Statewide Vision: An Arizona for everyone.

Agency Vision: To be the recognized national leader in providing equitable whole-person public healthcare.

Agency Mission: Helping Arizonans live healthier lives by ensuring access to quality healthcare 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 (health plans) to coordinate and pay for physical and behavioral health care services delivered by more than 93,000 health care providers to more than 2 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 Full-Time Employees (FTEs) and funding data by type (General fund (GF), other appropriated funds (AF), non-appropriated funds (NAF), and federal funds (FED). *Includes three years with actuals reflected for first year and approved for second and third year.*

FY	FTEs	Funding Types: GF	AF	NAF	FED	Total
23	1,163.5	$2,179,034,700	$424,969,000	$1,835,812,900	$18,599,327,500	$23,039,144,100
24	1,173.5	$2,475,457,000	$415,626,200	$3,405,188,300	$17,437,469,700	$23,733,741,200
25	1,274.5	$2,669,125,000	$455,284,500	$5,238,977,600	$17,192,785,500	$25,556,172,600

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

Executive Summary:

In the next five years, we will continue to work on increasing access to whole-person care by supporting participation in the Closed-Loop Referral System. We will also work with partners to make it easier to onboard new Community-Based Organizations (CBOs) and to streamline the process of making referrals.

This year, we will launch an effort to reduce the uninsured rate among those earning ≤ 138% of the federal poverty level (FPL). We plan to begin by targeting those who would be eligible for AHCCCS programs with a maximum eligibility of 138% FPL. In the first year, of this five-year plan, we will launch an outreach campaign to build awareness of AHCCCS benefits among communities most likely to be eligible and uninsured.

We will continue to excel in member satisfaction and will increase provider satisfaction. We are proud that over the last three years our Office of Communication, Advocacy, Resolution, and Enrollment (OCARE) call center customer satisfaction has consistently been near or at world class levels. We will continue to work to maintain that level of performance despite increased call volumes. This year, we will also begin to measure caller satisfaction in our Provider Enrollment call center. We anticipate that actions taken to address the sober living fraud will impact provider satisfaction in the near term, but we are committed to ensuring the same levels of customer service that we provide to our members.

Over the next five years, we will also work to promote and encourage use of preventive services by our members, as we know that increased utilization of such services has a positive impact on the overall health of our members.

We will continue to address fraud, waste, and abuse to ensure quality of care for our members. In the past legislative session, Governor Hobbs and the legislature appropriated additional staff to provide the agency with the resources needed to stop the bad actors from exploiting the system. In the coming year, AHCCCS will onboard these staff, continue to implement systemic changes/improvements based on data analysis, and implement a new prepay and postpay system to evaluate claims payments.

Summary of 5-Year Agency Outcomes
(Outcomes are the desired result or impact of addressing strategic issues)

#	Agency Five-Year Outcomes	Start Year	Linked to Gov. Priority Outcome?	Progress / Status
1	Improve member access to whole-person care by increasing the percentage of closed-loop referrals that are resolved (fulfilled) from 44% to 55% by 2029.	FY24	N/A	The AHCCCS Whole-Person Care team and Targeted Investment team have been working to address obstacles to enrollment in the Closed-Loop Referral System and to increase referrals. The AHCCCS Housing and Health Opportunities (H2O) demonstration program implementation, a Governor's Office proposed outcome, supports this outcome. The Data Warehouse Enterprise for Linkage Arizona (DWEL-AZ), a Governor's Office proposed outcome, also supports this outcome.
2	Decrease the uninsured rate among individuals earning < 138% of federal poverty level (FPL) by 35% by 2029.	FY25	(Subset of) 5% reduction in uninsured population	New agency outcome. We will develop a new measure to track those programs population categories with a maximum eligibility of < 138% FPL.
3	Increase provider satisfaction from 82% to 84% by 2029.	FY25	N/A	Provider satisfaction will be a new measure with the intention of retaining qualified providers.
4	Increase % of Targeted Preventive Care (TPC) measures meeting or exceeding the National Committee for Quality Assurance (NCQA) Medicaid Mean from 25% to 35% by 2029.	FY25	(Subset of) 30% increase in enrollment and utilization in prevention	The list of TPC measures is found in Table B in the AHCCCS Quality Strategy Evaluation at this link. In the coming year we will work to ensure providers promote utilization of preventive measures.
5	Improve quality of care and reduce fraud, waste, and abuse as indicated by an increase of 10 percentage points in claims approved after prepayment review of medical documentation by 2029.	FY25	Addressing fraud-quality in behavioral health	Last fiscal year we focused on restructuring the fee-for-service program. In the coming year, our focus will be on our evaluation of claims payments.

Outcome #	FY24 Annual Objectives	Objective Metrics	Annual Initiatives
1. Improve member access to whole-person care by increasing the % of closed-loop referrals that are resolved (fulfilled) from 44% to 55% by 2029.	Increase the % of resolved closed-loop referrals from 44% to 45.50% by June 30, 2025.	% of resolved closed-loop referrals	Work with Community-Based Organizations (CBOs) to improve onboarding and troubleshoot system issues that impact participation.
2. Decrease the uninsured rate among individuals earning < 138% FPL by 35% by 2029.	Decrease the uninsured rate among individuals earning < 138% FPL by 7% by June 30, 2025. (Breakthrough)	-Uninsured rate among individuals earning < 138% FPL (annual) -Month-over-month growth in AHCCCS population categories with a maximum eligibility of < 138% FPL	Launch an outreach campaign targeting population categories with a maximum eligibility of < 138% FPL.
3. Increase provider satisfaction from 82% to 84% by 2029.	Increase provider satisfaction from 82% to 83% by June 30, 2025. Maintain member satisfaction at or above 85%.	-% very satisfied provider callers -% very satisfied member callers	Establish a baseline of provider satisfaction, analyze dissatisfiers, and develop and deploy plans to address key issues. Monitor and maintain world-class member satisfaction rate of 85%
4. Increase % of Targeted Preventive Care (TPC) measures meeting or exceeding the NCQA Medicaid Mean from 25% to 35% by 2029.	Increase 25% of the Targeted Preventative Care Measures which were below the NCQA Mean in the previous reporting period by 2% by January 30, 2026.* *AHCCCS' performance measure results are available each year approximately in December for the prior calendar year; NCQA data are available approximately 4-5 months later; there will always be a lag of about 18 months.	% (TPC) measures meeting or exceeding the associated NCQA Medicaid Mean	-Reinstate pre-Covid accountability mechanisms for managed care organizations (MCOs) as outlined in the MCO contracts for value-based purchasing initiatives. -Develop a Differential Adjusted Payment (DAP) rate for non-Indian Health Service (IHS) providers.
5. Improve quality of care and reduce fraud, waste, and abuse as indicated by an increase of 10 percentage points in claims approved after prepayment review of medical documentation by 2029.	Increase the % of claims approved after prepayment review by 2 percentage points by June 30, 2025.	% claims approved after prepayment review	-Implement the prepay and postpay system to evaluate claims payments. -Develop a communication strategy that includes Technical Assistance (TA) and training of providers who are subject to prepayment review and regularly are denied payment.

Stakeholder Engagement Plan: Provide a summary of what stakeholders were involved and how. You should have a more detailed stakeholder engagement plan for the agency.

Internal: Select Division Assistant Directors, subject matter experts, and process owners.

External: None directly.

Communication Plan: Provide a summary of how this strategic plan will be communicated to stakeholders. You should have a more detailed communication plan for the agency.

Internal: Through Agency Town Halls and the CEO's email communication to all employees, AHCCCS Updates.

External: Presentations during: the State Medicaid Advisory Council (SMAC) meeting, Tribal Consultation, Community meetings.