Arizona Olmstead Plan

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Introduction:

Olmstead is a 1999 United States Supreme Court decision that provided a legal framework for the efforts of federal and state governments to integrate persons with disabilities into the communities in which they live. The population targeted to benefit from the Olmstead Plan consists of individuals who may be at risk of institutionalization, including individuals with behavioral health needs and members of the Arizona Long Term Care System (ALTCS) program, hereby collectively referred to as "members" throughout the Plan. Olmstead is intended to remove unnecessary segregation of members from the broader community and to ensure that members receive services in the most integrated setting appropriate to their needs.

Although the Supreme Court did not require state Medicaid programs to develop a plan, Arizona officials chose to create a plan as an opportunity for advocates, agencies, members, and community stakeholders to work together on a guide to further improve access to services for members and ensure they live and receive services in the most appropriate integrated setting in their community. AHCCCS considers the Olmstead Decision an opportunity for self-examination and an ongoing process to improve quality when establishing service delivery priorities in the context of other critical issues.

In 2001 (and subsequently in 2003), AHCCCS worked with the Arizona Department of Health Services (ADHS) and the Arizona Department of Economic Security (ADES) to develop and update the state's first Olmstead Plan.

Arizona's Practice of Advancing Olmstead:

AHCCCS has a history of innovation in health care that aligns with and advances Olmstead principles and practices, including system changes to and from integrated service delivery models to current priorities targeted to meet the needs of the whole person by seeking to address social risk factors of health experienced by members. Both of these efforts are designed and intended to streamline care coordination and communication, reduce fragmentation, and improve health outcomes for members.

Historically, the ALTCS program has been well-regarded and served as a model for other states with respect to integrated care models and community-based placement rates. Beginning in 1989, members of the ALTCS program, who are individuals that are elderly and/or have physical disabilities, have received their physical, behavioral, and long-term services and supports (LTSS) through one Managed Care Organization (MCO). Beginning in 2019, the ALTCS program for members with developmental and intellectual disabilities adopted a partially integrated model whereby members receive physical and behavioral health care from one MCO and the LTSS are provided by ADES. Designed to support members

to live and receive services in community-based settings, the ALTCS program has supported members to reside either in their own home or an alternative residential setting (e.g., assisted living facility, group home). Historically (2009), the percentage of ALTCS members residing in their own homes was as low as 49% and has currently grown to maintain a rate of 72% (since 2020), while the percentage of ALTCS members residing in institutions declined from 31% (2009) to the current rate of 9% (since 2020). The percentage of ALTCS members residing in alternative residential settings remains stable at 19% for the past five years. More information about the specific program elements employed by AHCCCS and the MCOs to support community-based care for ALTCS members may be found in the Home and Community Based Services Report provided to CMS on an annual basis and posted to the AHCCCS website.

Integrated service delivery models afford members the opportunity to receive coordinated access to both physical and behavioral health care needs in community-based settings, thereby reducing the risk of institutionalization by creating more potential opportunities for members to elect voluntary treatment. Beyond the ALTCS program, AHCCCS has applied a number of integrated delivery system models for the broader Medicaid membership, affording members to have access to physical health and behavioral health services through one MCO while ensuring that the MCO can also serve as a Medicare health plan for members with dual eligibility (Medicaid and Medicare). Specialty membership populations, such as children with special health care needs or individuals with a Serious Mental Illness (SMI) determination, also have the same access to an integrated MCO. More information on AHCCCS' system integration initiatives may be found on the AHCCCS website.

AHCCCS has also sought to integrate service delivery at the provider level by creating a one-stop-shop location point as an option for service delivery, which provides members access to medical services in the same place they would receive other services. Accessing services in one location reduces fragmentation and promotes care coordination to reduce gaps in care and thereby limits risks to institutionalization. One notable example is the Targeted Investment (TI) Program that began in 2017; TI is aimed at providing financial incentives to eligible AHCCCS providers who meet certain benchmarks for integrating and coordinating physical and behavioral health care for members. The TI Program incentivizes prescribed care coordination processes for different participating groups, such as justice clinics (e.g., required Forensic Peer and Family Support Training); adult health care providers (e.g., screening all members for social risk factors and behavioral health disorders); and pediatric health care providers (e.g., requirement to identify community-based resources and referral procedures for members). In the same vein, with the appropriation of additional state General Fund dollars, AHCCCS was able to expand and prioritize the provision of behavioral health services in schools. More information about the Targeted Investment Programs and behavioral health services in schools is available on the AHCCCS website.

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AHCCCS has adopted a culture of engagement and transparency with the community of stakeholders and, as a matter of practice, designs and implements system innovations resembling general Olmstead planning principles, while purposefully involving individuals affected by the changes and those with an otherwise vested interest in the service delivery system. The original 2001 Olmstead Plan was guided by planning principles set forth by CMS to develop a plan with the following intentions:

- Striving for outcomes of serving members in the most integrated setting appropriate,
- Involving members in the planning process,
- Assessing for opportunities to reduce and prevent institutionalization,
- Ensuring the availability of community-integrated services,
- Offering members and their families the opportunity to make informed decisions and choices regarding how their needs can best be met in community or institutional settings, and
- Evaluating implementation informed by quality assurance and improvement processes.

AHCCCS regularly employs these principles and practices as standards to inform plans for system changes as evidenced by the following examples.

Housing and Health Opportunities (H2O) Waiver Amendment - On 10/14/22, CMS approved Arizona's request for a five-year extension of its 1115 Waiver, continuing the long-standing authorities and programs that have made Arizona's Medicaid program innovative, effective, and efficient. In addition to renewing the historic programs, this 1115 Waiver includes approval for transformative projects intended to advance member health outcomes. This includes the AHCCCS Housing and Health Opportunities (H2O) demonstration. The goal of the AHCCCS H2O demonstration is to enhance and expand housing services and interventions for AHCCCS members who are homeless or at risk of becoming homeless. Under this demonstration proposal, the agency will seek to:

- Increase positive health and wellbeing outcomes for target populations, including the stabilization of members' mental health conditions, reduction in substance use, improvement in the utilization of primary care and prevention services, and increased member satisfaction,
- Reduce the cost of care for members successfully housed through decreased utilization of crisis services, emergency department utilization, and inpatient hospitalization, and
- Reduce homelessness and improve skills to maintain housing stability.

H2O is an example of AHCCCS' drive to innovate community-based care for targeted populations by providing transitional housing and/or expanding access to supportive services to ensure housing stability.

Behavioral Health Continuum of Care - AHCCCS facilitated an extensive stakeholder engagement process in May 2019 to assess and provide recommendations to enhance the service delivery system. The focus was on ensuring an array of options available to members on the continuum aimed at supporting individuals to receive treatment in the clinically appropriate least restrictive environment, creating opportunities for members to elect voluntary treatment. In addition to the original six monthly meetings whereby roughly 90 stakeholders contributed, stakeholders continued to participate in workgroups focusing on implementing recommendations specific to membership populations (children, adults experiencing General Mental Health/Substance Use challenges, and members with SMI determinations). In 2022, AHCCCS published a report of the progress of the recommendations proposed by the stakeholders, including changes that have been implemented, planned, or are under further review by the agency. This effort is a testament of AHCCCS' engagement with the community of stakeholders impacted by the delivery system to assess needs and make recommendations, while also providing transparency into the progress of implementation.

American Rescue Plan (ARP) Act - AHCCCS is leveraging resources available to utilize time-limited funding to expand and complement existing home and community-based programming, including members who are aging, members with disabilities, members with a SMI determinations, members accessing General Mental Health/Substance Use (GMH/SU) services, and children with behavioral health needs. One of the main philosophies of the ARP spending plan is to ensure continued access to community-based care by upholding the viability of provider agencies, and the provider network as a whole, while also ensuring the agencies have competent staff capacity to maintain quality of care, both of which were affected by the COVID-19 Public Health Emergency (PHE). This prioritization in the ARP spending plan demonstrates AHCCCS' commitment to network and workforce development as key drivers of the availability and accessibility of community-based services.

Home and Community Based Settings (HCBS) Rules - AHCCCS utilized the HCBS Rules to establish new standards by which to measure residential and non-residential settings in their efforts to support members to integrate into their community of choice and have full access to the benefits of community living. AHCCCS views the HCBS Rules as the equivalent of basic rights afforded to the ALTCS membership. The HCBS Rules will continue to reinforce Arizona's priority to support members to live and receive services in the most integrated setting. While maintaining a priority on ensuring individuals live in the most integrated setting, the HCBS Rules support focused

attention on prioritizing members to receive services in the most integrated setting by creating standards to be met by providers to ensure members are also actively engaged and participating in their communities to the same degree as any other Arizonan through employment, education, volunteerism, and social and recreational activities. The residential and non-residential providers were required to come into compliance by March 2023 in order to continue to receive Medicaid reimbursement for services. This is an example whereby AHCCCS is not just satisfied with simply providing community-based care but rather advancing the system to support members in fundamental human experiences of making meaningful contributions, relationships, and community engagement that lead to better health outcomes. The annual assessments used by MCOs to assess HCBS Rules compliance contained a member survey to be used to validate both provider self-assessments and the MCOs' overall findings of the assessments. To assess systemic level compliance, AHCCCS will be using the National Core Indicator (NCI) surveys.

While the Olmstead Plan was last updated in 2003, AHCCCS (in partnership with the relevant ADHS and ADES state partners) continued to not only accomplish the action items in the plan but have furthered the next iteration of the intended delivery system changes, contract and policy changes, and/or program and project initiatives. To demonstrate this fact, the following chart outlines a few examples of action plans in the 2001 version of the plan (and later updated in 2003) that have been accomplished and how the overall intention of the activity has progressively evolved into common practices or initiatives in the present day.

Focus Area	2003 Plan Accomplishments	Present Day Practices/Initiatives
Member Voice and Choice	Establishment of ALTCS Member/Provider Councils within each MCO contract.	Establishment of an Office of Individual and Family Affair (OIFA) within each MCO contract.
Placement Rates	Offer financial incentives to MCOs to continue improving HCBS placement rates for in-home and alternative residential placements.	Established performance targets in contract for MCOs to work towards moving people from alternative residential placements into their own homes.
Network Adequacy	Annual Network Development and Management Plans are required of MCOs.	Annual Workforce Development Plans are required of MCOs to ensure providers have enough competent staff to provide care.

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Focus Area	2003 Plan Accomplishments	Present Day Practices/Initiatives
Employment Services	Transition coordination and payment of long-term employment services from the ADES/Rehabilitation Services Administration to Medicaid coordinated by the MCOs.	Instituted policy for MCOs pertaining to the expectations for the provision of employment services.
Person-Centered Planning	Enhancement of the Person-Centered Planning process by ADES/DDD.	A new Person-Centered Service Planning process and standardized tool is being used by all ALTCS MCOs and focuses on personal goals and community integration.
Discharge Planning	Cross-agency Arizona State Hospital (ASH) discharge planning coordination.	MCOs are required to have policies and procedures, high-touch care management and behavioral health services, and provide status reports on discharged members.
Assertive Community Treatment (ACT)	Establishment of ACT teams.	As of January 2024, there are a total of 33 ACT teams across the state. AHCCCS has expanded ACT funding to increase capacity statewide, including four (4) ACT teams in northern Arizona and two (2) specialty ACT teams in Central Arizona. AHCCCS will also be working on creating capacity within these ACT teams to serve members with I/DD.
Consumer-Run Agencies	Expand consumer-run agencies.	Criteria and processes established for identifying new consumer- and family-run agencies.
Child and Family Teams (CFT)	Development of CFT practice and training.	Creation of protocols in policy, training competencies, and verification of competencies of facilitators and MCO monitoring standards.

Focus Area	2003 Plan Accomplishments	Present Day Practices/Initiatives
Service Delivery Model Expansion	Implementation of Spouse as Paid Caregiver and Self-Directed Attendant Care ALTCS in-home care service delivery models.	Implemented *Agency with Choice* model to afford members an opportunity to direct their care while also receiving support from the agency.

Arizona's Olmstead Plan In Development:

In July 2021, AHCCCS developed an Olmstead web page on the AHCCCS website that includes important Olmstead information designed to educate and update stakeholders and interested parties. AHCCCS also created an Olmstead Survey, which was designed to inform the updates to the Olmstead Plan by seeking input from members, family members, provider staff, and representatives from health plans and state agencies. This survey, summarized on the Olmstead web page (www.azahcccs.gov/Olmstead), was distributed to various stakeholder groups and added to the Olmstead web page for interested parties to access and respond. AHCCCS convened a workgroup, including members and family members across the state, to advise on the development of the Arizona Olmstead Plan, while bringing lived experiences to the table. AHCCCS also hosted two Olmstead Community Forums to educate stakeholders about the past, present, and future of the Arizona Olmstead Plan and seek additional feedback on the future areas of focus for Olmstead planning. For more information on updates and ways to engage in Olmstead planning, please visit www.azahcccs.gov/Olmstead.

It is important to note that the Plan is limited in scope to initiatives for which AHCCCS can have a direct impact on systemic change. With that said, AHCCCS acknowledges that there may be other critical infrastructure such as transportation, affordable housing, and education that can support members to have access to supports and services to live and be actively engaged in their communities. AHCCCS will continue with existing collaboration opportunities with state agencies and community-based organizations to further identify non-Medicaid services and support for Medicaid members, while welcoming new collaboration opportunities. The Olmstead Plan does not include all of AHCCCS' efforts to comply with the spirit and underlying principles of the Olmstead decision that ensure the provision of services and treatment in the most integrated setting. The Olmstead Plan represents specific targeted strategies that are directed at the reduction of institutionalization and supporting the successful transition of members from institutional settings into community-based living and service delivery.

Evaluation and Transparency:

The intent of the design of the Olmstead Plan is for it to be both an actionable and "living" plan. The plan contains specific timelines for objectives that are directed at completing a specified process while also including, as applicable, performance targets to measure positive change resulting from the objectives. It is important to note that not all objectives will have performance targets. With some objectives, the objective itself is the performance target and with others, performance targets may be added in the future when determined appropriate.

AHCCCS plans to post updates to the plan, when available, as well as available data on outcomes, ensuring the protection of member health information. AHCCCS plans on providing quarterly updates during AHCCCS Community Forums on accomplishments made during the quarter and to gather input from the stakeholders. AHCCCS also plans on providing annual updates to various committees and councils, such as the State Medicaid Advisory Committee (SMAC), Tribal Consultation, the Behavioral Health Planning Council (BHPC), the ALTCS Advisory Council, and the Office of Individual and Family Affairs (OIFA) Advisory Council. Annually, AHCCCS will hold a public comment period and convene stakeholder forums to conduct a reassessment of needs by soliciting input and feedback on the progress of the current plan, while considering suggestions for new areas of focus. Furthermore, AHCCCS has required the MCOs to review the Olmstead Plan on a regular basis, including any updates and progress made, with Member Advocacy Councils and Governance Committees to seek any feedback and recommendations. AHCCCS will also consider input received from stakeholders throughout the year. For more information on how to stay informed of opportunities for input on the Olmstead Plan, please visit www.azahcccs.gov/Olmstead. Here, interested parties have the option to:

- Subscribe to updates to receive the latest news regarding the Olmstead Plan,
- Receive information about open public comment periods, and
- Locate the Olmstead email address to share input to AHCCCS on Olmstead planning at any time.

AHCCCS will develop a one-page document as a companion to the Plan to outreach and inform interested parties about its contents and opportunities to share input with AHCCCS. AHCCCS will post the document to the Olmstead web page, promote the information in stakeholder meetings, and encourage partnering organizations to distribute the material to their respective audiences. AHCCCS will also develop an Olmstead Plan orientation to serve as a companion to both the Olmstead Plan and the one-page document in order to support awareness of the Olmstead Plan.

Lastly, under each strategy listed, AHCCCS has included a section to record a running list of major accomplishments that have occurred based on activities listed within the objectives and performance targets in order to track the successes of each strategy.

Concerns About Access to Care and Quality of Care

AHCCCS will develop a document as a companion to the Olmstead Plan that will outline the different ways to file a complaint, report an access to care issue, or appeal a health care coverage decision. The document will have a workflow that will explain how to report these to a provider, a health plan, or directly to AHCCCS.

AHCCCS currently has the following educational documents available to everyone with information on how to file a complaint, grievance, or appeal.

- Making a Complaint (Member Grievance) for all AHCCCS Members
- SMI Grievance Process
- How To File A Grievance For Arizona Long Term Care Services (ALTCS) Members with a Serious Mental Illness (SMI) Determination
- How to File an Appeal of a Health Care Coverage Decision

Members, or other individuals, with concerns about a member experiencing a barrier to receiving health care services, or has concerns about the quality of services received, can report that information directly to AHCCCS by email, by phone, or online. Information on how to report is provided on the AHCCCS website.

Arizona Olmstead Plan - Summary Overview

#	Strategy
1	**Effective Permanent Supportive Housing (PSH) for members to successfully reside in the community** – Increase housing choice and opportunities for individuals and ensure necessary support services are available to assist members to obtain and maintain the least restrictive, most integrated community setting possible.
2	**Reach-in discharge planning for hospital settings** – Increase the ease of access for care coordination and discharge planning for members in hospital settings, while reducing outpatient service barriers.
3	**Reach-in discharge planning for the justice system** – Improve discharge planning, reach-in care coordination, and service delivery for members exiting the justice system.
4	**Expansion of Home and Community-Based Services (HCBS) for aging individuals with Serious Mental Illness (SMI) determinations** – Explore the feasibility of expanding HCBS for the aging SMI population.
5	**Workforce Development initiatives** – Implement programs and systems that will enhance the capacity, capability, and commitment of the health care workforce.
6	**High quality network to ensure members are served in the most effective and least restrictive manner** – Ensure services are provided by high quality network providers in a timely manner.
7	**Person-centered planning enhancements** - Improve monitoring with service and treatment planning standards for Managed Care Organizations (MCOs).
8	**Aggregated Population Data** - Identify and monitor data to provide a systemic level review of members transitioning to least restrictive settings.

Strategy #1: Effective Permanent Supportive Housing (PSH) for members to successfully reside in the community

Objective #1	Target Date	Performance Targets	Progress Summary
Address barriers to the financing and delivery of supportive housing support and wrap-around services.			
A. Review and update the AHCCCS Medical Policy Manual (AMPM) Title XIX/XXI Behavioral Health Service Benefit policy (AMPM 310-B) to clarify expectations on housing support and wrap-around services and benefits related to Medicaid funding.	4/2024		
B. Modify the AHCCCS Contractor Operations Manual (ACOM) Housing policy (ACOM 448) to clearly outline how Medicaid services may be used to help members obtain and maintain housing.	1/2024 7/2024[1] 10/2024	• Transition and update ACOM 448 to AMPM 320-H and educate impacted MCOs. • Develop standardized training around evidenced based practices related to Permanent Supportive Housing. • Roll out standardized training and develop a tracking system to ensure all identified providers complete the training.	AHCCCS Housing team updated ACOM 448 and transitioned it to AMPM 320-H. It is currently under AHCCCS Executive Management review. Once complete, it will be sent out for public comment.

[1] Changed from 1/2024 to 7/2024 as the AHCCCS Housing team continues to work through the development of the standardized training around the evidence-based practice of PSH.

C. Establish baseline data on current utilization of existing housing support and wrap-around services to determine how services are being utilized to meet members' housing needs and to strategize opportunities for improvement.	7/2024		In order to establish baseline data, AHCCCS is working in partnership with the Statewide Housing Administrator to receive reports from the health plans on the supportive services members are receiving while they are in the AHCCCS Housing Program (AHP).
Objective #2	**Target Date**	**Performance Targets**	**Progress Summary**
Expand access and range of housing settings for all eligible populations.			
A. Develop new transitional housing options to facilitate transition from residential, inpatient, the justice system, and housing instability to the least restrictive community-based settings.	10/2024 7/2025	• Increase the number of transitional housing units to 50 • Maintain or exceed 95% occupancy across all units each month.	Currently working with the Arizona Department of Administration (ADOA) on the construction of Bower Park, which will be a new transitional housing facility in downtown Phoenix for individuals experiencing homelessness and living with an SMI determination.
B. Use covered Medicaid housing support services and partner with housing providers (e.g., Public Housing Authorities, 811 Project Rental Assistance, etc.) to expand permanent, community-based housing options.	7/2023 (Completed) 10/2026	• Establish baseline data of existing housing options provided to Medicaid members in conjunction with Medicaid covered services at the site. • Increase the number of housing units by 10%.	
Objective #3	**Target Date**	**Performance Targets**	**Progress Summary**
Increase speed with which appropriate housing options can be identified and provided.			

A. Strengthen screening, assessment, in-reach, outreach, member provider choice, and service coordination processes.	10/2024 10/2024	• Increase the number of members on the AHCCCS Housing Program (AHP) wait list who are identified on the Homeless Management Information System (HMIS) Unsheltered Reports. • Increase the number of providers who provide PSH following fidelity from the Substance Abuse and Mental Health Services Administration (SAMHSA).	The health plans have received the corresponding HMIS report to begin care coordination and ensure eligible AHCCCS members are referred to the AHP. AHCCCS' Integrated System of Care (ISOC) team is currently working on publishing a new policy titled "Implementation and Fidelity Monitoring of SAMHSA Evidence-Based Practices" to improve tracking towards this measure.
B. Improve PSH stability for members in AHCCCS Housing Programs (AHPs).	1/2024 (Completed) 7/2024[2] 7/2024[3]	• Establish baseline data for length-of-stay in AHCCCS housing units in order to determine subsequent strategies. • Reduce Behavioral Health Residential Facility (BHRF) utilization for members who reside in PSH. • Establish baseline data for the number of members residing in PSH who undergo Court-Ordered Evaluations (COEs) and strategize for a reduction in COEs.	As of SFY 2020, there was an 89% reduction of BHRF utilization for members in PSH compared to the previous year. AHCCCS is currently working on reports to monitor this data ongoing.

[2] Changed from 1/2024 to 7/2024 as the annual housing report requires more time for completion.
[3] Changed from 1/2024 to 7/2024 as the data pull requires more time for completion.

C. Utilize a standardized assessment tool to evaluate the most appropriate and least restrictive housing settings and supportive services.	10/2024 10/2024	• Review LOCUS utilization and evaluate opportunities for it to be the standardized assessment tool. • Develop standard prioritization criteria across available housing resources to improve care coordination and more quickly provide housing options to members.	

Strategy #1 Accomplishments **Effective Permanent Supportive Housing for members to successfully reside in the community**
Objective 2.B: As of June 2023, AHCCCS is leveraging supportive services to support 2,964 units through partnerships with housing providers. As of January 2024, the length of stay in AHCCCS Housing Program (AHP) is 1,338 days (approximately 3 ½ years).

Strategy #2: Reach-in discharge planning for hospital settings			
Objective #1	**Target Date**	**Performance Targets**	**Progress Summary**
Develop contract, policy, and/or other guidance document changes for Managed Care Organizations (MCOs) to strengthen provider oversight and compliance with care coordination and discharge planning.			
A. Increase usage of *Child and Adolescent Level of Care Utilization System* (CALOCUS) as standardized assessment tools used by the Provider network to determine service level needs across all MCOs.	10/2024	• Monitor and evaluate CALOCUS utilization on an organizational/ provider level with technical assistance and compliance action implemented based on qualitative and quantitative data.	
B. Evaluate the use of the *Level of Care Utilization System* (LOCUS) standardized assessment tool by the Provider network to connect members to the most appropriate and least restrictive services and level of care across all MCOs.	10/2024	• Evaluate current LOCUS utilization and feasibility of expanding through the adult system of care.	
Objective #2	**Target Date**	**Performance Targets**	**Progress Summary**
Use CommunityCares, the statewide Closed-Loop Referral System (CLRS), for members exiting hospital settings to increase member access to community resources addressing social risk factors of health.			

A. Monitor usage of CommunityCares by hospital/inpatient providers to community resources.	1/2025	• 30% of participating hospitals/inpatient providers will be facilitating at least 10 member referrals (on average) per month using CommunityCares.	Key Performance Indicators (KPIs) were established for tracking the number of referrals each month. AHCCCS is offering providers a Differential Adjusted Payment (DAP) incentive to sign on to the CLRS and begin using it for at least 10 member referrals a month.

Strategy #2 Accomplishments Reach-in discharge planning for hospital settings

Strategy #3: Reach-in discharge planning for the justice system

Objective #1	Target Date	Performance Targets	Progress Summary
Develop relationships with counties/ justice settings currently not participating in data sharing with AHCCCS to support enrollment suspense.	4/2024	• Encourage new counties/justice settings to participate in data sharing with AHCCCS, prioritizing outreach to counties with higher population density.	Since June 2023, there have been 3 new counties (Apache, Mohave, and Pima) that have transitioned from a manual process to an automated process for booking/releasing Medicaid members, making a total of 8 counties. Two additional counties (Gila and Navajo) are nearing implementation of their automated booking/release processes.
Objective #2	**Target Date**	**Performance Targets**	**Progress Summary**
Monitor enrollment suspense/pre-release inmate applications for care coordination.	6/2024[4]	• Collaborate with the Arizona Department of Corrections, Rehabilitation & Reentry (ADCRR) to develop a tracking mechanism that captures pre-release application data, identifies trends, and informs streamlined processes.	

[4] Changed from 1/2024 to 6/2024 as AHCCCS is currently working on a data request to comprehensively validate/inform reach-in data, which will be used to collaborate with ADCRR to identify a more appropriate metric to capture pre-release trends.

Objective #3	Target Date	Performance Targets	Progress Summary
Develop a discharge planning process which ensures inmates obtain medically necessary Durable Medical Equipment (DME) immediately upon release.	6/2024[5]	• Implement standardized process for pre-release coordination of medically necessary services, including DME, developed between justice system partners and AHCCCS health plans.	
Objective #4	**Target Date**	**Performance Targets**	**Progress Summary**
Use the Justice Reach-In Monitoring Report to analyze member-level data for justice-involved members with chronic and/or complex physical and/or behavioral health needs.			
A. Monitor members who have received a reach-in care coordination service based on referral from the justice system and verify service delivery following release.	10/2024	• Conduct a quality audit utilizing a statistically significant sample size to evaluate services received following release and evaluate system improvement efforts to increase service connection.	

[5] Changed from 4/2024 to 6/2024 as progress towards this objective will be made once the reach-in data request is implemented from Objective #2.

B. Perform utilization analysis to evaluate services provided post-release as compared to individuals being released who have not received a reach-in service to determine trends on: ○ Emergency Department usage, ○ Crisis Utilization, ○ Inpatient Stays, and ○ Rates of members returning to the justice system (recidivism).	10/2024		
C. Develop a baseline for desired outcomes and use the data to inform performance criteria/goals for Managed Care Organization (MCO) requirements.	10/2024		
D. Review and update contract, policy, and/or other guidance document changes to enhance MCO oversight and compliance with care coordination and discharge.	10/2024		
Objective #5	**Target Date**	**Performance Targets**	**Progress Summary**
Explore the use of CommunityCares, the statewide Closed-Loop Referral System (CLRS), in the justice system to increase member access to community resources addressing social risk factors of health.			

A. Collaborate with ADCRR and county jails to establish the types of justice settings that would be able to utilize the CLRS.	4/2024[6]	• Outline the types of justice settings that could benefit from participating in the CLRS and establish prioritization of implementing statewide, starting with at least one pilot site location.	AHCCCS has identified ADCRR and Maricopa County as the initial justice settings to connect members to services for health-related social needs prior to release and will begin working with them and Contexture, the organization that manages the CLRS, to start the enrollment and onboarding process for the pilot sites.
	1/2025	• Implement use of the CLRS in the justice system statewide based on the predetermined prioritization of settings from ADCRR and county jails.	
	4/2024[7]	• Explore with the justice liaisons from all MCOs the feasibility of monitoring and tracking of inmates who are scheduled for release with housing insecurity to be able to receive discharge planning assistance and reduce discharges to homelessness.	

Strategy #3 Accomplishments **Reach-in discharge planning for the justice system**

[6] Changed from 1/2024 to 4/2024 as the types of justice settings have been identified but the pilot sites have not started.
[7] Changed from 1/2024 to 4/2024 as this topic will be discussed at an upcoming justice liaison meeting.

Strategy #4: Expansion of Home and Community-Based Services (HCBS) for aging individuals with Serious Mental Illness (SMI) determinations			
Objective #1	**Target Date**	**Performance Targets**	**Progress Summary**
Explore options to provide medically necessary HCBS to the aging SMI population who do not meet institutional level of care criteria to become eligible for the Arizona Long Term Care System (ALTCS).			
A. Identify a group of individuals 65 years and older with an SMI designation who were denied ALTCS eligibility for medical reasons.	6/2024[8]		
B. Research health outcomes and service utilization, including cost, of the member group including hospitalizations, emergency department and crisis utilization, and outpatient services.	10/2024		
C. Explore potential Medicaid authority and/or funding options.	3/2025[9]		

Strategy #4 Accomplishments Expansion of Home and Community-Based Services (HCBS) for aging individuals with Serious Mental Illness (SMI) determinations

[8] Changed from 10/2024 to 6/2024 to reflect incremental milestones in all of Objective 1.
[9] Changed from 10/2024 to 3/2025 to reflect incremental milestones in all of Objective 1.

Strategy #5: Workforce Development initiatives

Objective #1	Target Date	Performance Targets	Progress Summary
Improve hiring and retention of Direct Care Workers (DCWs) and behavioral health technician (BHT)/behavioral health paraprofessional (BHPP) staff.			
A. Develop and implement a Provider Workforce Database and System to track and monitor the following: ● Retention rates (rates of keeping staff) ● Turnover rates (rates of staff leaving positions) ● Time-to-fill (length of time to fill positions)	1/2025	● Initiate collection of baseline data for retention, turnover, and time-to-fill metrics.	
B. Expand the scope and depth of the current training and development programs available to both behavioral health and long-term care direct care personnel by establishing a statewide partnership between AHCCCS and the public community colleges throughout Arizona. These programs will improve basic competencies and help create specialized and advanced competencies that support members with complex needs.	10/2024	● Develop content and curriculum for the following types of behavioral health training programs: ○ Behavioral health in-service training, ○ Specialized training for behavioral health providers that provide behavioral health services to members in the ALTCS program, ○ Direct Care Worker pre-service training and testing program, and ○ Direct Care Worker in-service training	

	4/2025	• Pilot the new and enhanced types of behavioral health training programs.	
	10/2025	• Implement the new and enhanced types of behavioral health training programs statewide.	
C. Create and implement an interactive Caregiver Career Pathway (CCP) planning tool into the Pipeline AZ platform for prospective health care staff to explore Arizona health care jobs, including their eligibility requirements, and map the career ladders and frameworks connected to actual job openings.	4/2024		
Objective #2	**Target Date**	**Performance Targets**	**Progress Summary**

Personnel, employed by ACC, ACC-RBHA, CHP, DES/DDD, and ALTCS- EPD providers, who are responsible for ensuring that members transition from one system to the other (e.g., ACC-RBHA to ALTCS) will be both knowledgeable and skilled in referring, planning, and linking members to the appropriate systems and assuring the transition is a successful and satisfying experience for both the members and their families.	10/2023 (Completed)
	
	4/2024
	
	10/2024
		• Explore options to expand the current learning management system to the ALTCS line of business.
		• Review, update, and/or develop contract and policy as necessary to incorporate this training among the following lines of business:
		  ○ Long Term Care, and
		  ○ Acute care.
		• Develop content for the training and distribute to health plans to implement.	

Strategy #5 Accomplishments Workforce Development initiatives
Objective 2:In September 2023, AHCCCS explored options to expand the learning management system to the ALTCS line of business and it was decided that ALTCS will utilize RELIAS.

Strategy #6: High quality network to ensure members are served in the most effective and least restrictive manner

Objective #1	Target Date	Performance Targets	Progress Summary
Use Electronic Visit Verification (EVV) to monitor access to care for Home and Community-Based Services (HCBS).			
A. Develop reporting criteria for AHCCCS and Managed Care Organizations (MCOs) to monitor and report the following access to care data: ● Percentage of visits scheduled, ● Percentage of missed appointments being rescheduled in accordance with the member's contingency plan, and ● Timeframes from when services were determined medically necessary to when services were actually provided.	2/2024[10]		AHCCCS has outlined the requirements for the EVV Business Intelligence Tool. The completion of these initial reports is expected by February 2024.
B. Develop and implement access to care performance targets for providers and require MCOs to monitor those requirements.	6/2024		

[10] Changed from 1/2024 to 2/2024 as completion of these initial reports is expected by February 2024.

Objective #2	Target Date	Performance Targets	Progress Summary
Monitor timeliness of appointments available for prescribers of psychotropic medications, general behavioral health providers, and children in legal custody of the Arizona Department of Child Safety (DCS) and adopted children per A.R.S. § 8-512.01.	Ongoing (review every six months)	• Using AHCCCS' Appointment Availability standards, maintain or exceed current network access to appointments.	Overall, AHCCCS health plans maintained or exceeded current network appointment access from October 2022 to October 2023.
Objective #3	**Target Date**	**Performance Targets**	**Progress Summary**
Increase provider network capability for serving members with co-occurring developmental disabilities and behavioral health needs and children/adolescents with behavioral health needs.			
A. MCOs to implement at least one Center of Excellence for children at risk of/with Autism Spectrum Disorder (ASD).	1/2024 (Completed)	• 100% of MCOs to implement at least one Center of Excellence for children at risk of/with ASD.	
B. MCOs to implement consistent definitions and requirements aligned with national standards for Centers of Excellence to allow for expansion of the network of Centers of Excellence available and competency to serve the population of children and adolescents at risk of/with ASD.	10/2025		The target date is pending the addition to 10/1/2024 contracts.

C. Increase and enhance the network of available service providers across all levels of care who are certified, or have completed specific coursework or training, in service provision to children and adolescents with complex behavioral health needs and co-occurring disorders, including those at risk/with ASD.	1/2024 (Completed) Ongoing 1/2024 (Completed)	• Establish baseline data for the number of available service providers with specific training or expertise in service provision. • Engage in additional marketing strategies to disseminate education and messaging to the health plans and provider network. • Offer financial incentives to providers who have completed specific coursework or training related to serving individuals with complex behavioral health needs and co-occurring disorders.	Through the contract with the National Center of START Services (NCSS) at the University of New Hampshire's (UNH) Institute on Disability, the following has occurred: • As of January 2024, 39 individuals have enrolled in the initial cohort of the Intellectual/Developmental Disabilities (I/DD) Care Coordination training course through NCSS. A second cohort is beginning enrollment and will start in March 2024. • *Crisis Mobile Responder*; *988 Operator*; and *Prescriber/ Behavioral Health Professional* training course enrollment is underway and these courses will start in March 2024.
D. Purchase and implement training for use of the *Early Childhood Service Intensity Instrument* (ECSII), to allow for assessment of children birth through five.	3/2024	• Implement training for provider, AHCCCS, and MCO staff on the ECSII tool.	

Strategy #6 Accomplishments High quality network to ensure members are served in the most effective and least restrictive manner
Objective 3.A: As of January 2024, 100% of MCOs have at least one contracted provider with a Center of Excellence for children at risk of/with ASD.
Objective 3.C: AHCCCS identified and endorsed several certification and training programs for providers serving children and adolescents with complex behavioral health needs and co-occurring disorders. AHCCCS established baseline data and also added an identifier to AHCCCS Registration to indicate specialized populations that providers can serve, as well as the level of expertise in working with that particular population. This will help monitor the increase of providers with this expertise.
Objective 3.C: DDD has offered a financial incentive to providers on training opportunities related to Objective. As of 12/31/2023, training completions are as follows: ● 46 behavioral health providers have enrolled one or more staff members in the 13 course training plan, which includes 12 computer based courses and one live virtual instructor led course. ● 1,239 behavioral health provider staff have completed one or more of the courses. ● 6,053 total courses in the training plan have been completed. ● 525 individuals have completed the live virtual instructor led course.

Strategy #7: Person-centered planning enhancements

Objective #1	Target Date	Performance Targets	Progress Summary
Implement performance measurements and targets for Arizona Long Term Care System (ALTCS) Managed Care Organizations' (MCOs), including Tribal ALTCS Programs, case management chart audits for more frequent performance monitoring and to ensure MCO compliance with the federally mandated Person-Centered Service Plan (PCSP) process and requirements.	10/2023 (Completed) 10/2024 and ongoing	• Modify ALTCS contracts to initiate MCO and Tribal ALTCS Program compliance reporting with performance targets, including adding a formal deliverable to the Chart of Deliverables. • MCOs and the Tribal ALTCS Programs to maintain 86% compliance in ensuring the PCSP process and documentation include: ○ Member choice of services and providers. ○ Member needs and progress towards personal goals and desired outcomes. ○ Verification that PCSPs were reviewed with members/ guardians and revised at least annually. ○ Services, including the type, scope, amount, duration, and frequency specified in the PCSPs, as well as verification of service delivery.	

Objective #2	Target Date	Performance Targets	Progress Summary
Increase the utilization of *Supplemental Security Income/Social Security Disability Insurance Outreach, Access, and Recovery (SOAR)* services provided to eligible members.			
Explore opportunities to coordinate efforts between providers and SOAR-certified staff, including incentivizing providers to support the following SOAR activities: ● Identifying SOAR Local Leads across the state, ● Providing education and training to expand and promote SOAR, ● Increasing the number of SOAR-certified staff dedicated to providing SOAR services, ● Tracking completed SOAR online trainings for individuals becoming SOAR-certified, ● Referring members to SOAR-certified staff within each region, and ● Monitoring utilization of SOAR services through Medicaid funding.	10/2024		

Strategy #7 Accomplishments Person-centered planning enhancements
Objective 1: Contracts, including the Chart of Deliverables, have been updated for ALTCS Contractors (EPD/DDD) effective 10/1/2023, which incorporates case management chart audits for more frequent performance monitoring.

Strategy #8: Aggregated Population Data

Objective #1	Target Date	Performance Targets	Progress Summary
Provide and publicly post systemic level reports of member utilization data of services on the continuum of home/community-based, residential, and institutional services to inform Olmstead Planning.			
A. Annually obtain data related to the following elements to identify trends and future direction: ● Demographic data, ● Enrollment numbers by geographic service area and health plan, ● Average cost per person by geographic service area and health plan, ● Average cost per person by service type and eligibility (e.g., home-based services), and ● Average length-of-stay and readmission rates.	1/2024[11] 3/2024 4/2024 and annually thereafter 4/2024 and annually thereafter	● Conduct a baseline data analysis and interpret results. ● Identify opportunities for tracking and trending the data. ● Post report for the population of members who are determined to have a Serious Mental Illness (SMI). ● Post report for the population of members who are enrolled in the Arizona Long Term Care System (ALTCS).	

[11] AHCCCS is currently in the process of redetermining the methodology for the data report.

B. Explore options to identify and report on members living in their own homes, breaking out those members who own/lease directly and those members who might live with family members or other individuals of their choice.	4/2024		

Strategy #8 Accomplishments Aggregated Population Data

Key Terms

KEY TERMS	DEFINITION
811 Project Rental Assistance	A Department of Housing and Urban Development (HUD) program that provides supportive housing for persons with disabilities and is the leading source of funding for affordable housing opportunities that the Department of Economic Security/Division of Developmental Disabilities (DES/DDD) can access for members. Qualified members need to: ● Be eligible for DES/DDD, ● Be between the ages of 18 and 61, ● Have a current Person-Centered Service Plan (PCSP), ● Meet eligibility requirements, and ● Be willing to live in the area where housing opportunities are available.
1115 Research and Demonstration Waiver	Allows AHCCCS the ability to make program and service changes outside of the Social Security Act (SSA). The 1115 Waiver must be renewed by the Centers for Medicare and Medicaid Services (CMS) every five years.
AHCCCS Contractor Operations Manual (ACOM)	The ACOM is the AHCCCS manual consisting of Administrative, Claims, Financial, and Operational policies.
AHCCCS Housing Program (AHP)	Funded by the Arizona State Legislature, AHP provides rental subsidies, eviction prevention, and move-in assistance to AHCCCS members throughout the state through a Housing Administrator. The majority of the funding is dedicated to members with Serious Mental Illness (SMI) determinations.
AHCCCS Medical Policy Manual (AMPM)	The AMPM is the AHCCCS manual for services that are covered within the AHCCCS program.

Alternative residential settings	Alternative residential settings include but are not limited to Assisted Living Centers (ALC), Assisted Living Homes (ALH) Adult Foster Care (AFC) Homes, and Behavioral Health Supportive Homes.
American Rescue Plan (ARP) ACT	An emergency legislative package to fund vaccinations, provide immediate, direct relief to families impacted by the COVID-19 Public Health Emergency, and support struggling communities.
Americans with Disabilities Act (ADA)	A civil rights law that prohibits discrimination based on disability.
Appointment Availability standards	With AHCCCS health plans being required to ensure members are able to see medical professionals in a timely manner, this is a set of appointment standards that apply to Primary Care Providers (PCP), Specialist, Dental, Maternity, and Behavioral Health providers that includes the mandated time frames for services being rendered (e.g., for PCP, if urgent, no later than two business days of request and if routine, within 21 calendar days of request).
Arizona Department of Child Safety (DCS)	Program that seeks to help families by strengthening the ability of parents, guardians, or custodians to provide good care for their children.
Arizona Department of Corrections, Rehabilitation & Reentry (ADCRR)	Also known as the Arizona Department of Corrections, the ADCRR is the law enforcement agency responsible for the incarceration of inmates in 13 prisons across Arizona.
Arizona Department of Economic Security (ADES)	The Department of Economic Security is the State agency that provides protective and assistance services to Arizona's children, adults, and families while administering a broad range of programs related to children's services, guardianship and adoption, child support enforcement, developmental disabilities, vocational rehabilitation, domestic violence, adult protective services, medical assistance eligibility, nutritional assistance, independent living, employment assistance, and unemployment insurance.
Arizona Department of Health Services (ADHS)	Through direct care, science, public policy, and leadership, ADHS promotes and protects the health of all Arizonans.

Arizona Department of Housing (ADOH)	ADOH is primarily funded by federal funds and serves as a funder to housing providers who might be profit or non-profit developers, faith-based organizations, service organizations, or state, county and city entities who apply for and are awarded funds.
Arizona Developmental Disabilities Planning Council (ADDPC)	ADDPC serves Arizona residents with intellectual and developmental disabilities (I/DD), along with their families, providing original research, education advocacy, and financial support to disability-serving organizations that encourage Arizonans with I/DD to advocate for themselves and create more inclusive communities.
Arizona Health Care Cost Containment System (AHCCCS)	Arizona's Medicaid program jointly funded by federal and State governments.
Arizona Long Term Care System (ALTCS)	ALTCS is an AHCCCS program for individuals who are age 65 or older, or who have a disability, and who require nursing facility level of care. Services may be provided in an institution or in a home or community-based setting.
Assertive Community Treatment (ACT)	A way of delivering comprehensive and effective services to consumers who have needs that have not been met by traditional approaches to delivering services by directly delivering services to consumers instead of brokering services from other agencies or providers.
Autism Spectrum Disorder (ASD)	A complex developmental condition involving persistent challenges with social communication, restricted interests, and repetitive behavior.
Behavioral Health Paraprofessional (BHPP)	As specified in A.A.C. R9-10-101, an individual who is not a Behavioral Health Professional who provides behavioral health services at or for a health care institution according to the health care institution's policies and procedures that: 1. If the behavioral health services were provided in a setting other than a licensed health care institution, the individual would be required to be licensed as a behavioral professional under A.R.S. § 32, Chapter 33, and 2. Are provided under supervision by a Behavioral Health Professional.

Behavioral Health Technician (BHT)	1. An individual licensed under A.R.S. § 32, Chapter 33, whose scope of practice allows the individual to: a. Independently engage in the practice of behavioral health as specified in A.R.S. § 32-3251, or b. Except for a licensed substance abuse technician, engage in the practice of behavioral health as specified in A.R.S. § 32-3251 under direct supervision as specified in A.A.C. R4-6-101. 2. A psychiatrist as specified in A.R.S. § 36-501. 3. A psychologist as specified in A.R.S. § 32-2061. 4. A physician. 5. A behavior analyst as specified in A.R.S. § 32-2091. 6. A registered nurse practitioner licensed as an adult psychiatric and mental health nurse, or 7. A registered nurse: a. A psychiatric-mental health nursing certification, or b. One year of experience providing behavioral health services.
Care coordination	The organization of a patient's care across multiple health care providers.
Caregiver Career Pathway (CCP)	A platform to encourage individuals to start their health care career as a Direct Care Worker (DCW) that includes an interactive career "map" that illustrates how a DCW can gain the experience, skills, and credentials needed for a lifelong health care career.
Centers for Medicare & Medicaid Services (CMS)	The federal agency within the United States Department of Health and Human Services (HHS) which administers the Medicare (Title XVIII) and Medicaid (Title XIX) programs and the State Children's Health Insurance Program (Title XXI).
Center of Excellence	A facility and/or program that is recognized as providing the highest levels of leadership, quality, and service. Centers of Excellence align physicians and other providers to achieve higher value through greater focus on appropriateness of care, clinical excellence, and patient satisfaction.
Child and Adolescent Level of Care Utilization System (CALOCUS)	A standardized tool used to determine the intensity of services needed for children and adolescents from ages 6-18 years that includes individualized strength-based and culturally sensitive service planning, supporting the use of intensive care coordination or wraparound planning teams when indicated, and providing a broad service array that includes natural supports as well as clinical services.

Child and Family Team (CFT)	A group of individuals that includes, at a minimum, the child and their family, or Health Care Decision Maker (HCDM). A behavioral health representative, and any individuals important in the child's life that are identified and invited to participate by the child and family. This may include teachers, extended family members, friends, family support partners, healthcare providers, coaches, and community resource providers, representatives from churches, temples, synagogues, mosques, or other places of worship/faith, agents from other service systems like the Arizona Department of Child Safety (DCS) or the Department of Economic Security/Division of Developmental Disabilities (DES/DDD). The size, scope, and intensity of involvement of the team members are determined by the objectives established for the child, the needs of the family in providing for the child, and by who is needed to develop an effective service plan, and can therefore, expand and contract as necessary to be successful on behalf of the child.
Closed-Loop Referral System (CLRS)	An electronic tool that enables health care providers to screen and refer members to community based social service organizations to address social risk factors of health. The name of Arizona's statewide CLRS is CommunityCares.
Community Living Program (CLP)	Fixed Site Housing for members with Serious Mental Illness (SMI) determinations. Properties are purchased or rehabilitated with State SMI Housing Trust Funds on behalf of a provider owner/operator with a requirement for the property to provide Permanent Supportive Housing (PSH) for persons with SMI determinations. The AHCCCS Housing Program (AHP) often provides rental support or subsidies for program members residing in CLP units.
Differential Adjusted Payment (DAP)	A positive adjustment to the AHCCCS Fee-for-Service (FFS) rates to distinguish providers who have committed to supporting designated actions that improve patients' care experience, improve members' health, and reduce cost of care.
Direct Care Worker (DCW)	An individual who assists an elderly individual or an individual with a disability with activities necessary to allow them to reside in their home. These individuals, also known as Direct Support Professionals, must be employed/contracted by DCW Agencies or, in the case of member-directed options, employed by ALTCS members in order to provide services to ALTCS members.

Division of Developmental Disabilities (DDD)	The Division of Developmental Disabilities is housed under the Department of Economic Security (DES), serving eligible Arizona residents with intellectual/developmental disabilities. AHCCCS contracts with DES/DDD to serve Medicaid eligible individuals with intellectual/developmental disabilities.
Durable Medical Equipment (DME)	Equipment and supplies ordered by a health care provider for a medical reason for repeated use, such as wheelchairs, walkers, and hospital beds.
Early Childhood Service Intensity Instrument (ECSII)	A standardized assessment tool designed to focus on determining intensity of need for infants and toddlers (ages 0-5) to help guide ongoing service planning.
Electronic Visit Verification (EVV)	A computer-based system that electronically verifies the occurrence of authorized service visits by electronically documenting the precise time a service delivery visit begins and ends, the individuals receiving and providing a service, and type of service performed.
General Mental Health/Substance Use	Behavioral health services provided to adult members ages 18 and older who have not been determined to have a Serious Mental Illness (SMI).
Governance Committee	A formal committee that includes peers and family of members enrolled with Managed Care Organizations (MCOs) who are receiving, or have received, physical health and behavioral health services for the purpose of directing strategic planning process improvement and decision making for the MCOs' physical and behavioral health delivery system.
Home and Community Based Services (HCBS)	Provides opportunities for Medicaid beneficiaries to receive services in their own home or community rather than institutions or other isolated settings. These programs serve a variety of targeted populations groups, such as people with intellectual or developmental disabilities, physical disabilities, and/or mental illnesses.

Home and Community Based Services Rules	The purpose of the HCBS Rules is to ensure individuals receiving HCBS are integrated into their communities and have full access to the benefits of community living. These new requirements, from the Centers for Medicare and Medicaid Services (CMS), impact individuals receiving services in residential and non-residential settings, such as assisted living facilities, group homes, adult day health, day treatment and training, center-based employment programs, etc. All service settings must come into compliance by March 2023. For more information on the HCBS Rules and the requirements for State Medicaid programs, visit the CMS Website.
Independent Oversight Committee (IOC)	Previously referred to as the Human Rights Committees (HRC) and established in the Arizona Department of Administration (ADOA), the IOC provides an advocate/client/guardian perspective to multi-billion-dollar programs in developmental disabilities and mental health services. The purpose of each committee is to provide independent oversight to: ● Ensure the rights of clients are protected, ● Review incidents of possible abuse, neglect, or denial of a client's rights, and ● Make recommendations to the director and the legislature regarding laws, rules, policies, procedures, and practices to protect clients receiving behavioral health and developmental disability services.
Institutionalization	Placement of an individual in an institution for therapeutic or correctional purposes or when he or she is incapable of living independently, often as a result of a physical or mental condition.
Level of Care Utilization System (LOCUS)	A single instrument used to guide assessment, level of care placement decisions, continued stay criteria, and clinical outcomes.
Long-term services and supports (LTSS)	Services and supports provided to members of all ages who have functional limitations and/or chronic illnesses that have the primary purpose of supporting the ability of the member to live or work in the setting of their choice, which may include the individual's home, a provider-owned or controlled residential setting, a nursing facility, or other institutional setting.
Managed Care Organization (MCO)	Also known as health care/health insurance companies, AHCCCS contracts with these MCOs to provide quality care to enrolled AHCCCS members.

Medicaid	Governed by States, according to federal requirements, Medicaid provides health coverage to millions of Americans, including eligible low-income adults, children, pregnant women, elderly adults, and persons with disabilities.
Member Advocacy Council (MAC)	A committee facilitated by the Managed Care Organization's (MCO) Office of Individual and Family Affairs (OIFA) department that gathers and discusses issues and barriers; identifies challenges and problem solving; and shares information and strategies to strengthen the service delivery system. The council includes: ● Peers and family members enrolled with MCOs who are receiving, or have received, physical health and behavioral health services, ● An individual from the MCO's Executive Management team, and ● Others, including professionals and advocates.
Member Voice and Choice	The Managed Care Organization's (MCO) service delivery system shall ensure access to high-quality health care services that are culturally and linguistically appropriate, maximize personal and family voice and choice, and implement a trauma-informed and responsive care approach while ensuring Service Plans maximize personal and family voice and choice.
National Alliance on Mental Illness (NAMI)	The nation's largest grassroots mental health organization, NAMI provides advocacy, education, support, and public awareness so that all individuals and families affected by mental illness can build better lives.
Office of Individual and Family Affairs (OIFA)	As part of the AHCCCS Division of Community Advocacy & Intergovernmental Relations (DCAIR), OIFA promotes recovery, resiliency, and wellness for individuals with mental health and substance use challenges and their families by building partnership with individuals, families, youth, communities, organizations, and key stakeholders.
Permanent Supportive Housing (PSH)	An intervention that combines affordable housing assistance with voluntary support services to address the needs of chronically homeless people.
Person-Centered Service Plan (PCSP)	A process used during planning meetings to complete assessments and determine needed services and supports to help members reach their goals.

Public Housing Authorities	A government entity authorized to administer Department of Housing and Urban Development (HUD) housing programs.
Regional Behavioral Health Agreement (RBHA)	A contracted Managed Care Organization (also known as a health plan) responsible for the provision of comprehensive behavioral health services to all eligible individuals assigned by the administration and provision of comprehensive physical health services to eligible individuals with a Serious Mental Illness (SMI) designation who are enrolled by the Administration.
Rehabilitation Services Administration/ Vocational Rehabilitation (RSA/VR)	An administration within the Department of Economic Security (DES) that oversees several programs which are designed to assist eligible persons with disabilities to achieve employment outcomes and enhanced independence by offering comprehensive services and supports. VR is a program under RSA that provides a variety of services to persons with disabilities, with the ultimate goal to prepare for, enter into, or retain employment.
Serious Mental Illness (SMI)	Persons aged 18 and older who have a diagnosable behavioral, mental, or emotional condition as defined by the American Psychiatric Association's Diagnostic and Statistical Manual (DSM) of Mental Disorders.
Social risk factors of health	Non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. Examples, which can influence health equity in positive and negative ways, include income and social protection; education; unemployment and job insecurity; working life conditions; food insecurity; housing; basic amenities and the environment; early childhood development; social inclusion and non-discrimination; structural conflict; and access to affordable health services of decent quality.
Supplemental Security Income/Social Security Disability Insurance Outreach, Access, and Recovery (SOAR)	A national program designed to assist with the completion of Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) applications for individuals experiencing or at-risk of homelessness who have a mental health or co-occurring substance use disorder.
Targeted Investment (TI) Program	A strategy managed by AHCCCS to provide financial incentives to participating AHCCCS providers to develop systems for integrated care.

Title XIX/XXI	Title XIX of the Social Security Act is known as Medicaid. The program provides federal grants to States for medical assistance programs. Title XIX enables States to furnish medical assistance to those who have insufficient income and resources to meet the costs of necessary medical services, rehabilitation, and other services, to help those families and individuals become or remain independent and able to care for themselves. Title XIX members include but are not limited to those eligible under Section 1931 of the Social Security Act, Supplemental Security Income (SSI), SSI-related groups, Medicare cost sharing groups, Breast and Cervical Cancer Treatment Program, Freedom to Work Program, and others. Title XXI of the Social Security Act provides funds to States to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner that is coordinated with other sources of child health benefits coverage.
Transitional housing	A shelter or housing program that is designed to provide housing and appropriate supportive services to homeless persons, or other designated populations, to facilitate movement to independent living. The housing is short-term, typically less than 24 months. In addition to providing safe housing for those in need, other services are available to help members become self-sufficient.
Workforce development	The process of acquiring, developing, and retaining a sufficiently staffed, qualified, capable, and committed workforce.