DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

October 9, 2026

Roberta Harrison, Interim Medicaid Director
Arizona Health Care Cost Containment System
150 North 18th Avenue
Phoenix, AZ 85007

Dear Ms. Roberta Harrison:

In accordance with 42 CFR 438.6(c), the Centers for Medicare & Medicaid Services (CMS) has reviewed and is approving Arizona's submission of a proposal for a state directed payment (SDP) under Medicaid managed care plan contract(s). The proposal was received by CMS on September 30, 2026. The proposal has a control name of AZ_Fee_PC.BHO.Oth_Renewal_20261001-20270930**.**

CMS has completed our review of the following Medicaid managed care SDP:

- Uniform increase for primary care, behavioral health outpatient, and justice involved clinic services for the rating period covering October 1, 2026 through September 30, 2027 incorporated in the capitation rates through a separate payment term amount up to $41,000,000.

This letter satisfies the regulatory requirement in 42 CFR 438.6(c)(2) for SDPs described in 42 CFR 438.6(c)(1). This letter pertains only to the actions identified above and does not apply to other actions currently under CMS's review. This letter does not constitute approval of any specific Medicaid financing mechanism used to support the non-federal share of expenditures associated with these actions. All relevant federal laws and regulations apply. CMS reserves its authority to enforce requirements in the Social Security Act and the applicable implementing regulations.

The state is required to submit contract action(s) and related capitation rates that include all SDPs, including those that do not require written prior approval as specified in 42 CFR 438.6(c)(2)(i). Additionally, all SDPs must be addressed in the applicable rate certifications. CMS recommends that states share this letter and the preprint(s) with the certifying actuary. Documentation of all SDPs must be included in the initial rate certification as outlined in Section I, Item 4, Subsection D, of the Medicaid Managed Care Rate Development Guide. The state and its actuary must ensure all documentation outlined in the Medicaid Managed Care Rate Development Guide is included in the initial rate certification. Failure to provide all required documentation in the rate certification will cause delays in CMS review.

Approval of this SDP proposal for the applicable rating period does not preclude CMS from requesting additional materials from the state, revision to the SDP proposal design, or any other modifications to the proposal for this rating period or future rating periods, if CMS determines that such modifications are required for the state to meet relevant federal requirements.

CMS approval of this SDP preprint is conditioned on the state's continued compliance with Medicaid program integrity requirements, including 42 CFR 438 and 42 CFR 455. The state

must ensure that the state and its managed care plans appropriately support program integrity activities, including the prevention, detection, investigation, referral, and resolution of fraud, waste, and abuse through appropriate staffing, oversight, controls, data, analytics, reporting, audits, and other actions. The state is responsible for monitoring all aspects of the managed care program, including the performance of every managed care plan related to program integrity as required in 42 CFR 438.66(b)(9). Any material changes to managed care plans' program integrity responsibilities must be clearly effectuated through the state's managed care contracts submitted to CMS for review and approval in accordance with 42 CFR 438.3(a).

If you have any questions concerning this letter, please contact StateDirectedPayment@cms.hhs.gov.

Sincerely,

MEAGAN T. KHAU -S
Digitally signed by MEAGAN T. KHAU -S
Date: 2026.10.09 12:33:20 -04'00'

Meagan Khau
Deputy Director, Managed Care Group
Center for Medicaid and CHIP Services

Section 438.6(c) Preprint

42 C.F.R. § 438.6(c) provides States with the flexibility to implement delivery system and provider payment initiatives under MCO, PIHP, or PAHP Medicaid managed care contracts (i.e., state directed payments). 42 C.F.R. § 438.6(c)(1) describes types of payment arrangements that States may use to direct expenditures under the managed care contract. Under 42 C.F.R. § 438.6(c)(2)(ii), contract arrangements that direct an MCO's, PIHP's, or PAHP's expenditures under paragraphs (c)(1)(i) through (c)(1)(ii) and (c)(1)(iii)(B) through (D) must have written approval from CMS prior to implementation and before approval of the corresponding managed care contract(s) and rate certification(s). This preprint implements the prior approval process and must be completed, submitted, and approved by CMS before implementing any of the specific payment arrangements described in 42 C.F.R. § 438.6(c)(1)(i) through (c)(1)(ii) and (c)(1)(iii)(B) through (D). Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules using State plan approved rates as defined in 42 C.F.R. § 438.6(a).

Submit all state directed payment preprints for prior approval to: StateDirectedPayment@cms.hhs.gov.

SECTION I: DATE AND TIMING INFORMATION

1. Identify the State's managed care contract rating period(s) for which this payment arrangement will apply (for example, July 1, 2020 through June 30, 2021):
   October 1, 2026 - September 30, 2027
2. Identify the State's requested start date for this payment arrangement (for example, January 1, 2021). *Note, this should be the start of the contract rating period unless this payment arrangement will begin during the rating period.* October 1, 2026
3. Identify the managed care program(s) to which this payment arrangement will apply:
   AHCCCS Complete Care /AHCCCS Complete Care Regional Behavioral Health Agreement (ACC/ACC-RBHA)
4. Identify the estimated **total dollar amount** (federal and non-federal dollars) of this state directed payment: $ 41.00 M including the impact of premium tax (All Areas of Concentration- BH, Justice, PCP)
   a. Identify the estimated federal share of this state directed payment: $30.61 M
   b. Identify the estimated non-federal share of this state directed payment: $10.39 M

   Please note, the estimated total dollar amount and the estimated federal share should be described for the rating period in Question 1. If the State is seeking a multi-year approval (which is only an option for VBP/DSR payment arrangements (42 C.F.R. § 438.6(c)(1)(i)-(ii))), States should provide the estimates per rating period. For amendments, states should include the change from the total and federal share estimated in the previously approved preprint.

5. Is this the initial submission the State is seeking approval under 42 C.F.R. § 438.6(c) for this state directed payment arrangement? ☐ Yes ☒ No

6. If this is not the initial submission for this state directed payment, please indicate if:

a. ☐ The State is seeking approval of an amendment to an already approved state directed payment.

b. ☒ The State is seeking approval for a renewal of a state directed payment for a new rating period.

i. If the State is seeking approval of a renewal, please indicate the rating periods for which previous approvals have been granted:
FFY23, FFY24, FFY25, FFY26

c. Please identify the types of changes in this state directed payment that differ from what was previously approved.

☐ Payment Type Change
☐ Provider Type Change
☐ Quality Metric(s) / Benchmark(s) Change
☒ Other; please describe:

Updates to question 1- rating period (October 1, 2026-September 30, 2027), question 2- rating period start date, question 4- updated amounts, question 8- updated payment arrangement details, question 19b-uniform dollar increas

☐ No changes from previously approved preprint other than rating period(s).

7. ☒ Please use the checkbox to provide an assurance that, in accordance with 42 C.F.R. § 438.6(c)(2)(ii)(F), the payment arrangement is not renewed automatically.

SECTION II: TYPE OF STATE DIRECTED PAYMENT

8. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(A), describe in detail how the payment arrangement is based on the utilization and delivery of services for enrollees covered under the contract. The State should specifically discuss what must occur in order for the provider to receive the payment (e.g., utilization of services by managed care enrollees, meet or exceed a performance benchmark on provider quality metrics).

In Year 5 of TI 2.0, participants will need to meet quantitative performance measures to earn payments. The TI 2.0 Program applies for members served by AHCCCS Complete Care (ACC) and AHCCCS Complete Care-RBHA (ACC-RBHA) health plans.

Milestones and program requirements for all areas of concentration (Adult/Peds PCP, Adult/Peds BH, and Adult Justice) can be found at the link below: https://www.azahcccs.gov/PlansProviders/Downloads/TI/Milestone/Year5MilestoneRequirements.pdf

a. ☒ Please use the checkbox to provide an assurance that CMS has approved the federal authority for the Medicaid services linked to the services associated with the SDP (i.e., Medicaid State plan, 1115(a) demonstration, 1915(c) waiver, etc.).

b. Please also provide a link to, or submit a copy of, the authority document(s) with initial submissions and at any time the authority document(s) has been renewed/revised/updated.

The provider classes included in this SDP are included in the State Plan and 1115 Waiver:
https://www.azahcccs.gov/Resources/StatePlans/

State Plan document:
https://www.azahcccs.gov/Resources/Downloads/StatePlans/EntireStatePlan.pdf

1115 Demonstration Waiver document:
https://www.azahcccs.gov/Resources/Federal/waiver.html

https://www.azahcccs.gov/Resources/Downloads/Federal/AHCCCS_ExtensionSTCs_Final10142022.pdf

State Plan: Attachment 3.1-A: https://www.azahcccs.gov/Resources/Downloads/StatePlans/Section3/SP_3.1-A.pdf

State Plan: Attachment 3.1-A Limitations: https://www.azahcccs.gov/Resources/Downloads/StatePlans/Section3/SP_3.1-A_Limits.pdf

The provider types included in this SDP are integral to the AHCCCS delivery system, as well as to advancing the system integration that the TI program 2.0 is working to achieve.

9. Please select the general type of state directed payment arrangement the State is seeking prior approval to implement. (Check all that apply and address the underlying questions for each category selected.)

a. ☐ **VALUE-BASED PAYMENTS / DELIVERY SYSTEM REFORM:** In accordance with 42 C.F.R. § 438.6(c)(1)(i) and (ii), the State is requiring the MCO, PIHP, or PAHP to implement value-based purchasing models for provider reimbursement, such as alternative payment models (APMs), pay for performance arrangements, bundled payments, or other service payment models intended to recognize value or outcomes over volume of services; or the State is requiring the MCO, PIHP, or PAHP to participate in a multi-payer or Medicaid-specific delivery system reform or performance improvement initiative.

If checked, please answer all questions in Subsection IIA.

b. ☒ **FEE SCHEDULE REQUIREMENTS:** In accordance with 42 C.F.R. § 438.6(c)(1)(iii)(B) through (D), the State is requiring the MCO, PIHP, or PAHP to adopt a minimum or maximum fee schedule for network providers that provide a particular service under the contract; or the State is requiring the MCO, PIHP, or PAHP to provide a uniform dollar or percentage increase for network providers that provide a particular service under the contract. **[Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules using State plan approved rates as defined in 42 C.F.R. § 438.6(a).]**

If checked, please answer all questions in Subsection IIB.

SUBSECTION IIA: VALUE-BASED PAYMENTS (VBP) / DELIVERY SYSTEM REFORM (DSR):

This section must be completed for all state directed payments that are VBP or DSR. This section does not need to be completed for state directed payments that are fee schedule requirements.

10. Please check the type of VBP/DSR State directed payment the State is seeking prior approval for. *Check all that apply; if none are checked, proceed to Section III.*

- ☐ Quality Payment/Pay for Performance (Category 2 APM, or similar)
- ☐ Bundled Payment/Episode-Based Payment (Category 3 APM, or similar)
- ☐ Population-Based Payment/Accountable Care Organization (Category 4 APM, or similar)
- ☐ Multi-Payer Delivery System Reform
- ☐ Medicaid-Specific Delivery System Reform
- ☐ Performance Improvement Initiative
- ☐ Other Value-Based Purchasing Model

11. Provide a brief summary or description of the required payment arrangement selected above and describe how the payment arrangement intends to recognize value or outcomes over volume of services. If "other" was checked above, identify the payment model. The State should specifically discuss what must occur in order for the provider to receive the payment (e.g., meet or exceed a performance benchmark on provider quality metrics).

12. In Table 1 below, identify the measure(s), baseline statistics, and targets that the State will tie to provider performance under this payment arrangement (provider performance measures). Please complete all boxes in the row. To the extent practicable, CMS encourages states to utilize existing, validated, and outcomes-based performance measures to evaluate the payment arrangement, and recommends States use the CMS Adult and Child Core Set Measures when applicable. If the state needs more space, please use Addendum Table 1.A and check this box: ☐

TABLE 1: Payment Arrangement Provider Performance Measures

Measure Name and NQF # (if applicable)	**Measure Steward/ Developer**[1]	**Baseline**[2] **Year**	**Baseline**[2] **Statistic**	**Performance Measurement Period**[3]	**Performance Target**	**Notes**[4]
Example: Percent of High-Risk Residents with Pressure Ulcers – Long Stay	*CMS*	*CY 2018*	*9.23%*	*Year 2*	*8%*	*Example notes*
a.						
b.						
c.						
d.						
e.						

1. Baseline data must be added after the first year of the payment arrangement
2. If state-developed, list State name for Steward/Developer.
3. If this is planned to be a multi-year payment arrangement, indicate which year(s) of the payment arrangement that performance on the measure will trigger payment.
4. If the State is using an established measure and will deviate from the measure steward's measure specifications, please describe here. Additionally, if a state-specific measure will be used, please define the numerator and denominator here.

13. For the measures listed in Table 1 above, please provide the following information:

a. Please describe the methodology used to set the performance targets for each measure.

b. If multiple provider performance measures are involved in the payment arrangement, discuss if the provider must meet the performance target on each measure to receive payment or can providers receive a portion of the payment if they meet the performance target on some but not all measures?

c. For state-developed measures, please briefly describe how the measure was developed?

14. Is the State seeking a multi-year approval of the state directed payment arrangement?
☐ Yes ☐ No

a. If this payment arrangement is designed to be a multi-year effort, denote the State's managed care contract rating period(s) the State is seeking approval for.

b. If this payment arrangement is designed to be a multi-year effort and the State is **NOT** requesting a multi-year approval, describe how this application's payment arrangement fits into the larger multi-year effort and identify which year of the effort is addressed in this application.

15. Use the checkboxes below to make the following assurances:

a. ☐ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(A), the state directed payment arrangement makes participation in the value-based purchasing initiative, delivery system reform, or performance improvement initiative available, using the same terms of performance, to the class or classes of providers (identified below) providing services under the contract related to the reform or improvement initiative.

b. ☐ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(B), the payment arrangement makes use of a common set of performance measures across all of the payers and providers.

c. ☐ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(C), the payment arrangement does not set the amount or frequency of the expenditures.

d. ☐ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(D), the payment arrangement does not allow the State to recoup any unspent funds allocated for these arrangements from the MCO, PIHP, or PAHP.

SUBSECTION IIB: STATE DIRECTED FEE SCHEDULES:
This section must be completed for all state directed payments that are fee schedule requirements. This section does not need to be completed for state directed payments that are VBP or DSR.

16. Please check the type of state directed payment for which the State is seeking prior approval. *Check all that apply; if none are checked, proceed to Section III.*

a. ☐ Minimum Fee Schedule for providers that provide a particular service under the contract *using rates other than State plan approved rates* [1] (42 C.F.R. § 438.6(c)(1)(iii)(B))

b. ☐ Maximum Fee Schedule (42 C.F.R. § 438.6(c)(1)(iii)(D))

c. ☒ Uniform Dollar or Percentage Increase (42 C.F.R. § 438.6(c)(1)(iii)(C))

[1] Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules that use State plan approved rates as defined in 42 C.F.R. § 438.6(a).

17. If the State is seeking prior approval of a fee schedule (options a or b in Question 16):

a. Check the basis for the fee schedule selected above.

i. ☐ The State is proposing to use a fee schedule based on the **State-plan approved rates** as defined in 42 C.F.R. § 438.6(a). [2]

ii. ☐ The State is proposing to use a fee schedule based on the **Medicare or Medicare-equivalent rate**.

iii. ☐ The State is proposing to use a fee schedule based on an **alternative fee schedule established by the State**.

1. If the State is proposing an alternative fee schedule, please describe the alternative fee schedule (e.g., 80% of Medicaid State-plan approved rate)

b. Explain how the state determined this fee schedule requirement to be reasonable and appropriate.

18. If using a maximum fee schedule (option b in Question 16), please answer the following additional questions:

a. ☐ Use the checkbox to provide the following assurance: In accordance with 42 C.F.R. § 438.6(c)(1)(iii)(C), the State has determined that the MCO, PIHP, or PAHP has retained the ability to reasonably manage risk and has discretion in accomplishing the goals of the contract.

b. Describe the process for plans and providers to request an exemption if they are under contract obligations that result in the need to pay more than the maximum fee schedule.

c. Indicate the number of exemptions to the requirement:

i. Expected in this contract rating period (estimate)

ii. Granted in past years of this payment arrangement

d. Describe how such exemptions will be considered in rate development.

[2] Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules that use State plan approved rates as defined in 42 C.F.R. § 438.6(a).

19. If the State is seeking prior approval for a uniform dollar or percentage increase (option c in Question 16), please address the following questions:

a. Will the state require plans to pay a ☒ uniform dollar amount **or** a ☐ uniform percentage increase? (*Please select only one.*)

b. What is the magnitude of the increase (e.g., $4 per claim or 3% increase per claim?)

PCP: Urban $38.9451/member served; PCP w/NCQA: Urban $39.0129; PCP: Rural $48.6813/member served; PCP w/NCQA: Rural $48.7661/member served; BH: Urban $2.0762/service unit served; BH w/NCQA: Urban $2.0726/service unit ser

c. Describe how will the uniform increase be paid out by plans (e.g., upon processing the initial claim, a retroactive adjustment done one month after the end of quarter for those claims incurred during that quarter).

AHCCCS will require that Contractors provide the specific uniform dollar increase to all providers in the cohort who meet the established eligibility criteria. AHCCCS shall calculate and communicate to the Contractors the uniform dollar amount to be paid to each provider by the Contractor. The increase will be paid outside of the monthly capitation payments through a separate payment to the plans.

d. Describe how the increase was developed, including why the increase is reasonable and appropriate for network providers that provide a particular service under the contract

As shown in Table 2, when considering managed care base payments and Targeted investment payments along with other SDPs for these provider classes, total managed care payments are estimated under commercial reimbursement. AHCCCS believes the proposed payment increases are reasonable and necessary for achieving its goals and objectives for this directed payment arrangement, while

SECTION III: PROVIDER CLASS AND ASSESSMENT OF REASONABLENESS

20. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(B), identify the class or classes of providers that will participate in this payment arrangement by answering the following questions:

a. Please indicate which general class of providers would be affected by the state directed payment (check all that apply):

- ☐ inpatient hospital service
- ☐ outpatient hospital service
- ☐ professional services at an academic medical center
- ☒ primary care services
- ☐ specialty physician services
- ☐ nursing facility services
- ☐ HCBS/personal care services
- ☐ behavioral health inpatient services
- ☒ behavioral health outpatient services
- ☐ dental services
- ☒ Other: Justice- FQHC/RHCs and ICs

b. Please define the provider class(es) (if further narrowed from the general classes indicated above).

The TI PCP Program includes adult and pediatric services rendered by:
(a) Physicians (MDs and DOs) including specialties of Family Practice, General Practice, Internal Medicine, Obstetrician and/or Gynecologist, and Pediatrician, and
(b) Physician's Assistants, and
(c) Registered Nurse Practitioners

c. Provide a justification for the provider class defined in Question 20b (e.g., the provider class is defined in the State Plan.) If the provider class is defined in the State Plan, please provide a link to or attach the applicable State Plan pages to the preprint submission. Provider classes cannot be defined to only include providers that provide intergovernmental transfers.

These provider classes are included in the State Plan and 1115 Waiver.

State Plan links and documents:
https://www.azahcccs.gov/Resources/StatePlans/
https://www.azahcccs.gov/Resources/Federal/waiver.html

State Plan Waiver documents:
https://www.azahcccs.gov/Resources/Federal/waiver.html

The below provider types are defined and included on the following pages of the 1115 Waiver:
https://www.azahcccs.gov/Resources/Downloads/Federal/AHCCCS_ExtensionSTCs_Final10142022.pdf

Integrated Clinics: 1115 Waiver, page 33
Primary Care Clinics: 1115 Waiver, page 33
Behavioral Healthcare Clinics: 1115 Waiver, page 33
Justice Clinic (FQHC/RHCs): 1115 Waiver, page 33
Clinics (pediatric, adult and family practice): 1115 Waiver, page 33

The below provider types are defined and included on the following pages of the State Plan: Attachment 3.1-A:
https://www.azahcccs.gov/Resources/Downloads/StatePlans/Section3/SP_3.1-A.pdf

Integrated Clinics: Attachment 3.1-A, page 4
Physicians, PAs, NPs: Attachment 3.1-A, page 2
FQHC/RHCs: Attachment 3.1-A, page 1
Clinics: Attachment 3.1-A, page 4

The below provider types are defined and included on the following pages of the State Plan: Attachment 3.1-A Limitations:
https://www.azahcccs.gov/Resources/Downloads/StatePlans/Section3/SP_3.1-A_Limits.pdf

Behavioral Health Outpatient: Attachment 3.1-A Limitations, page 9(h)
Behavioral Health Services: Attachment 3.1-A Limitations, page 5
Physicians, PAs, NPs: Attachment 3.1-A Limitations, pages 6 and 9(g)
Clinic services, Attachment 3.1-A Limitations, page 7

21. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(B), describe how the payment arrangement directs expenditures equally, using the same terms of performance, for the class or classes of providers (identified above) providing the service under the contract.

All providers selected and participating in the primary care, behavioral health or justice focus area are subject to the same milestones for area(s) of concentration in which they participate.

22. For the services where payment is affected by the state directed payment, how will the state directed payment interact with the negotiated rate(s) between the plan and the provider? Will the state directed payment:

a. ☐ Replace the negotiated rate(s) between the plan(s) and provider(s).

b. ☐ Limit but not replace the negotiated rate(s) between the plans(s) and provider(s).

c. ☒ Require a payment be made in addition to the negotiated rate(s) between the plan(s) and provider(s).

23. For payment arrangements that are intended to require plans to make a payment in addition to the negotiated rates (as noted in option c in Question 22), please provide an analysis in Table 2 showing the impact of the state directed payment on payment levels for each provider class. This provider payment analysis should be completed distinctly for each service type (e.g., inpatient hospital services, outpatient hospital services, etc.).

This should include an estimate of the base reimbursement rate the managed care plans pay to these providers as a percent of Medicare, or some other standardized measure, and the effect the increase from the state directed payment will have on total payment. *Ex: The average base payment level from plans to providers is 80% of Medicare and this SDP is expected to increase the total payment level from 80% to 100% of Medicare.*

If the state needs more space, please use Addendum 2.A and check this box: ☒

TABLE 2: Provider Payment Analysis

Provider Class(es)	Average Base Payment Level from Plans to Providers (absent the SDP)	Effect on Total Payment Level of State Directed Payment (SDP)	Effect on Total Payment Level of Other SDPs	Effect on Total Payment Level of Pass-Through Payments (PTPs)	Total Payment Level (after accounting for all SDPs and PTPs
Ex: Rural Inpatient Hospital Services	*80%*	*20%*	*N/A*	*N/A*	*100%*
a. See "Attachment A_TI 2.0_FFY27_ Addendum Table 2"					
b.					
c.					
d.					
e.					
f.					
g.					

24. Please indicate if the data provided in Table 2 above is in terms of a percentage of:

- **a.** ☐ Medicare payment/cost
- **b.** ☐ State-plan approved rates as defined in 42 C.F.R. § 438.6(a) *(Please note, this rate cannot include supplemental payments.)*
- **c.** ☒ Other; Please define: ACR and Medicare

25. Does the State also require plans to pay any other state directed payments for providers eligible for the provider class described in Question 20b? ☒ Yes ☐ No

If yes, please provide information requested under the column "Other State Directed Payments" in Table 2.

26. Does the State also require plans to pay pass-through payments as defined in 42 C.F.R. § 438.6(a) to any of the providers eligible for any of the provider class(es) described in Question 20b? ☐ Yes ☒ No

If yes, please provide information requested under the column "Pass-Through Payments" in Table 2.

27. Please describe the data sources and methodology used for the analysis provided in response to Question 23.

For FFY 2027, AHCCCS calculated the percentages outlined in Table 2/Attachment A based on Average Commercial Rate (ACR) for Justice and Behavioral Health Providers/Clinics. AHCCCS computed the percentages as a percent of Medicare for PCPs.

For Behavioral Health Outpatient/Integrated Clinics and Behavioral Health Providers Classes: AHCCCS computed the percentage estimates by looking at the total amount paid for these provider classes compared to the amount that would have been paid using rates listed in a third-party consultant Behavioral Health Rate Study that examined specific services that are paid to Behavioral Health Outpatient (BHOP)/Behavioral Health Providers and Integrated Clinics under this SDP. AHCCCS then applied the directed payment increase to calculate the impact of the SDP as a percentage of these rates.

For Justice Clinics: AHCCCS computed the percentage estimates by looking at the total amount paid for Behavioral Health and Physical Health to Integrated Clinics under this SDP.

For Behavioral Health services within Justice Clinics: AHCCCS compared to the amount that would have been paid using rates listed in a third-party consultant Behavioral Health Rate Study that examined specific services that are paid for Behavioral Health.

For Physical Health services within Justice Clinics, the Medicare rates were used for comparison. AHCCCS then applied the directed payment increase to calculate the impact of the SDP as a percentage of these rates.

For PCPs: the percentage estimates were computed by looking at the total amount paid compared to the amount that would have been paid using Medicare rates. AHCCCS then applied the directed payment increase to calculate the impact of the SDP as a percentage of these rates.

For each of the programs, AHCCCS then allocated amounts across the subcategories of Rural or Urban, according to actual utilization for each subcategory. The additional incentive funds for accredited NCQA providers are a single one-time payment.

In addition to the managed care base payments and the TI SDP, the analysis also included the following "Other SDPs":

- Differential Adjusted Payments (DAP)
- Access to Professional Services Initiative (APSI)

28. Please describe the State's process for determining how the proposed state directed payment was appropriate and reasonable.

As shown in Table 2, when considering managed care base payments and Targeted investment payments along with other SDPs for these provider classes, total managed care payments are estimated to be under Medicare and commercial reimbursement. AHCCCS believes the proposed payment increases are reasonable and necessary for achieving its goals and objectives for this directed payment arrangement, while establishing reimbursement levels that remain below Medicare and commercial rates for each class.

SECTION IV: INCORPORATION INTO MANAGED CARE CONTRACTS

29. States must adequately describe the contractual obligation for the state directed payment in the state's contract with the managed care plan(s) in accordance with 42 C.F.R. § 438.6(c). Has the state already submitted all contract action(s) to implement this state directed payment? ☒ Yes ☐ No

a. If yes:

i. What is/are the state-assigned identifier(s) of the contract actions provided to CMS?

ACC/ACC-RBHA YH19-0001 and YH19-0001R

ii. Please indicate where (page or section) the state directed payment is captured in the contract action(s).

Attachment F5

b. If no, please estimate when the state will be submitting the contract actions for review.

SECTION V: INCORPORATION INTO THE ACTUARIAL RATE CERTIFICATION

Note: Provide responses to the questions below for the first rating period if seeking approval for multi-year approval.

30. Has/Have the actuarial rate certification(s) for the rating period for which this state directed payment applies been submitted to CMS? ☐ Yes ☒ No

a. If no, please estimate when the state will be submitting the actuarial rate certification(s) for review.
10/31/2026

b. If yes, provide the following information in the table below for each of the actuarial rate certification review(s) that will include this state directed payment.

Table 3: Actuarial Rate Certification(s)

Control Name Provided by CMS (List each actuarial rate certification separately)	Date Submitted to CMS	Does the certification incorporate the SDP?	If so, indicate where the state directed payment is captured in the certification (page or section)
i.			
ii.			
iii.			
iv.			
v.			

Please note, states and actuaries should consult the most recent Medicaid Managed Care Rate Development Guide for how to document state directed payments in actuarial rate certification(s). The actuary's certification must contain all of the information outlined; if all required documentation is not included, review of the certification will likely be delayed.)

c. If not currently captured in the State's actuarial certification submitted to CMS, note that the regulations at 42 C.F.R. § 438.7(b)(6) requires that all state directed payments are documented in the State's actuarial rate certification(s). CMS will not be able to approve the related contract action(s) until the rate certification(s) has/have been amended to account for all state directed payments. Please provide an estimate of when the State plans to submit an amendment to capture this information.

Actuarial Contact Information for CMS Reference: Erica Johnson, ASA, MAAA, Chief Actuary, (erica.johnson@azahcccs.gov); Matt Varitek, FSA, MAAA, Actuary (matthew.varitek@azahcccs.gov); and Luna Zong, ASA, MAAA ,Actuary (luna.zong@

31. Describe how the State will/has incorporated this state directed payment arrangement in the applicable actuarial rate certification(s) (please select one of the options below):

- **a.** ☐ An adjustment applied in the development of the monthly base capitation rates paid to plans.
- **b.** ☒ Separate payment term(s) which are captured in the applicable rate certification(s) but paid separately to the plans from the monthly base capitation rates paid to plans.
- **c.** ☐ Other, please describe:

32. States should incorporate state directed payment arrangements into actuarial rate certification(s) as an adjustment applied in the development of the monthly base capitation rates paid to plans as this approach is consistent with the rate development requirements described in 42 C.F.R. § 438.5 and consistent with the nature of risk-based managed care. For state directed payments that are incorporated in another manner, particularly through separate payment terms, provide additional justification as to why this is necessary and what precludes the state from incorporating as an adjustment applied in the development of the monthly base capitation rates paid to managed care plans.

Implementation of TI payments as a separate payment term allows AHCCCS to ensure correct payments are made to providers and results in administrative efficiencies for all parties involved in the directed payment. AHCCCS believes it would be administratively burdensome to include this time-limited program in the capitation rates.

33. ☒ In accordance with 42 C.F.R. § 438.6(c)(2)(i), the State assures that all expenditures for this payment arrangement under this section are developed in accordance with 42 C.F.R. § 438.4, the standards specified in 42 C.F.R. § 438.5, and generally accepted actuarial principles and practices.

SECTION VI: FUNDING FOR THE NON-FEDERAL SHARE

34. Describe the source of the non-federal share of the payment arrangement. Check all that apply:

- **a.** ☐ State general revenue
- **b.** ☒ Intergovernmental transfers (IGTs) from a State or local government entity
- **c.** ☐ Health Care-Related Provider tax(es) / assessment(s)
- **d.** ☐ Provider donation(s)
- **e.** ☒ Other, specify: Designated State Health Programs (DSHP)

35. For any payment funded by **IGTs (option b in Question 34)**,

- **a.** Provide the following (respond to each column for all entities transferring funds). If the state needs more space, please use Addendum Table 4.A and check this box: ☐

Table 4: IGT Transferring Entities

Name of Entities transferring funds (enter each on a separate line)	Operational nature of the Transferring Entity (State, County, City, Other)	Total Amounts Transferred by This Entity	Does the Transferring Entity have General Taxing Authority? (Yes or No)	Did the Transferring Entity receive appropriations? If not, put N/A. If yes, identify the level of appropriations	Is the Transferring Entity eligible for payment under this state directed payment? (Yes or No)
i. 'alleywise, Maricopa Special Health Care Distric	Non-state public hospital district	$2,500,000.00	Yes	N/A	Yes
ii.					
iii.					
iv.					
v.					
vi.					
vii.					
viii.					
ix.					
x.					

b. ☒ Use the checkbox to provide an assurance that no state directed payments made under this payment arrangement funded by IGTs are dependent on any agreement or arrangement for providers or related entities to donate money or services to a governmental entity.

c. Provide information or documentation regarding any written agreements that exist between the State and healthcare providers or amongst healthcare providers and/or related entities relating to the non-federal share of the payment arrangement. This should include any written agreements that may exist with healthcare providers to support and finance the non-federal share of the payment arrangement. Submit a copy of any written agreements described above.

AHCCCS is including the fully executed IGA for reference. See "See Attachment B_FFY25-FFY27 TI 2.0 Support IGA_VWH_YH26-0042_signed_FE”

36. For any state directed payments funded by **provider taxes/assessments (option c in Question 34)**,

a. Provide the following (respond to each column for all entries). If there are more entries than space in the table, please provide an attachment with the information requested in the table.

Table 5: Health Care-Related Provider Tax/Assessment(s)

Name of the Health Care-Related Provider Tax / Assessment (enter each on a separate line)	Identify the permissible class for this tax / assessment	Is the tax / assessment broad-based?	Is the tax / assessment uniform?	Is the tax / assessment under the 6% indirect hold harmless limit?	If not under the 6% indirect hold harmless limit, does it pass the "75/75" test?	Does it contain a hold harmless arrangement that guarantees to return all or any portion of the tax payment to the tax payer?
i. N/A						
ii.						
iii.						
iv.						
v.						

b. If the state has any waiver(s) of the broad-based and/or uniform requirements for any of the health care-related provider taxes/assessments, list the waiver(s) and its current status:

Table 6: Health Care-Related Provider Tax/Assessment Waivers

Name of the Health Care-Related Provider Tax/Assessment Waiver (enter each on a separate line)	Submission Date	Current Status (Under Review, Approved)	Approval Date
i. N/A			
ii.			
iii.			
iv.			
v.			

37. For any state directed payments funded by **provider donations (option d in Question 34)**, please answer the following questions:

a. Is the donation bona-fide? ☐ Yes ☐ No

b. Does it contain a hold harmless arrangement to return all or any part of the donation to the donating entity, a related entity, or other provider furnishing the same health care items or services as the donating entity within the class?
☐ Yes ☐ No

38. ☒ **For all state directed payment arrangements**, use the checkbox to provide an assurance that in accordance with 42 C.F.R. § 438.6(c)(2)(ii)(E), the payment arrangement does not condition network provider participation on the network provider entering into or adhering to intergovernmental transfer agreements.

SECTION VII: QUALITY CRITERIA AND FRAMEWORK FOR ALL PAYMENT ARRANGEMENTS

39. ☒ Use the checkbox below to make the following assurance, "In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(C), the State expects this payment arrangement to advance at least one of the goals and objectives in the quality strategy required per 42 C.F.R. § 438.340."

40. Consistent with 42 C.F.R. § 438.340(d), States must post the final quality strategy online beginning July 1, 2018. Please provide:

- **a.** A hyperlink to State's most recent quality strategy: https://www.azahcccs.gov/PlansProviders/Downloads/QualityStrategyJuly2024Final.pdf
- **b.** The effective date of quality strategy. July 1, 2024

41. If the State is currently updating the quality strategy, please submit a draft version, and provide:

- **a.** A target date for submission of the revised quality strategy (month and year):
- **b.** Note any potential changes that might be made to the goals and objectives.

Note: The State should submit the final version to CMS as soon as it is finalized. To be in compliance with 42 C.F.R. § 438.340(c)(2) the quality strategy must be updated no less than once every 3-years.

42. To obtain written approval of this payment arrangement, a State must demonstrate that each state directed payment arrangement expects to advance at least one of the goals and objectives in the quality strategy. In the Table 7 below, identify the goal(s) and objective(s), as they appear in the Quality Strategy (include page numbers), this payment arrangement is expected to advance. If additional rows are required, please attach.

Table 7: Payment Arrangement Quality Strategy Goals and Objectives

Goal(s)	Objective(s)	Quality strategy page
Example: Improve care coordination for enrollees with behavioral health conditions	*Example: Increase the number of managed care patients receiving follow-up behavior health counseling by 15%*	*5*
a. Improve the health of AHCCCS members	Increasing members' access to integrated care that meets the member's' individual needs within their local communities.	36
b. Limit avoidable growth in healthcare costs while enhancing member access to quality care and services that address whole person care	Developing collaborative strategies and initiatives with state agencies and other external partners, such as: -Strategic partnerships to improve access to health care services and affordable health care coverage	37
c.		
d.		

43. Describe how this payment arrangement is expected to advance the goal(s) and objective(s) identified in Table 7. If this is part of a multi-year effort, describe this both in terms of this year's payment arrangement and in terms of that of the multi-year payment arrangement.

Targeted Investments 2.0 (TI 2.0) is a multi-year program that supports Arizona's goal to fully transform the Medicaid delivery system to an integrated whole person care structure by encouraging providers to thoughtfully develop infrastructure and protocols to optimize coordination of services designed to meet the member's acute, behavioral, and non-medical drivers of health and use population health techniques to identify and engage subpopulations with the poorest quality of health outcomes address identified health disparities amongst their patient populations. AHCCCS will achieve this goal by supporting providers throughout the state to develop and enhance care coordination processes with healthcare and community-based organizations and provide guidance, tools, and technical assistance for internal population health analyses. Provider payments are expected to advance the objectives listed in Table 7.

TI 2.0 Year 1 (FFY 23) payments supported the infrastructure and staffing enhancements needed to develop the program's future initiatives, such as identifying non-medical drivers of health to satisfy Year 2 (FFY 24) and Year 3 (FFY 25) milestones. Qualified participants must meet requirements such as having a certified Electronic Health Record (EHR) system that is capable of bi-directional data exchange, having minimum volume thresholds, and participating in the Learning/Quality Improvement Collaborative established to support TI program participants. The structure of the program includes milestones related to processes in Years 2 (FFY 24) and 3 (FFY 25) (e.g., establishment of a community provider registry, implementation of non-medical drivers of health screening and referral protocols, engaging subpopulations that experience poor health outcomes, and National Committee for Quality Assurance [NCQA] Healthcare Effectiveness Data and Information Set [HEDIS] performance measure targets in Years 4; FFY 26 and 5; FFY 27).

In addition, the payments are intended to enable the providers to establish systems and procedures that support the integration and coordination for provision of whole person care. For example, identifying behavioral health conditions in new caregivers, placing dental varnish in-office and/or connecting the individual to a dentist when they do not have one, and effective processes for community-based referrals.

Lastly, related to the Justice population, AHCCCS providers and probation/parole officers will be co-located in the same setting, ensuring access to forensic peer and family support services, coordination with release planning staff to engage members prior to release, and outreach to high-risk members. Most individuals released to community supervision will be applying for AHCCCS prior to release and will likely be Medicaid eligible for at least the first 6 months after release. For people who are already in the community on parole, the parole officers will be able to refer individuals to the co-located clinic where staff will complete Medicaid eligibility checks. If an individual is not Medicaid eligible, they will be connected to needed services or served with non-Medicaid funding.

44. Please complete the following questions regarding having an evaluation plan to measure the degree to which the payment arrangement advances at least one of the goals and objectives of the State's quality strategy. To the extent practicable, CMS encourages States to utilize existing, validated, and outcomes-based performance measures to evaluate the payment arrangement, and recommends States use the CMS Adult and Child Core Set Measures, when applicable.

a. ☒ In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(D), use the checkbox to assure the State has an evaluation plan which measures the degree to which the payment arrangement advances at least one of the goals and objectives in the quality strategy required per 42 C.F.R. § 438.340, and that the evaluation conducted will be *specific* to this payment arrangement. *Note:* States have flexibility in how the evaluation is conducted and may leverage existing resources, such as their 1115 demonstration evaluation if this payment arrangement is tied to an 1115 demonstration or their External Quality Review validation activities, as long as those evaluation or validation activities are *specific* to this payment arrangement and its impacts on health care quality and outcomes.

b. Describe how and when the State will review progress on the advancement of the State's goal(s) and objective(s) in the quality strategy identified in Question 42. For each measure the State intends to use in the evaluation of this payment arrangement, provide in Table 8 below: 1) the baseline year, 2) the baseline statistics, and 3) the performance targets the State will use to track the impact of this payment arrangement on the State's goals and objectives. Please attach the State's evaluation plan for this payment arrangement.

TABLE 8: Evaluation Measures, Baseline and Performance Targets

Measure Name and NQF # (if applicable)	**Baseline Year**	**Baseline Statistic**	**Performance Target**	**Notes**[1]
Example: Flu Vaccinations for Adults Ages 19 to 64 (FVA-AD); NQF # 0039	*CY 2019*	*34%*	*Increase the percentage of adults 18–64 years of age who report receiving an influenza vaccination by 1 percentage point per year*	*Example notes*
i. Child and Adolescent Well Care Visits (WCV)	FFY 2022	51.7%	62.0%	Description: The percentage of members ages 3–21 years of age who had one or more comprehensive Well-care visits with a primary care provider or OB/GYN during the measurement year. Numerator: One or more well-care visits during the measurement year. The well-care visit must occur with a PCP or an OB/GYN practitioner, but the practitioner does not have to be the practitioner assigned to the member. School-based health clinic visits count for this measure if they're for a well-care exam and the physician completing the exam is a primary care provider. A sports physical does not qualify for a well-care visit because it does not include required components for a well-care exam such as the health history, preventive care, behavioral and development screenings. Denominator: The eligible population attributed to Peds PCP and BH participating
ii. Follow-Up After Hospitalization for Mental Illness- Adult [7 Days] (FUH7-AD)	FFY 2022	81.6%	93.4%	Description: Percentage of discharges for members ages 18 and older who were hospitalized for a principal diagnosis of mental illness, or any diagnosis of intentional self-harm and had a mental health follow-up service. [The percentage o discharges where the member received follow-up within 7 days of their discharge]. Numerator: A follow-up visit with a mental health practitioner within 7 days after acute inpatient discharge. Visits that occur on the date of discharge will not count toward compliance. Telehealth and telephone visits are acceptable to address the care opportunity. Denominator: Patients 18 years of age and older who were discharged from an acute inpatient setting (including acute care psychiatric facilities) with a principal diagnosis of mental illness on or between January 1 and December 1 of the measurement period that were attributed to
iii. Follow-Up After Hospitalization for Mental Illness- Child [7 Days] (FUH7-CH)	FFY 2022	87.67%	96.6%	Description: Percentage of discharges for members ages 6-18 who were hospitalized for a principal diagnosis of mental illness, or any diagnosis of intentional self-harm and had a mental health follow-up service. [Percentage of discharges where the member received follow-up within 7 days of their discharge]. Numerator: A follow-up visit with a mental health practitioner within 7 days after acute inpatient discharge. Visits that occur on the date of discharge will not count toward compliance. Telehealth and telephone visits are acceptable to address the care opportunity. Denominator: Patients 6-18 years of age who were discharged from an acute inpatient setting (including acute care psychiatric facilities) with a principal diagnosis of mental illness on or between January 1 and December 1 of the measurement period that were attributed to
iv. Engagement of Substance Use Disorder Treatment (IET)	FFY 2022	36.8%	53.0%	Description: Percentage of patients 13 years of age and older with a new substance use disorder (SUD) episode who received the following; [Engagement- The percentage of patients who engaged in ongoing treatment including two additional interventions or medication treatment events for SUD, or one long-acting medication event for the treatment of SUD, within 34 days of the initiation]. Numerator: Engagement in ongoing SUD treatment within 34 days of initiation includes: 1. A long-acting SUD medication on the day after the initiation through 34 days after the initiation of treatment. 2. One of the following options on the day after the initiation of treatment through 34 days after the initiation of treatment: a) two engagement visits, b) two engagement medication treatment events, c) one engagement visit and one engagement medication treatment event.

1. If the State will deviate from the measure specification, please describe here. If a State-specific measure will be used, please define the numerator and denominator here. Additionally, describe any planned data or measure stratifications (for example, age, race, or ethnicity) that will be used to evaluate the payment arrangement.

c. If this is any year other than year 1 of a multi-year effort, describe (or attach) prior year(s) evaluation findings and the payment arrangement's impact on the goal(s) and objective(s) in the State's quality strategy. Evaluation findings must include 1) historical data; 2) prior year(s) results data; 3) a description of the evaluation methodology; and 4) baseline and performance target information from the prior year(s) preprint(s) where applicable. If full evaluation findings from prior year(s) are not available, provide partial year(s) findings and an anticipated date for when CMS may expect to receive the full evaluation findings.

Please see the attachment titled "Attachment C_TI 2.0_Evaluation_Findings_FFY 2027"

PREPRINT SECTION III: PROVIDER CLASS AND ASSESSMENT OF REASONABLENESS

ADDENDUM TABLE 2.A. PROVIDER PAYMENT ANALYSES

Column 1	Provider Class(es)	Average Base Payment Level from Plans to Providers (absent	Effect on Total Payment Level of	Effect on Total Payment Level of Other SDPs	Effect on Total Payment Level of Pass-Through	Total Payment Level (after accounting for all SDPs and
a.	PCP Urban (ACC/ACC-RBHA)	76.40%	2.15%	12.63%	N/A	91.18%
b.	PCP Urban NCQA (ACC/ACC-RBHA)	76.40%	2.31%	11.15%	N/A	89.86%
c.	PCP Rural (ACC/ACC-RBHA)	76.40%	2.15%	12.16%	N/A	90.71%
d.	PCP Rural NCQA (ACC/ACC-RBHA)	76.40%	2.31%	10.04%	N/A	88.75%
e.	BH Urban (ACC/ACC-RBHA)	65.88%	0.80%	1.14%	N/A	67.82%
f.	BH Urban NCQA (ACC/ACC-RBHA)	33.43%	0.41%	1.41%	N/A	35.26%
g.	BH Rural (ACC/ACC-RBHA)	65.80%	0.80%	1.16%	N/A	67.76%
h.	BH Rural NCQA (ACC/ACC-RBHA)	33.43%	0.41%	0.02%	N/A	33.86%
i.	Justice Urban (ACC/ACC-RBHA)	58.90%	1.55%	1.24%	N/A	61.69%
j.	Justice Urban NCQA (ACC/ACC-RBH	18.04%	0.51%	0.04%	N/A	18.59%
k.	Justice Rural (ACC/ACC-RBHA)	58.95%	1.55%	1.05%	N/A	61.55%
l.	Justice Rural NCQA (ACC/ACC-RBH	18.08%	0.51%	0.04%	N/A	18.63%

State Directed Payment Evaluation Findings Template

As indicated in the preprint, states must "describe prior year(s) evaluation findings and the payment arrangement's impact on the goal(s) and objective(s) in the states quality strategy" in "any year other than Year 1 of a multi-year effort." By providing evaluation data for each year of the payment arrangement, states will be able to understand the impact of the payment arrangement over time.

States may use the tables below to provide evaluation findings in their renewal preprints. The **tables are optional but** encompass CMS' expectations for what states include when sharing evaluation findings and describing their evaluation methodology.

Table 1. Arizona's Evaluation Findings for Targeted Investments (TI) 2.0, AZ_Fee_PC.BHO.Oth_Renewal_20261001-20270930 (Federal Fiscal Years 2022-2025)

Evaluation Data						
Metric Name	**Baseline Year**	**Baseline Statistic**	**Performance Target**	**FFY 2023**	**FFY 2024**	**FFY 2025**
Child and Adolescent Well-Care Visits (WCV) [1]	FFY 2022	51.7%	56.5%	51.0%	51.2%	60.6%
Follow-Up After Hospitalization for Mental Illness- Adult (FUH-7 AD)[2]	FFY 2022	81.6%	70.8%	82.3%	80.4%	92.9%
Follow-Up After Hospitalization for Mental Illness- Child (FUH-7 CH)[1]	FFY 2022	87.6%	80.0%	85.4%	83.9%	96.1%
Engagement of Substance Use Disorder Treatment (IET)	FFY 2022	36.8%	44.5%	36.3%	44.0%	52.2%

[1] WCV and FUH-7 CH are limited to members attributed to TI 2.0 Pediatric (PCP and BH, respectively).

[2] FUH-7 AD is limited to members attributed to TI 2.0 Adult BH participants only.

[3] In FFY 2025, ASU TIPQIC upgraded the TI 2.0 Year 4 performance measures from the MY 2023 to the MY 2025 HEDIS specifications. AHCCCS also approved H0023 as a numerator-qualifying code for the TI 2.0 FUH7 AD and FUH7 CH measures. Additionally, performance for the WCV measure now includes physician assistants as primary care providers.

*Federal fiscal year (FFY) refers to the measurement period of October 1st – September 30th

Note: The performance targets in Table 1 are reflective of the initial evaluation plan previously submitted and are not reflective of the updated performance measure rates. Please see Table 8 in the preprint document for the forward-facing performance targets.

Table 2. Arizona's Evaluation for: AZ_Fee_PC.BHO.Oth_Renewal_20261001-20270930.

Prompt	***Response***
Evaluation metrics	
Please share the data source(s) and year(s) of data used to calculate the evaluation metrics.	ASU Targeted Investments Program Quality Improvement Collaborative (TIPQIC) provided all data used to calculate the evaluation metrics. The data is reflective of Federal Fiscal Year (FFY) October 1st - September 30th, for FFY 2022-FFY2025.
Please confirm that the data used to calculate the evaluation metrics was limited to Medicaid managed care enrollees.	Yes, AHCCCS confirms that the data used was limited to Medicaid managed care enrollees only. ACC and ACC-RBHA lines of business only.
Please confirm that the data used to calculate the evaluation metrics was limited to providers participating in the payment arrangement.	Yes, AHCCCS confirms that the data used was limited to providers participating in the payment arrangement only.
Evaluation methodology	
Please identify the entity conducting the evaluation.	ASU TIPQIC and AHCCCS are the entities conducting the evaluation.
Please describe the analytic methods used to understand the impact of the payment arrangement. For example, comparison groups, pre-post study design, etc.	The TI-attributed rates for each measure are calculated at the end of each program year, so the amalgamation could be interpreted as an interrupted time series design. The WCV and FUH-7 CH measures are limited to members attributed to TI 2.0 Pediatric (PCP and BH, respectively) participants. The FUH-7 AD measure is limited to members attributed to TI 2.0 Adult BH participants only. All TI rates are calculated based on participating AHCCCS billing and servicing provider identification numbers of participating providers in the respective area of concentration. Please refer to Table 8 of the preprint for the listing of performance measures and forward-facing targets.
Please share any limitations of the state's evaluation plan.	There are no limitations to the state's evaluation plan.

Prompt	Response
Findings	
Please share the state's assessment of the impact of this payment arrangement.	The following impacts of the payment arrangement have been noted: • A significant theme emerging from discussions is the importance of creating a partnership framework that incorporates primary care, behavioral health, and social service agencies. There is an increased focus on standardizing data, enhancing equal access to health care, improving health care access through analyses, clarifying non-medical drivers of health (NMDOH) processes, and fostering collaboration with providers and community-based organizations to address social needs and improve care coordination. • Positive trend toward improved communication and coordination between primary and specialty care providers within TI participating organizations. • Demonstrated stability in care delivery and care coordination. • Children and their families generally experience high-quality, respectful communication from their doctors. • Generally comparable mental health outcomes between TI and non-TI beneficiaries. • Programmatic requirements led to the development of NMDOH screening and referral documentation using administrative methods, helping to systematically identify and address patients' social needs. This can improve patient experience by ensuring NMDOH are recognized and managed, resulting in more comprehensive, coordinated care that better supports overall well-being. • Performance trends were compared among the same providers over time. Attribution remained consistent across runs, so the performance decreases are unlikely due to attribution and are more likely the result of a system-wide impact. • TI providers demonstrated a stronger ability to sustain performance through the TI program, which helped them develop infrastructure that fostered resiliency under these challenges.
Please share any relevant context (e.g., changes to the managed care program) that may have impacted the evaluation results	In FFY 2025, the TI 2.0 program updated the Year 4 performance measures from the measurement year (MY) 2023 to the MY 2025 HEDIS specifications. AHCCCS also approved T1016 (already part of MY HEDIS 2025) and H0023 as numerator-qualifying codes for the TI 2.0 FUH7-AD and FUH7-CH

Prompt	Response
	measures. These additions improve consistency in reporting, better capture services provided to justice-involved and behavioral health populations and recognize the role of ancillary services in advancing population health and supporting inclusive, whole-person care. Additionally, performance for the WCV measure now includes physician assistants (PAs) as eligible primary care providers. This update reflects current practice within the AHCCCS system, where many adolescent members are assigned to PAs as their managed care organization (MCO)-assigned primary care provider (PCP), resulting in more accurate measurement of preventive care. The results in Table 1 were recalculated using the FFY 2025 TI 2.0 attribution methodology and applied to prior program years for comparison purposes. As a result, these results differ from those produced using the attribution methodology in effect during FFY 2022. Engagement of Substance Use Disorder Treatment (IET): The modified IET quality metric was retired and replaced with the unmodified IET quality metric to better align with the current program quality measures and provider incentive structure. Justice Clinic providers are incentivized on the IET measure in TI 2.0, rather than the IET Modified measure from TI 1.0. The focus is on measures that are actively incentivized and inform current quality improvement efforts, rather than measures from the first program iteration. Note: On Table 8 of the previous year's preprint, the IET measure was incorrectly labeled as IET Modified instead of IET without modifications. This was updated in Table 8 of the preprint document for this submission to reflect the correct naming of the IET measure. Membership Declines: AHCCCS membership increased by 85,000 from July 2022 to July 2023 but then decreased by 244,000 members from July 2023 to July 2024 (acute population excluding FES). The reduction in membership, driven by national Medicaid policy changes, is potentially disruptive to providers in terms of revenue, staff availability, and training. Additionally, changes to the underlying risk pool for the target population resulting from these disenrollments remain unknown until further policy analysis is conducted. Behavioral health services may be more impacted by membership declines than other specialties, which can limit providers' ability to best serve their patients under greater staff constraints and increased service demands.

Prompt	*Response*
For all evaluation metrics that did not improve over baseline, please share any plans the state has to address declining performance.	All four quality measures (WCV, FUH-7 AD, FUH-7 CH, and IET) improved from baseline statistics and the previous year's performance. The following actions will continue to be implemented; • The provider incentive structure is intended to incentivize improved performance and align with the current program quality measures. In Year 4 of the TI program (FFY 2026), the TI program ties select performance measures to a total of 50% of the total annual TI financial incentive payment. • All TI 2.0 participating organizations will need to complete milestone requirements to earn incentive payment. • QIC workgroups and dashboards to track performance are intended to further support participating providers in identifying areas of opportunity as well as provide tracking and trending of performance during the measurement year. • AHCCCS continues to partner with ASU TIPQIC to support providers in their efforts and provide data feedback and benchmarking through personalized dashboards; educate TI participants on and assist with quality improvement (QI) strategies and techniques; distribute best practices and facilitate peer learning; aid TI participants' with improving internal reporting processes and identifying areas for improvement; maximize the opportunity to achieve performance measure targets; provide Continuing Education (CE) credits for Medical, Nursing, Psychology, Social Work, and Interprofessional certifications. AHCCCS and ASU TIPQIC hold regular meetings to provide assistance. AHCCCS continues to partner with ASU TIPQIC to provide Quality Improvement Collaboratives (QICs). As part of their participation in the TI program, providers are encouraged to engage in QICs. Participation in QICs is tied to a percentage of the provider incentive TI providers can earn each year of the TI program. • Enhancing data systems and analytics remains a critical area for ongoing focus. AHCCCS partners with ASU TIPQIC to develop and

Prompt	*Response*
	maintain dashboards that allow TI providers to view their performance on their TI measures.