission, only the first is considered a readmission. If the first readmission is considered planned or is excluded, any subsequent unplanned readmission is not considered.
Denominator Statement: Total number of index admissions Admissions for beneficiaries who are 65 years and older and are discharged from an Arizona general acute care hospital with a complete claims history for the 12 months prior to the index admission. Index admissions are attributed to the hospital where the index admission took place, regardless of whether the readmission occurred at a different general acute care hospital.
Denominator Exclusions: Exclude index admissions for patients: 1. Admitted to Prospective Payment System (PPS)-exempt cancer hospitals; 2. Without at least 30 days post-discharge enrollment in Medicaid MCO; 3. Discharged against medical advice; 4. Admitted for primary psychiatric diagnoses; 5. Admitted for rehabilitation; 6. Admitted for medical treatment of cancer; 7. With a principal diagnosis code of COVID-19 or with a secondary diagnosis code of COVID-19 coded as present on admission

Limitations

The information contained in this document is prepared solely for the business use of the Arizona Health Care Cost Containment System (AHCCCS) for the purpose of providing technical specifications for hospitals to report quality measures selected by AHCCCS, and is not appropriate for other purposes. Any user of the information in this document must possess a certain level of expertise in hospital quality measurement that will allow appropriate use of the information presented.

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Milliman has not advocated for, recommended, or endorsed any particular Arizona hospital quality measure program or Arizona Medicaid hospital quality incentive payments design. Implementation of Arizona hospital quality program design and requirements into Arizona Medicaid hospital quality incentive payments are subject to approval by AHCCCS and CMS. All final policy decisions regarding the design, modeling methodology, parameters, assumptions, and requirements of the Arizona hospital quality measures and Arizona Medicaid hospital quality incentive payments are the responsibility of AHCCCS.

For technical questions or questions related to the submission process please contact:

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Solutions for a world at risk™

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CONTACT
Ben Mori
ben.mori@milliman.com

Justin St. Andre
justin.standre@milliman.com

Noelle Gaughen
noelle.gaughen@milliman.com

Milliman

For more information about Milliman, please visit us at: milliman.com