Olmstead Public Comment Responses (July 2022 – September 2022)			
#	**Respondent Affiliation***	**Public Comment**	**AHCCCS Response**
1	Family Member	I raised a child for 18 years who had severe needs. Integration into the community is best for society as a whole! Please do all possible to move away from institutions. We can do better as a society than that.	Thank you for your comment.
2	Member with Lived Experience	I was reading the Arizona Developmental Disabilities Planning Council Facebook page and saw that y'all are looking for suggestions! My suggestions are to go around to places that are "wheelchair accessible" and make sure they are adhering with compliance, because they're not . Also, since a lot of wheelchair users are on a fixed income and can't afford a car with insurance and are left to travel the city sidewalks/crosswalks, I suggest someone travel it in a wheelchair to see where improvements or repairs need to be made. Plus it will be smoother for able bodied individuals as well. And because wheelchair users are only afforded a wheelchair every five years, gotta make it last !	We recommend that you research whether or not your local community has an Americans with Disabilities Act (ADA) Coordinator who could assist you with reporting road and/or general accessibility improvements. You may also consider referencing the resources and self-advocacy guides provided by the Arizona Center for Disability Law.
3	Advocate	I appreciate your interest in my comments today in the Olmstead forum. I have worked in disability advocacy in Tucson for over a decade and have experience navigating the AHCCCS complaint system from the member perspective. While I am aware that there is meant to be support, practically speaking this system is neither accessible or particularly effective for people with significant disabilities. In my experience, unless the member has an advocate or family support they are either not able to complete a complaint or, perhaps worse, they are not taken seriously when they do. Unfortunately, the staff most familiar with the members who may be best situated to support them are often the folks being complained about. Therefore the member is not able to find support that is objective, familiar or convenient. Their difficulties are compounded by a lack of technology skills/access and often past trauma associated with self-advocacy and/or service systems. In my opinion, all of these facts mean that members need a complaint system that 1) comes to them 2) is truly accessible 3) assumes good faith, and 4) is more opt-out then opt-in. Here are my thoughts about some possible solutions. I fully recognize that my	AHCCCS has added language in a new section within the introduction with information about current educational documents for filing grievances and appeals, as well as AHCCCS' plan to create an additional 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, which will also include a workflow that will explain how to report these to a provider, a health plan, or directly to AHCCCS.

		perspective is solely that of members and their families, so I have little knowledge of what these ideas would require to implement.	
4	Other/ Unknown	Nice set of lofty goals with no cogent plan on how to achieve them.	As mentioned in the introduction section, the intent of the design of the Olmstead Plan is for it to be both an actionable and “living” plan while containing specific timelines for objectives that are directed at completing a specified process. This includes specific performance targets, when applicable, to measure positive change resulting from the objectives. AHCCCS plans to post updates to the plan, when available, including available data on outcomes.
5	Advocate	This plan addresses most of the barriers that we are currently facing. Extremely well done.	Thank you for your comment.
6	Other/ Unknown	I'm not sure how but it would be helpful if the plan and goals were translated into language more easily understood by all stakeholder. I'm reading them and don't fully understand the impact of most of them.	AHCCCS has made a post-public comment change to the Plan in response to the feedback. AHCCCS plans to develop a one-page educational document to outreach and inform interested parties about its contents and to be used both as an educational tool and an awareness builder in more plain language. Please see the "*Evaluation and Transparency*" section in the introduction of the Olmstead Plan. To also assist interested parties in understanding different acronyms and terms, AHCCCS has developed a "*Key Terms*" appendix to be included at the end of the Olmstead Plan.
7	Family Member	The internal appeals process does not work because the Supreme Court ruled that members do not have right to challenge compliance. We can appeal for lack of services but not compliance or contract compliance.	Thank you for your comment.
8	Other/ Unknown	Competive Employment is not working as well as should be. DDD members not enough competively employed. In isolated workshops or working on a crew. AZ still struggling to meet national expectations. REcommendations should be included in Olmstead Plan	While in the spirit of Olmstead, this is being addressed through the Home and Community-Based Services (HCBS) Rules compliance initiatives that went into effect on 3/17/2023.
9	Other/ Unknown	Echo Competive Employment comment. Community Integration definition should include employment.	While in the spirit of Olmstead, this is being addressed through the Home and Community-Based Services (HCBS) Rules compliance initiatives that went into effect on 3/17/2023.
10	Advocate	**Baseline Benchmark Data**: Good benchmark data to monitor and track progress with this Plan. Is there accurate benchmark data? If not, how will progress be tracked? Additionally, there needs to be improved community participation in the Plan review and development. The low participation in the	AHCCCS has made a post-public comment change to the plan in response to your feedback to clarify how to keep in touch with Olmstead activities. Please see the "*Evaluation and Transparency*" section in the introduction of the Olmstead

		Olmstead survey is quite concerning. It is important to go where the youth, peer and family members are located – we can't assume they will find us.	Plan.
11	Advocate	**Evaluative Approach**: The claim is this is a "living" Plan. What are the plans for keeping it updated and holding AHCCCS to meeting its stated benchmarks in the coming years? What kind of stakeholder engagement and public transparency on these metrics has been built into the plan? In other words, how frequent and how open will the "living" part of the document be? The Olmstead Plan has not been updated since 2003. If this is to be a "living" document what specific assurance will AHCCCS provide and be accountable for?	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. 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 the AHCCCS Olmstead web page.
12	Advocate	The Plan is supposed to have clear, measurable targets for achieving its stated goals. Many of the various parts do include substantive targets; however, some of the other sections (person-centered planning, access to HCBS care) do not appear to identify clearly measurable goals.	Thank you for your comment.
13	Advocate	The details listed in the objectives and sub-objectives, along with target dates, are valuable. How will AHCCCS monitor this Plan? Who will do what? How will AHCCCS measure the gains? What if a performance target is not met? This should most definitely be identified in the final Plan. It's not clear what the enforcement strategy for this plan will be if state fails to meet the goals.	As mentioned in the introduction section, the intent of the design of the Olmstead Plan is for it to be both an actionable and "living" plan while containing specific timelines for objectives that are directed at completing a specified process. This includes specific performance targets, when applicable, to measure positive change resulting from the objectives. AHCCCS plans to post updates to the plan, when available, including available data on outcomes. Also, each strategy has at least one subject matter expert that will be responsible for managing their area(s).
14	Advocate	Identify how peer and family members will be heard. Public comments are great, but without the bilateral communication and follow up individuals often feel as though their comments are unheard and unimportant. In addition, when a peer and family member attend an AHCCCS meeting, such as a AHCCCS Hot Topic, and shares a comment or ask a question, they are discouraged from returning when there is not follow up. How will AHCCCS ensure that the Plan's updates and progress are transparent with the public?	There are a number of opportunities for peers, family members, and community members to have their voices heard in different AHCCCS-related activities. When AHCCCS hosts different community events, like forums or meetings such as "*AHCCCS Hot Topics*", AHCCCS brings in different subject matter experts to answer questions from attendees. If answers are not able to be provided during those events, AHCCCS takes the questions back internally to determine the answers and email the response directly to the individuals asking the questions (or other means based on the individuals' preferences).

15	Advocate	Refer to ACMI Olmstead plan to see an example of reporting and interagency transparency	Thank you for your comment.
16	Member with Lived Experience	I would of course appreciate any response and conversation about my above comments. As I have been made more aware recently, thru my becoming involved in several member committees and public meetings and presentations, it DOES seem that a lot still needs to be done in the arena of including members in the building and changing of the system upon which we literally depend. I've literally had to push and pull to find out about groups, committees that are available that might include members in the everyday goings on in AZ AHCCCS and ALTCS. Our disabilities, ages and illnesses should hold no limit onto our presence and choices. Far more needs to be done to invite and made sure members know they are welcome in all aspects of the decisions made about and for them.	Thank you for your comment.
17	Provider	We value how AHCCCS continues to innovate and develop new programs to meet the needs of its enrollees. The integration of physical and behavioral health across plans is one such example. While MCOs and health plans are in the early years of this integration on behalf of individuals with A/I/DD, this work is especially important for neurodiverse individuals. The National Autism Indicators Reports note that 60% of youth on the spectrum have at least two health or mental health conditions in addition to autism. During high school, nearly 50% of teens on the autism spectrum use mental health services, and of those who do, 49% receive this support while at school. As a result, transition services for these individuals are more complex. It is critical we create ASD Centers of Excellence (COEs) that focus on adults with autism.	Centers of Excellence for children at risk of/with Autism Spectrum Disorder (ASD) is addressed in Strategy #6 (*Network*), Objective #3, Sub-Objective A.
18	Advocate	Additionally, transportation should be a key component of the Plan because nonemergency medical transportation is a Medicaid covered service, and the lack of reliable transportation has long made community integration more challenging for members with disabilities in Arizona. AHCCCS should work with all State agencies who may have an impact on community integration for people with disabilities, and develop a unified Statewide Olmstead Plan that addresses every aspect of community integration.	AHCCCS, after vetting this through the Office of the General Counsel (OGC), believes the Olmstead Plan covers what is mandated by the Americans with Disabilities Act (ADA) and Olmstead.

19	Advocate	While ACDL appreciates the intent to regularly update the Plan and solicit stakeholder input, it is concerning that the previous Olmstead Plan was developed in 2003 and is being revisited 19 years later. As such, this portion of the Plan should provide more detail related to planning to ensure that data regarding the progress of the Plan is collected throughout the year and that the Plan is reviewed on an annual basis. This paragraph is also rather vague regarding this type of data that will be made available to stakeholders, and who will be considered a stakeholder. The Plan should also include specific assurances that identified stakeholders will be involved in future revisions of the Plan, rather than simply providing comments after the Plan is already complete.	As mentioned in the introduction section, the intent of the design of the Olmstead Plan is for it to be both an actionable and "living" plan while containing specific timelines for objectives that are directed at completing a specified process. This includes specific performance targets, when applicable, to measure positive change resulting from the objectives. AHCCCS plans to post updates to the plan, when available, including available data on outcomes. 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. 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 the AHCCCS Olmstead web page.
20	Advocate	ACDL disagrees that the Plan should be limited in scope to initiatives upon which AHCCCS can have a direct impact because an Olmstead Plan is a State plan that requires the State to ensure that persons with disabilities reside in the most integrated setting appropriate. The Olmstead decision interpreted the Americans with Disabilities Act (ADA) integration mandate, and a State's obligations under the ADA are independent of Medicaid requirements. This statement also contradicts the Plan because permanent supported housing is listed as one of the pillars of the Plan.	AHCCCS, after vetting this through the Office of the General Counsel (OGC), believes the Olmstead Plan covers what is mandated by the Americans with Disabilities Act (ADA) and Olmstead.
21	Advocate	ACDL is concerned that this portion of the Plan does not provide information about what the residential placement rates currently are in Arizona. This action should also provide more specific information as to why attention is focused upon employment, education, volunteerism, and social and recreation activities without any mention of programs that allow individuals to reside in their own homes or the most integrated setting appropriate. There are still opportunities to focus on moving individuals into their own residences because the percentage of members in alternative residential settings has not changed in the last five years.	AHCCCS has made a post-public comment change to the Plan in response to your feedback to clarify that AHCCCS continues to maintain a focus on supporting individuals to live in the least restrictive setting while also ensuring that they are receiving services in a least restrictive environment and have opportunities to be engaged participants in their communities. Please see the "*Home and Community Based Settings (HCBS) Rules*" section in the introduction of the Olmstead Plan. AHCCCS has also made a post-public comment change to the plan in response to your feedback to add a new strategy

			in the Olmstead Plan related to population data. Please see the "*Strategy #8: Aggregated Population Data*" section.
22	Provider	With the ever-increasing population of adults with a diagnosis of autism and/or intellectual/developmental disabilities (A/I/DD), we must begin to identify data sets that demonstrate effective reach and/or gaps in service delivery. For example, the 2022 Arizona Olmstead Plan includes data on the proportion of members who reside in their own home or an alternative residential setting. Unfortunately, if we do not distinguish between one's own home where the member is a mortgage or leaseholder and a home where the member resides in a home with a family member who is the mortgagee or leaseholder, we may miss a critical data point. Many adults with A/I/DD will outlive their caregivers. In 2017, 1.3 million people with A/I/DD in the U.S. lived with a caregiver over age 60. We encourage AHCCCS and its ALTCS MCOs to gather data to distinguish between these two types of homes for adult members.	AHCCCS has made a post-public comment change to the Plan in response to your feedback to add a new strategy in the Olmstead Plan related to population data. Please see the "*Strategy #8: Aggregated Population Data*" section. AHCCCS will also consider this idea outside of the Olmstead Plan as part of the agency's overall effort to modernize the Medicaid Management Information System (MMIS), which is planned to include updates to the case management modules.
23	Advocate	According to guidance by the United States Department of Justice (DOJ), the Plan "must reflect an analysis of the extent to which the public entity is providing services in the most integrated setting." As such, it is important for the Plan to include relevant population data with more detail provided here. For example, persons with developmental and/or intellectual disabilities may be more likely to reside in alternative residential settings. More detailed population data would allow members of the disability community and other stakeholders to understand which subgroups of people with disabilities have been able to more successfully residing in their own homes, and which subgroups are not receiving the necessary services to reside in their own homes.	AHCCCS, after vetting this through the Office of the General Counsel (OGC), believes the Olmstead Plan covers what is mandated by the Americans with Disabilities Act (ADA) and Olmstead. AHCCCS has made a post-public comment change to the Plan in response to your feedback to add a new strategy in the Olmstead Plan related to population data. Please see the "*Strategy #8: Aggregated Population Data*" section.
24	Advocate	The population data should also include the population numbers upon which percentages based, and the number of individuals in each subgroup that have requested a more integrated setting but have not received it. Lastly, a reference to the Access website for more information on Home and Community Based Services is an inadequate substitute for the Plan including data relevant to programs currently being offered and their effect on the number of individuals being able to reside in their own homes.	While in the spirit of Olmstead, AHCCCS will utilize this input to revisit, consider changes, and/or monitor contract/policy requirements to potentially identify individuals who are preparing to leave an institutional setting and the time it took for the individual to transition to a medically necessary least restrictive setting. AHCCCS addresses network sufficiency and provider access through plan oversight activities outlined in policies outside of the scope of the Olmstead Plan, such as ACOM Policies 415, 417, 436, and 439.

25	Advocate	**Consumer Experience/Satisfaction Enhancements**: AHCCCS should consider an alternative way for a member to file a grievance. The system lacks a process of bi-directional return. The complaint and grievance process is not effective. There have been long-standing discussions to this point. Individuals, young adults and families do not feel comfortable filing a grievance directly with their provider, nor with their health plan or the Clinical Resolutions Team at AHCCCS, thus individual and system level issues are not captured, trended or responded to. AHCCCS is not getting grievances. There needs to be a neutral yet formal process in place to file a grievance, without the fear of retribution that allows for tracking, trending, resolution and communication back out to members and/or family members. Consider formalizing through a third-party entity charged with fielding, addressing, reviewing and reporting on all Medicaid complaints and/or grievances. Lastly, Grievances should go directly to AHCCCS and the health plans. Also, consider secret shoppers to help address systems gaps. The APFC would be delighted to work alongside AHCCCS to employ secret shoppers.	AHCCCS has added language in a new section within the introduction with information about current educational documents for filing grievances and appeals, as well as AHCCCS' plan to create an additional 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, which will also include a workflow that will explain how to report these to a provider, a health plan, or directly to AHCCCS.
26	Advocate	**Community-based Specialty Programs**: There is a system gap and a lack of community-based service providers for individuals, youth and young adults with neurodevelopmental disabilities. Consider the expansion of community-based service agencies with a specialty focus of peer and family support services for youth and youth adults with neurodevelopmental disabilities to include but not limited to intellectual and developmental disabilities and autism spectrum disorder.	While in the spirit of Olmstead, AHCCCS has current plans outside of the Olmstead Plan for implementing strategies to address network sufficiency and increase ability to serve individuals with complex needs, including those with Autism Spectrum Disorder (ASD), through American Rescue Plan (ARP) Act funding. Also, providers of Peer and Family Support services are able to create those specialty peer and family services.

27	Advocate	**Network Development**: Network Adequacy is driven by an algorithm with the Managed Care Organizations. How is member and family voice and choice considered in network adequacy or inadequacy determination and reporting? To that, how does the grievance and appeals process influence network expansion, specific to special populations? Further, what formal mechanisms are in place from AHCCCS to Managed Care Organizations and to Member/Community informing and demonstrating choice in network design and service provision? Additionally, the network adequacy targets do not seem to be spelled out clearly. How will AHCCCS ensure that enough providers are available? AHCCCS should use utilization data to measure network sufficiency, member access to care and choice of providers. This is called a network penetration analysis and has been adopted by some states as a more robust means of measuring network sufficiency. In the Plan, AHCCCS should add some language addressing how COVID affected the Home and Community-based Services (HCBS) networks and what the state will do to address those challenges AND how it will adapt when FMAP boosts from COVID related laws (the 6.2% Families First Medicaid boost and the American Relief Plan 10% HCBS bump) expire.	While in the spirit of Olmstead, this is being addressed outside of the Olmstead Plan in the network plan and ACOM Policies 415, 436, and 417. We anticipate that the Centers for Medicare & Medicaid Services (CMS) will be releasing new access to care requirements and will incorporate this input once those are received in order to build a more comprehensive approach to network development and adequacy. AHCCCS is standing up a network tracking methodology within provider registration in which providers will be able to self-identify their level of specialization and availability to serve individuals who have Autism Spectrum Disorder (ASD), or any other types of specialized treatment needs. AHCCCS also has current plans for implementing strategies to address network sufficiency and increase ability to serve individuals with complex needs through American Rescue Plan (ARP) Act funding.
28	Advocate	**Regulatory Oversight & Monitoring Enhancements**: In the ALTCS system there are structural safeguards and extensive oversight to ensure ALTCS members receive choice of in-network service providers and minimize Conflicts of Interest (COI) in service delivery. AHCCCS should monitor existing contract and policy standards to assure non-ALTCS Members seeking behavioral health services are also given choice of in-network service providers and that COIs in behavioral health service delivery are minimized.	While in the spirit of Olmstead, this is being addressed outside of the Olmstead Plan. AHCCCS addresses non-ALTCS (Arizona Long Term Care System) plan Behavioral Health network sufficiency and provider access in ACOM Policies 415, 417, and 436. Also, the AHCCCS Office of Individual and Family Affairs (OIFA) currently educates the community on Voice and Choice and offers system navigation assistance to any members and family members. Along with that, the OIFA Alliance is partnering with workforce development to develop a training campaign on Voice and Choice and are in the beginning stages of this process.
29	Advocate	**HCBS Expansion**: We support the expansion of HCBS services for older adults with SMI who may not qualify for ALTCS "institutional" level of care. To identify members with SMI who are already receiving personal care services, AHCCCS should run data on the utilization of the HCPCS code Personal Care, which is a covered behavioral health service, provided on an out-patient basis (T1019 and T1020) and also in a residential setting (H0018 with modifier "TF" for intermediate care).	Thank you for your comment. AHCCCS is addressing this under Strategy #4 (*Expansion of Home and Community-Based Services*), Objective #1, Sub-Objective B.

30	Advocate	**Data-driven Decision-making**: Also, we encourage the idea of studying those members who cost the system the most and are in and out of the criminal justice system frequently – what need do they have that the system is missing? Where are these gaps? Which models are currently being used that our community to utilize? Studying these individuals will allow for appropriate intervention and cost savings. This has been done in many cities. Staff from the APFC have been involved in such projects in other cities.	AHCCCS is addressing this under Strategy #3 (*Reach-in justice settings*), Objective #4, Sub-Objective C.
31	Advocate	Provide Northern Arizona with ACT teams.	While in the spirit of Olmstead, AHCCCS has been working with the northern Regional Behavioral Health Agreement (RBHA), Care1st, to support the standing up of Assertive Community Treatment (ACT) teams in northern Arizona. AHCCCS has expanded ACT funding to increase capacity statewide, including four (4) ACT teams in northern Arizona.
32	Advocate	**ACT Specialty Team Expansion**: Consider the expansion of specialty teams, such as Assertive Community Treatment (ACT) Teams for the members with a dual diagnosis of a behavioral health need and neurodevelopmental disabilities to include but not limited to individuals with intellectual and developmental disabilities and autism spectrum disorder. Utilize resources from the Mental Health and Developmental Disabilities National Training Center:https://www.mhddcenter.org/.	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
33	Advocate	According to the AHCCCS HCBS Annual Report, it notes that participation in self-directed attendant care seems to have suffered a major decline in 2021. In addition, there has also been steady and substantial declines in the "Agency with Choice” member direct option. The Olmstead Plan should address these two issues.	The use of these service delivery models is directly attributed to member choice. AHCCCS has requirements for ALTCS (Arizona Long Term Care System) MCOs (Managed Care Organizations) to provide the education and guidance but does not make decisions for members regarding the level of participation they want in their service delivery.
34	Advocate	**Member/Family Voice inclusion**: Any and all external program evaluation requirements should include specific language requiring peer and family member representatives as members of the evaluation team.	AHCCCS has added language in the introduction in the section titled, “*Evaluation and Transparency*” with information about how AHCCCS intends to evaluate the plan.
35	Other/ Unknown	PCSPs not member driven. Not getting down to families and members.	AHCCCS will utilize this input to revisit, consider changes, and/or monitor contract/policy requirements for the Arizona Long Term Care System (ALTCS) program.
36	Other/ Unknown	Strategy 7, more obvious support system for members who are trying to complain. Actual 1:1 assistance, like Ombudsman, who can walk them through the complaint process.	AHCCCS has added language in a new section within the introduction with information about current educational documents for filing grievances and appeals, as well as AHCCCS’ plan to create an additional 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, which will also include a workflow that will explain how to report these to a provider, a health plan, or directly to AHCCCS.
37	Advocate	Strategy #7? incorporating peer support to the person centered planning process	Peer Support is a covered service currently available to members with behavioral health needs in the Arizona Long Term Care System (ALTCS) program. If the member is provided with a medically necessary Peer Recovery Support Specialist (PRSS), the peer support is able to participate in the Person-Centered Service Plan (PCSP) meeting, if the member agrees, in line with federal and state policies. AHCCCS, in partnership with the Arizona Long Term Care System (ALTCS) Managed Care Organizations (MCOs), will explore opportunities to bring more awareness about the service, including the use of peer support in the service planning process. Outside of the Olmstead Plan, AHCCCS is exploring ways to provide access to peer support, or similar services, for individuals without a behavioral health diagnosis.
38	Member with Lived Experience	I would just like this to be clearer in its goals and systems, performance measurements and targets. I think some mention of the actual metrics being expected should be listed here.	The metrics in the Olmstead Plan under Strategy #7 (*Person-centered planning*), Objective #1, are standard metrics required by the Centers for Medicare & Medicaid Services (CMS).
39	Advocate	Create a system where AHCCCS QCC happen automatically if a complaint is not resolved at the health plan level. For example, member completes a grievance at Mercy Care and receives a resolution they are not happy with. Mercy Care is required to report the resolution of the concern AND whether or not the member is content with the outcome within a certain time period. If Mercy Care reports that the member is not content, AHCCCS contacts the member directly to initiate a QCC.	AHCCCS has added language in a new section within the introduction with information about current educational documents for filing grievances and appeals, as well as AHCCCS' plan to create an additional 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, which will also include a workflow that will explain how to report these to a provider, a health plan, or directly to AHCCCS.

40	Family Member	From 2015 to 2018 the state paid for 2 home attendants and I paid for 2. Since 2018, when I proved that was wrong, the state has paid for 3 attendants and I still paid for one attendant. My meager SS could not provide that, so I have been borrowing on a revolving line of credit. I should not have had to pay for home care that would have been covered by Medicaid and the state plan. I should not have to be in debt for the rest of my life because there was willful ignorance without oversight or accountability. To succeed, we must know HCBS, train administrators, and change the 30 year mindset.	Thank you for your comment.
41	Other/ Unknown	LTC SMI and GMH certain diagnosis ASD, IDD, MH extreme behaviors they don't meet SMI and asking for that. DD processes are different, go thorugh DES. What happens is that there is not enough staff, services. Getting lost. Not getting quickly served. Group home are anaother one that is part of it. Sorely missing. BH side split from DD side. Disconnect. Family has to fight for this and is not seriously addressed. Quality need improvement. Impacting families.	While in the spirit of Olmstead, AHCCCS has current plans (outside of the Olmstead Plan) for implementing strategies to address network sufficiency and increase ability to serve individuals with complex needs through American Rescue Plan (ARP) Act funding.
42	Other/ Unknown	Pieces aren't connecting together, particular with complex cases. Looking at the issues together and not separate. DDD is separate, LTC is over hear, AHCCCS throws it to whatever health plan, etc., not working together.	AHCCCS is very concerned about member transitions and coordination of care between health plans and annually revises these requirements and solicits public comment on them (See ACOM Policy 402 and AMPM Policy 520 on the AHCCCS website).
43	Advocate	Thanks Susan, unfortunately the existing system is not effective for many people with significant barriers. I would advocate for a more extensive network of support	AHCCCS has added language in a new section within the introduction with information about current educational documents for filing grievances and appeals, as well as AHCCCS' plan to create an additional 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, which will also include a workflow that will explain how to report these to a provider, a health plan, or directly to AHCCCS.
44	Provider	From a systems perspective, is there a way to implement the changes that you're suggesting in existing health plan contracts or to put language in new contracts coming forward to assure accountability and timeliness in making sure services are received and the strategies that you've identified are implemented?	AHCCCS will utilize this input to revisit, consider changes, and/or monitor contract/policy requirements in response to the finalized version of the Olmstead Plan.

45	Advocate	**Population Data Breakdown**: There is extensive discussion of what accomplishments have been made in the ALTCS system both for DDD and elderly/physically disabled. AHCCCS should, however, breakdown the populations served by both ALTCS and AHCCCS in the ability to provide supportive services in a community based or least restrictive setting. Data needs to show supportive services by type provided to the member in his/her own home as well as what residential settings that members may be served by whether enrolled in ALTCS or AHCCCS. APFC is particularly concerned about the ability to provide those supportive services for individuals served because of an underlying mental health issue.	AHCCCS has made a post-public comment change to the Plan in response to your feedback to add a new strategy in the Olmstead Plan related to population data. Please see the "*Strategy #8: Aggregated Population Data*" section.
46	Advocate	**Additions and/or Clarifications**: AHCCCS should add to or clarify the following strategies and objectives. ***Objective #3***: Increase network adequacy for behavioral health services, including members with developmental disabilities and behavioral health needs and children/adolescents with behavioral health needs; AL Implementation of Centers of Excellence (CoE) for children at risk of/with Autism Spectrum Disorder (ASD). It is concerning that there is only one service provider in the State (Child and Family Support Services (CFSS) that offers a non-ABA/Relationship-based Autism program for children, youth and young adults under the age of 18. Furthermore, there are no program offerings, similar to that of CFSS for transitioning youth to the adult system. What strategic initiatives will address this gap in the network?	While in the spirit of Olmstead, this is being addressed outside of the Olmstead Plan in the network plan and ACOM Policies 415, 436, and 417. We anticipate that the Centers for Medicare & Medicaid Services (CMS) will be releasing new access to care requirements and will incorporate this input once those are received in order to build a more comprehensive approach to network development and adequacy. AHCCCS is standing up a network tracking methodology within provider registration in which providers will be able to self-identify their level of specialization and availability to serve individuals who have Autism Spectrum Disorder (ASD), or any other types of specialized treatment needs. AHCCCS also has current plans for implementing strategies to address network sufficiency and increase the ability to serve individuals with complex needs through American Rescue Plan (ARP) Act funding.
47	Member with Lived Experience	I understand clearly the E.V.V. program is a federal mandate, tying Medicaid payment to its use. That in itself does not make it a good option for the use it has been advocated. Wanting to make it convenient for billing does not make it safe or ethical for the clients now obliged to use it to receive services.	Thank you for your comment.
48	Member with Lived Experience	***Objective #1 A***: This is deceptive, this information could be gleaned from ALL member services in any time period up to now. E.V.V. does not make this before now uncollated information suddenly visible or understandable. HAS it been collected up to now? If not, why not? How is it REALLY different information using paper vs E.V.V.? It is certainly not more efficient.	Thank you for your comment.
49	Member with Lived Experience	***Objective #1 B***: Again, this information should and could have been collected long before now. Connecting it to E.V.V. as if it suddenly made it possible is deceptive. Targets should already exist, based on decades of experience and	Thank you for your comment.

		member care.	
50	Member with Lived Experience	I absolutely see the mandate to use this system as a top-down money tap for everyone involved in E.V.V.. Money from Medicaid that should be used to improve the system in other ways and the care for those who depend on it, including raising wages as I have mentioned and will continue to mention. I assume a lot of money is being spent on E.V.V. and its accompanying apps, that could and should be spent on other system development, raises, benefits and better training for care workers, which as stated above, would solve far more problems perceived within the system than the implementation of E.V.V.	Thank you for your comment.
51	Member with Lived Experience	I have been forced to use the E.V.V. for a few years now, working slowly towards the mandated implementation date for all services. I have not once been talked to about nor instructed in the mandate or the use of the E.V.V. by anyone. Ever. I've had to figure it out on my own thru the caregivers who are also unhappy with the implementation and my own reading about it online. To me, this lack of discussion and instruction shows a deliberate dismissal of the role of the members in this decision, the implementation and use. Those same caregivers have passed on stories of agency staff who also have limited understanding or misunderstanding of how the apps and E.V.V. work, making the caregivers jobs more difficult. Alongside that is the requirement for caregivers and or clients to have the apps and cell phones that make the E.V.V. functional. IF agencies (as I've been told) or the system itself require those cell phones and adequate data plans, then agencies and the system should be paying for cell service for the employees. Again, money that should be going to raises for improving worker retention numbers instead. Also, the E.V.V. apps are also not dependable or reliable, even as they depend on all the various cell phone and data service variations, making the job of the caregivers more difficult, not easier. I hear constant reports from caregivers having shorted checks because apps didn't record sign in or sign out at random times. And, again, difficulty dealing with agency staff who are under trained on the systems they think the caregivers should be pros at using.	AHCCCS has created an Electronic Visit Verification (EVV) policy (AMPM Policy 540) to ensure members have options and provider agencies are speaking with members to include their choices as part of the EVV program. AHCCCS monitors an EVV email address to support members, families, and providers in onboarding with EVV. Please feel free to contact us at EVV@azahcccs.gov.

52	Member with Lived Experience	To be clear, E.V.V. does nothing to protect members themselves from neglect, abuse or fraud. Zero. An abusive care worker can fake or intimidate a client into signing, E.V.V. or paper. A fraudulent caregiver can still forge a signature, E.V.V. or on paper. A caregiver can still show up and do no work. E.V.V. does nothing to mitigate the intimidation factor of those few caregivers who DO abuse or neglect their charges. It does nothing to change the work ethic of caregivers who may show up but do little or nothing or do things poorly during the time while they ARE signed into E.V.V. Also, there are clients who may be reluctant to receive or ask for services while any caregiver is in their home, simply shy or unaccustomed to having another person to help them. Far too many clients will NOT speak up regarding abuse or neglect- don't know how or are afraid to, fearing losing their services for speaking up at all. Meaning caregivers need to be more self-directed to help those clients or to recognize abuse or neglect and that comes with better trained, better paid caregivers, not E.V.V. All I see is a not-so-subtle intimation that either the clients or the workers are suspect in some way. E.V.V. being mandated only means it is now easier to electronically install surveillance on the money, but does nothing to really protect members or caregivers. (In my understanding, most fraud is from the administrative level of the medical system and NOT the users or workers.)	Thank you for your comment.
53	Member with Lived Experience	I am also concerned about the loss of my autonomy with the mandated GPS lock requirement of the E.V.V. to my home. It DOES make me tied to my home, though the definition of ALTCS services specifically state that my services are NOT tied to my home, but may be used out in the community. I nor anyone else referred to in the Olmstead Plan are nor should be implied to be 'home-bound' due to health and/or age, but rather community inclusive, per definition. This seems to me that, should I want to make some change to my care 'schedule', time or location, for any reason, I have to report to the agencies and that feels like I am having to ask for permission. This feels like a reversal of the independence I am supposed to have within the definitions of Medicaid and ALTCS. I nor anyone else should be expected to give up our independence and autonomy in exchange for the securing of billing for Medicaid.	AHCCCS has created an Electronic Visit Verification (EVV) policy (AMPM Policy 540) to ensure members have options and provider agencies are speaking with members to include their choices as part of the EVV program. AHCCCS monitors an EVV email address to support members, families, and providers in onboarding with EVV. Please feel free to contact us at EVV@azahcccs.gov.
54	Member with Lived Experience	The signature requirement is also problematic. I cannot sign while lying down, some clients can't sign at all. That physical detail is in no way a diminishment of anyone's mental facilities. How does EVV make that any different? Some people use a stamp on paper, one cannot do that electronically. At least with a signature stamp, one has to tell someone, while watching it done, 'use my stamp on that.' A caregiver with nefarious intentions could sign or not without permission on the E.V.V. apps. This means that we are in position of losing	AHCCCS has created an Electronic Visit Verification (EVV) policy (AMPM Policy 540) to ensure members have options and provider agencies are speaking with members to include their choices as part of the EVV program. AHCCCS monitors an EVV email address to support members, families, and providers in onboarding with EVV. Please feel free to contact us at EVV@azahcccs.gov.

		control over our autonomy, our own signatures. [Evidence, my brother: has a stamp he COULD use on paperwork and cannot use in the app]. So, how does E.V.V. prevent fraud? It also tells me that member signatures really aren't important to the system as a whole.	
55	Advocate	***Objective #1***: Moreover, it is critical that AHCCCS regularly assess the adequacy of its provider networks, using internal and external data, including Electronic Visit Verification (EVV), and grievance trends. The plan should set forth timelines for the development and implementation of a corrective action plan if a systemic inadequate network issue arises.	AHCCCS addresses network sufficiency and provider access through plan oversight activities outlined in policies outside of the scope of the Olmstead Plan, such as ACOM Policies 415, 417, 436, and 439.
56	Advocate	***Objective 1.B***: This objective does not contain any performance target, violating the requirement that the Plan include measurable goals.	Strategy #6 (*Network*), Objective #1, Sub-Objective B calls for the development of these performance targets. AHCCCS will develop these targets and address plan compliance requirements in policy after a baselined reporting period.
57	Advocate	***Objective 1.B***: Moreover, in addition to developing and monitoring performance targets, providers should be held accountable for failures to meet minimum standards. The plan should require the MCOs and/or AHCCCS to investigate those providers who fail to meet specified minimum performance standards, and to suspend and/or require a corrective action plan be developed and implemented to timely correct deficiencies.	AHCCCS and the health plans will monitor the data during a baseline period in an effort to develop performance metrics that may be used to incentivize provider performance through vehicles such as Value-Based Purchasing (VBP) arrangements, Differential Adjusted Payment (DAP) initiatives, or quality monitoring reviews. AHCCCS is monitoring data during a baseline period (January 1, 2023 - December 31, 2023) after the initiation of the claim enforcement period.
58	Advocate	***Objective 1.B***: The plan should further address standards for resolving grievances filed against providers, MCOs, and AHCCCS, including an assessment of whether the review, investigation, and resolution of such grievances are accurate and timely. Timelines should also be implemented for assessing whether the grievance process sufficiently permits the identification by AHCCCS of systemic issues to be resolved (whether the assessment for systemic issues is occurring manually or using automated keywords).	AHCCCS annually reviews its policies and requirements related to the grievance and appeals process. This is also evaluated by all AHCCCS regulators to ensure responses are timely and in adherence to the policies and regulations.
59	Advocate	***Objective 1.B***: The plan should also set forth a timeline to regularly assess the geographic adequacy of the provider network, including for less common services, such as Assertive Community Treatment (ACT) services, and a range of services for eligible children, to permit those members in more rural areas the ability to receive medically necessary services from their home communities.	AHCCCS currently reviews geographic adequacy for providers, including in rural areas (See ACOM Policy 436). Outside of that policy a broader range of providers and their access is addressed in narrative form in each Managed Care Organization's (MCO) network plan. We anticipate that the Centers for Medicare & Medicaid Services (CMS) will be releasing new access to care requirements and will incorporate this input once those are received in order to build a more comprehensive approach to network

			development and adequacy. AHCCCS also has current plans for implementing strategies to address network sufficiency and increase the ability to serve individuals with complex needs through American Rescue Plan (ARP) Act funding.
60	Provider	*We also recommend the following, and in summary, additional elements be considered to create effective permanent supportive housing, allowing members with a diagnosis of A/I/DD to successfully reside in the community:* 1. Collect data to enable a comparison between the needs of individuals with A/I/DD who are income-eligible for AHCCCS and those who are ALTCS-eligible. We believe there may be more innovative ways to support income-eligible individuals to live independently, prevent homelessness and avoid negative outcomes. Focus on adults and advance a center of autism excellence. While the autism spectrum disorder (ASD) advisory committee discussed the needs of adults, much of the completed work focused on children and youth—work that has enabled Arizona to catapult forward in meeting the needs of this population.	AHCCCS has multiple initiatives to address the needs of this population in relation to independent living, and the full continuum of services available, including supportive housing. AHCCCS has begun compiling annual data reporting for the population of individuals diagnosed with Autism Spectrum Disorder (ASD), both who are enrolled in the Arizona Long Term Care System (ALTCS)/Department of Economic Security, Division of Developmental Disabilities (DES/DDD) and who are not. This will be continuously monitored through the Olmstead work and includes some of the existing goals of the Autism Spectrum Disorder (ASD) Advisory Committee and its membership, as well as those identified in the Arizona Developmental Disabilities Planning Council (ADDPC) Policy Recommendations document.
61	Provider	*Address recommendations from the 2022 Policy Recommendations: Arizona's Crisis Response & People Who Have Intellectual/Developmental Disabilities (I/DD), issued by the ADDPC.* *https://addpc.az.gov/sites/default/files/Crisis%20Response%20IDD%20Final%20Report%20for%20Public%20Dissemination.pdf* There are 7 recommendations from this report, which are listed separatey below. **Summary of Recommendations (from the referenced report document above, p. 2-4)** **1.Require stronger accountability of crisis service providers** A. AHCCCS should require T/RBHAs to monitor their providers more closely by directly obtaining member feedback to ensure providers are providing services, following up, and communicating with member health plans. There should be full public transparency and reporting of findings. B. AHCCCS should work with the ID/DD and larger disability community to set benchmarks and standards for T/RBHAs and crisis providers to ensure	Regional Behavioral Health Agreements (RBHAs) and health plans are required to make sure the providers are following up with the members within 72 hours after a crisis system contact whether from the provider or the health plan.

		services are timely, accessible, inclusive, and effective.	
62	Provider	**Summary of Recommendations (see row 110 for the referenced report document, p. 5-6)** **2. Monitor communication protocols** AHCCCS and DDD need to monitor and follow up to ensure contractual requirements are implemented and members are receiving follow up services.	While in the spirit of Olmstead, AHCCCS will consider these comments and concerns outside of the Olmstead Plan.
63	Provider	**Summary of Recommendations (see row 110 for the referenced report document, p. 15-16)** **6.Families and people with ID/DD need education on navigating the crisis/behavioral health system** A. Health plans, T/ RBHAs, DDD, and law enforcement together need to educate members with ID/DD and their families on how to navigate the crisis response system, what to expect, and what they should do to better advocate for themselves. B. AHCCCS' contractual requirements should mandate that individual health plan identification cards require a crisis phone number.	While in the spirit of Olmstead, AHCCCS will consider these comments and concerns outside of the Olmstead Plan.
64	Advocate	Trained peer support specialists that do quarterly check-ins with members. Allowing them to give feedback in-person or on the phone to someone not directly involved in their services. They could work for the ombudsman offices within the RBHAs with expectations written by AHCCCS and included in the contracts.	AHCCCS will utilize this input to revisit and consider changes to contract/policy requirements for Managed Care Organizations (MCOs) related to the Office of Individual and Family Affairs (OIFA) responsibilities.
65	Advocate	The same type of service but delivered directly by AHCCCS instead within the health plans	AHCCCS has added language in a new section within the introduction with information about current educational documents for filing grievances and appeals, as well as AHCCCS' plan to create an additional 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, which will also include a workflow that will explain how to report these to a provider, a health plan, or directly to AHCCCS.

66	Family Member	I am concerned that the experience would be the same for anyone. I am concerned that it is now 4 months and we are all experiencing that agencies are not actually hiring and many clients have been waiting for services for months because there have been no available caregivers. My daughter only has 2 clients for 20 hours per week total. I am concerned that the case managers are not recognizing or acknowledging specialty needs beyond the initial assessment. We report to the agency, but no case manager is engaged to review. I am concerned that of the many caregiver positions that we have applied for, there are no dementia clients.	AHCCCS is aware of the current staffing crisis not only in Arizona, but nationwide as well. Both the Olmstead and American Rescue Plan (ARP) Act Plans include objectives on the hiring and retention of Direct Care Workers (DCWs) and behavioral health technician (BHT)/behavioral health paraprofessional (BHPP) staff. Other strategies are also being pursued through Home and Community-Based Services (HCBS) ARP funding.
67	Advocate	**Additions and/or Clarifications**: AHCCCS should add to or clarify the following strategies and objectives. ***Objective 1***. It is essential that all staff have a good understanding of the basics of the full range of services provided to AHCCCS as well as ALTCS members. This needs to be a requirement for all providers so members can be easily transitioned from one part of the program to the other with a particular focus on members needing behavioral health services.	ACC, ACC-RBHA, and ALTCS-EPD contractors each have designated key staff positions called Transition Coordinators who possess appropriate training and experience for the positions. These positions are to serve as an advocate for members leaving and joining the Contractor. Each contractor also has a key staff position called Medical Management Manager that requires local staff reporting to this position with appropriate physical and behavioral health knowledge and expertise to support whole-person health and to comply with contractual and policy requirements. Even with these staff available, AHCCCS believes additional training is required to the provider workforce under each AHCCCS line of business to become educated on the AHCCCS delivery system, including when and how to refer to another line of business. This may be found in the Olmstead Plan under Strategy #5 (*Workforce Development initiatives*), Objective #2.
68	Advocate	Do market analysis on direct care salaries and bring salaries to the current market level.	The Paid Caregivers Survey conducted by PHI National in 2020 reported an average wage for Direct Care Workers (DCWs) to be $12.65 which was slightly higher than the average wages paid by surrounding states as well as higher than the national average. When implemented, the Workforce Database Initiative funded through the American Rescue Plan (ARP) Act will include a more systematic annual reporting and analysis of compensation rates paid by providers of all lines of business and will enable better comparisons. In addition, AHCCCS has recently conducted rate adequacy studies for behavioral health and long-term care services.

69	Advocate	Provide staff retention and turnover rates.	This will be a feature of the Provider Workforce Database referenced under Strategy #5 (*Workforce Development Initiatives*), Objective #1, Sub-Objective A.
70	Advocate	Provide plans to retain direct care staff.	AHCCCS is aware of the current staffing crisis not only in Arizona, but nationwide as well. Both the Olmstead and American Rescue Plan (ARP) Act Plans include objectives on the hiring and retention of Direct Care Workers (DCWs) and behavioral health technician (BHT)/behavioral health paraprofessional (BHPP) staff. Other strategies were also developed through Home and Community-Based Services (HCBS) ARP funding.
71	Member with Lived Experience	I've seen this topic identified in all of the previous Olmstead Plans, meaning it has been an identified issue for the duration of the Plan itself and before. Data collection and management isn't the solution to the problem. Caregiver pay and benefits NEED to be honestly addressed. Trying to find some OTHER way to address and fix the issue is absurd. I watched the original county agency "Pima Home Health" be dismantled into the contracted, for-profit agencies system we have now. And I've watched their pay diminish as well as their benefits and training with the adoption of the agency - contract administration of member care. *The VERY simple answer to Improving hiring and retention of workers is better pay and better training.* As it stands, fast food workers make more money and AREN'T responsible for another person's wellbeing. There NEEDS to be value PAID to the workers or of COURSE they won't value the work or the members they are supposed to care for. They also need to know they have basic benefits from the agencies hiring them, such as sick days, vacation days, etc. It is an insult that in home caregivers make barely over minimum wage. Calling the work 'unskilled labor' is an insult to the workers and the members dependent on that care. Every SINGLE caregiver I have had, though most love the work, want better pay. I have lost MANY GREAT caregivers to jobs outside of healthcare that pay far more in hourly wages. The majority of them are heads of families who find they cannot afford to BE caregivers due to the low wages and lack of sick days, vacation time off, etc. There IS no other fix to "workforce development initiatives". They don't want pizza parties or 'employee of the month' certificates.	AHCCCS is aware of the current staffing crisis not only in Arizona, but nationwide as well. Both the Olmstead and American Rescue Plan (ARP) Act Plans include objectives on the hiring and retention of Direct Care Workers (DCWs) and behavioral health technician (BHT)/behavioral health paraprofessional (BHPP) staff. Other strategies were also developed through Home and Community-Based Services (HCBS) ARP funding.

72	Member with Lived Experience	As for training, the 90-day time frame guideline that dictates when care workers are trained needs to be drastically reduced. At this time, caregivers are far too often sent into members' homes without training. I know this because I've experienced it, having had to train a majority of my own workers and many have TOLD me they were sent out with zero training. No wonder so many quit. You cannot send anyone into a home not knowing what possible injury, disability or mental health issue they may need to work WITH in a member's home. How can you expect anyone to respect or stick with a job when they are basically thrown under a bus? No care caregiver should be permitted to go into any client's home without training or proof of training FIRST. Denying caregivers deserve better pay and better training really does reflect how little members are respected on the whole.	AHCCCS has made a post-public comment change to the plan in response to your feedback. Please see Strategy #5 (*Workforce Development Initiatives*), Objective 1, Sub-Objective B for details.
73	Advocate	***Objective #1***: According to DOJ guidance, an Olmstead Plan must include measurable goals for which the public entity can be held accountable. Strategy #5 includes only once performance target, and does not contain any performance targets that are measurable. The only performance target is to initiate collection of baseline data regarding retention, turnover and time to fill. This is not a measurable objective because it lacks any detail on how this data will be collected, where it will be compiled, who is responsible for reviewing and reporting the data, and from which types of agencies this data will be collected. The goals regarding enhancement of competencies and a caregiver career pathway not only lacks measurable goals, but lack any performance target whatsoever.	Performance Targets have been added to Strategy #5 (*Workforce Development Initiatives*).
74	Advocate	***Objective #1***: In addition to the foregoing, Strategy #5 will not be effective unless a thorough rate study is completed that will allow AHCCCS to assess the accurate costs and rates required to retain a quality healthcare workforce that meets the critical needs of our members. The plan should include a rate study for all critical services positions, including but not limited to attendant care, respite, transportation, and nursing. In addition to a rate study and correction to address the current recruitment and retention crisis, the plan should include an accountable method of maintaining competitive rates for providers to prevent future workforce crises that will lead to unacceptable gaps in critical services. Such methods could include regular rate studies, or rates that, once adjusted, are regularly recalculated to account for inflationary and other economic factors.	AHCCCS has recently conducted rate adequacy studies for behavioral health and long-term care services.

75	Provider	While individuals with the most complex needs require the most coordination of their services, there continues to be a separation between the coordination of services by the responsible agency (MCO, DDD and behavioral health). Individuals and families need to know that one entity is ultimately responsible for coordination and can be held accountable when that coordination does not happen. It is important MCOs hire, train, and supervise case management professionals to ensure their ability to understand and navigate, these varied systems on behalf of their members.	AHCCCS will utilize this input to revisit and consider changes to contract/policy requirements for Managed Care Organizations (MCOs) related to case management responsibilities.
76	Provider	We recommend AHCCCS include objectives and performance targets ensuring case managers have the skills, knowledge, and experience to meet the needs of individuals with A/ I/DD— whether served through ALTCS or Targeted Case Management.	AHCCCS will utilize this input to revisit and consider changes to contract/policy requirements for Managed Care Organizations (MCOs) related to case management responsibilities.
77	Provider	**Summary of Recommendations (see row 110 for the referenced report document, p. 6-10)** **3.Training, resources, and potential legislative changes are needed for law enforcement** A. AHCCCS should require MCOs' Justice Liaisons, including those at DDD, to have a standard email box and phone number that is easy to access by health plans, the justice system, law enforcement, and the general public when the interaction involves law enforcement, jail, or the judicial system. B. All police departments should be legislatively required to track and annually report to AZ POST the percentage of Crisis Intervention Team (CIT) trained officers they have on staff. Police, especially in rural areas, would benefit from training to better support interactions with the ID/DD community. C. Current state legislation regarding police apprehension and transport of people requiring court-ordered emergency evaluations and potential transport of those in crises needs to be re-examined. Additional funding also needs to be allocated to increase the number of mobile crisis teams throughout the state. D. Jails/prisons should be monitored to ensure they are consistently collecting disability data and accommodations needed at intake.	AHCCCS will utilize this input to revisit and consider changes to contract/policy requirements for Managed Care Organizations (MCOs) related to justice reach-in responsibilities.

78	Provider	**Summary of Recommendations (see row 110 for the referenced report document, p. 11-12)** **4.DDD Support Coordinators and health plans require additional training on behavioral health needs of the ID/DD community** To increase behavioral health services referrals from DDD Support Coordinators and the health plans, training is needed on behavioral health services and their associated benefits for ID/DD members (including nonverbal members).	AHCCCS will utilize this input to revisit and consider changes to contract/policy requirements for Managed Care Organizations (MCOs) related to case management responsibilities.
79	Provider	**Summary of Recommendations (see row 110 for the referenced report document, p. 12-15)** **5.DDD-contracted providers & vendors require additional guidance on behavioral health needs of ID/DD members** A. Training is needed for behavioral health service vendors on how to successfully accommodate individuals with ID/DD, including how to use Augmentative and Alternative Communication (AAC) devices. B. DDD-contracted providers and vendors require additional training, resources, and funding to adequately serve people who have ID/DD and co-occurring mental health diagnoses.	AHCCCS has made a post-public comment change to the plan in response to your feedback. Please see Strategy #5 (*Workforce Development Initiatives*), Objective 1, Sub-Objective B for details. Also, while in the spirit of Olmstead, AHCCCS has procured consulting services to develop Continuing Education Units/Continuing Medical Education (CEU/CME) training modules specific to best practices, empathy, cultural/familial sensitivity, and member-centric care for providers who serve members with an Intellectual/Developmental Disability (I/DD). Courses may also be developed by the Department of Economic Security (DES)/Division of Developmental Disabilities (DDD) and/or their subcontracted health plans, based on identified needs, such as co-occurring physical and mental health considerations and substance use disorders. While care and treatment have come a long way in recent years, there are still providers who are reluctant to serve individuals with an I/DD and/or do not understand how to effectively engage these members in their care journey. Additionally, it is not uncommon for providers to inaccurately write-off member conditions as part of their I/DD diagnosis or claim that treatment will be ineffective because of their I/DD diagnosis. The primary goal of the CEU/CME courses is to reduce stigma, educate on person-centric care models for people diagnosed with an I/DD, and promote a more informed and engaged workforce.

80	Provider	**Summary of Recommendations (see row 110 for the referenced report document, p. 16)** **7.Improve training on ID/DD for medical students, family practice residents, and general physicians** Both the physical and behavioral health needs of individuals with ID/DD need to be adequately addressed by the medical community	While in the spirit of Olmstead, AHCCCS has procured consulting services to develop Continuing Education Units/Continuing Medical Education (CEU/CME) training modules specific to best practices, empathy, cultural/familial sensitivity, and member-centric care for providers who serve members with an Intellectual/Developmental Disability (I/DD). Courses may also be developed by DES/DDD and/or their subcontracted health plans, based on identified needs, such as co-occurring physical and mental health considerations and substance use disorders. While care and treatment have come a long way in recent years, there are still providers who are reluctant to serve individuals with an I/DD and/or do not understand how to effectively engage these members in their care journey. Additionally, it is not uncommon for providers to inaccurately write-off member conditions as part of their I/DD diagnosis or claim that treatment will be ineffective because of their I/DD diagnosis. The primary goal of the CEU/CME courses is to reduce stigma, educate on person-centric care models for people diagnosed with an I/DD, and promote a more informed and engaged workforce.
81	Advocate	***Objective #1 A & B***: At least annually conduct a workforce analysis regarding recompense, benefits, etc. focusing on direct care staff (analysis/comparison should include other similar cost-of-living states/communities).	This is being addressed in the Olmstead Plan under Strategy #5 (*Workforce Development Initiatives*), Objective #1, Sub-Objective A. AHCCCS is using American Rescue Plan (ARP) Act funds to develop and implement a Provider Workforce Database and Decision Support System. The system will collect and process data from all lines of business and is intended to produce the following outputs: * Demographic description of each workforce including data about compensation. * Comparing the current capacity of the workforce to provide services to the demand for those services. * Information about the training, competency, and commitment of the workforce. * Impact of provider workforce development initiatives upon workforce capacity, capability, and commitment and a projective function for forecasting workforce trends and requirements.

82	Advocate	***Objective #1 A & B***: Monitor and evaluate the rate of turnover of direct care staff by each MCO (frequent staff turnover is detrimental to continuity of care and appropriate patient care).	This is being addressed in the Olmstead Plan under Strategy #5 (*Workforce Development Initiatives*), Objective #1, Sub-Objective A. AHCCCS is using American Rescue Plan (ARP) Act funds to develop and implement a Provider Workforce Database and Decision Support System. The system will collect and process data from all lines of business and is intended to produce the following outputs: * Demographic description of each workforce including data about compensation. * Comparing the current capacity of the workforce to provide services to the demand for those services. * Information about the training, competency, and commitment of the workforce. * Impact of provider workforce development initiatives upon workforce capacity, capability, and commitment and a projective function for forecasting workforce trends and requirements. A common formula for calculating, retention, turnover, and time-to-fill are among the metrics the Provider Workforce Database will report.
83	Advocate	***Objective #1 A & B***: Identify what levels of training are currently required for BHT and other direct care staff including case management and peer support.	Language has been added to the Plan to create a relationship with the community colleges that increases the pool of individuals who apply for caregiver jobs with pre-service training. Please see Strategy #5 (*Workforce Development Initiatives*), Objective 1, Sub-Objective B for details.

84	Advocate	***Objective #1 A & B***: Require training in trauma informed care of all direct care staff.	AHCCCS currently has in contract the coordination and provision of quality health care services that are culturally and linguistically appropriate, maximize personal and family voice and choice, and implement a trauma-informed care approach. The contract also states that the Contractor shall ensure provision of Trauma Informed Care (TIC) service delivery approaches, including routine trauma screenings and development of a network of therapists trained and certified in trauma-focused Evidence Based Practice. Also in contract, the Contractor's network of behavioral health providers shall include, at a minimum the following: * Master's and doctoral level trained clinicians in the fields of social work, counseling, marriage and family therapy, psychology, and substance abuse counseling, who are trained in implementation of best practices for medically and behaviorally complex conditions such as intellectual/cognitive disabilities, trauma-related disorders, Substance Use Disorders (SUD), sexual offenders, sexual abuse victims, services for those in need of dialectical behavior therapy, and special age groups such as transition-age youth and members aged birth to five years old.
85	Advocate	***Objective #1 A & B***: Establish statewide certification (by attendance at standardized courses) for direct care staff (it appears that there is little statewide consistency/standardization in course content or quality).	Language has been added to the Plan to create a relationship with the community colleges that increases the pool of individuals who apply for caregiver jobs with pre-service training. Please see Strategy #5 (*Workforce Development Initiatives*), Objective 1, Sub-Objective B for details. As part of the ARP funded Career Education and Training (CET) initiative with the Community Colleges, on-going in-service training programs will be developed for specific job roles in both behavioral health and long-term care settings (e.g. behavioral health Case Manager, Direct Care Worker etc.). For both behavioral health and long-term care job roles that are directly involved in assisting Members transition from one system to the other, a training course and competency evaluation process will be included in their job specific

			in-service training program.
86	Advocate	**Additions and/or Clarifications**: AHCCCS should add to or clarify the following strategies and objectives. ***Objective 1***. Does AHCCCS have the necessary data to effectively identify members who are SMI but not yet ALTCS eligible? If not, how does the agency begin to identify SMI members on the cusp of ALTCS eligibility?	AHCCCS has already initiated the process of determining service utilization and expenditures from a pre-identified cohort of members who fall into this category.
87	Advocate	Provide plans for those elderly SMI folks that have been rejected from ALTCS.	This may be able to be addressed in the Olmstead Plan under Strategy #4 (*Expansion of HCBS*), Objective #1, Sub-Objective C as we explore options.
88	Advocate	Develop specialized homes to care for the elderly whose primary issues are BH and medical issues related to aging.	As an extension of AHCCCS' efforts to comply with the Home and Community Based Settings Regulations (HCBS Rules), AHCCCS is working in partnership with health plans and ADHS to re-envision long-term placement options for individuals who are aging with behavioral health needs.
89	Advocate	Report recidivism for each level of care. Report length of stay at each level of care.	AHCCCS has made a post-public comment change to the Plan in response to your feedback to add a new strategy in the Olmstead Plan related to population data. Please see the "*Strategy #8: Aggregated Population Data*" section.
90	Advocate	**Additions and/or Clarifications**: AHCCCS should add to or clarify the following strategies and objectives. ***Objective 1***. Work with existing counties to encourage and foster the ability to provide in-reach services in county jails. Consider developing financial incentives for non-participating counties.	While AHCCCS has no authority to enforce data sharing agreements, it is a priority to develop relationships with the non-participating counties. Updates on newly formed agreements will be addressed and included in the Plan under Strategy #3 (*Reach-in justice settings*), Objective 1.
91	Advocate	**Additions and/or Clarifications**: AHCCCS should add to or clarify the following strategies and objectives. ***Objective 2***. Increase the target to 75% of released inmates from ADCRR having pre-release AHCCCS applications submitted prior to release.	The initial 55% goal of all inmates released from Arizona Department of Correction, Rehabilitation and Reentry (ADCRR) to have a pre-release application submitted to AHCCCS prior to release has been removed. It was determined that the data AHCCCS formerly collected no longer applies because of a change in a tracking system that was being used at that time. AHCCCS will work with ADCRR on developing a new tracking system to be able to identify trends and inform more streamlined processes. Please keep an eye on Strategy #3 (*Reach-in justice settings*), Objective #2 for future updates.
92	Advocate	**Additions and/or Clarifications**: AHCCCS should add to or clarify the following strategies and objectives. ***Objective 3***. Support the target of 75% of inmates having necessary DME at	The initial 75% goal of all inmates released from Arizona Department of Correction, Rehabilitation and Reentry (ADCRR) who require Durable Medical Equipment (DME) to

		release and would advocate for that percentage to increase to 85% if not higher. The necessary steps must be taken to allow the inmate to successfully transition to the community.	obtain that DME the same day of release has been removed because there are too many variables outside of the contractual requirements of reach-in to be able to pinpoint a target percentage at this time. Instead, AHCCCS will assist with developing and implementing a standardized process for pre-release coordination of medically necessary services, including DME, between the justice system partners and AHCCCS health plans. Please keep an eye on Strategy #3 (*Reach-in justice settings*), Objective #3 for future updates.
93	Advocate	**Additions and/or Clarifications**: AHCCCS should add to or clarify the following strategies and objectives. How will these steps impact the ongoing health care lawsuit around health care for ADCCR? It appears this is particularly problematic in the use of the Closed-Loop Referral System.	AHCCCS has decided to incorporate a sub-objective to collaborate with Arizona Department of Corrections, Rehabilitation & Reentry (ADCRR) and county jails to establish the types of justice settings that would be able to utilize the Closed-Loop Referral System (CLRS). This will provide a clearer picture on the future utilization of CLRS with justice settings. Please keep an eye on Strategy #3 (*Reach-in justice settings*), Objective #5 for future updates.
94	Advocate	***Objective 4A***: What type of crimes are the persons with SMI committing? Are these related to crimes of survival or symptoms of their diagnosis? The BH system needs to take responsibility for these folks not getting sufficient time to stabilize before release. Where was case management in this process, and how effective was the care team to have this failure? Stop the vicious cycle. Measure all failures when stepping down by forced utilization and incorrect understanding of medical necessity.	This is being addressed in the Olmstead Plan under Strategy #3 (*Reach-in justice settings*), Objective #4, Sub-Objectives A, B, C, & D. Part of the intent of this objective is to obtain some insight into the member experience with the system to inform reach-in policy and contract reach-in requirements.
95	Advocate	***Objective 3***: “Medical Necessity” means a covered service is provided by a physician or other licensed practitioner of the healing arts within the scope of practice under state law to prevent disease, disability, or other adverse health conditions or their progression, or to prolong life. When “Medical Necessity” is not properly applied to persons in these and other vulnerable circumstances, their “adverse health conditions” are aggravated, their illness and psychosis progresses, and they absorb increasing public resources, including costs of emergency rooms, hospitals (e.g., “walked into traffic and got it by a car”), psychiatric hospitals, police interactions, courts and jails.	Thank you for your comment.
96	Advocate	***Objective #2***: ACDL is concerned that this objective is not adequately ambitious to ensure that inmates approaching discharge are connected with needed community integration services because the progress to date listed under this objective shows that 50% of inmates are already having a pre-release application submitted prior to release. Given the fact that a process	The initial 55% goal of all inmates released from Arizona Department of Correction, Rehabilitation and Reentry (ADCRR) to have a pre-release application submitted to AHCCCS prior to release has been removed. It was determined that the data AHCCCS formerly collected no

		for submission of pre-release applications is already in place, a 5% increase in submission of these applications within more than a full year is inadequate.	longer applies because of a change in a tracking system that was being used at that time. AHCCCS will work with ADCRR on developing a new tracking system to be able to identify trends and inform more streamlined processes. Please keep an eye on Strategy #3 (Reach-in justice settings), Objective #2 for future updates.
97	Advocate	***Objective #4 A***: As also noted above, ensure that a "warm handoff" occurs when individuals with special needs or who are SMI are leaving an institutional setting for a lesser restrictive setting to assist in a safe transition.	This is being addressed in the Olmstead Plan under Strategy #1 (*Housing*), Objectives A and B.
98	Advocate	***Objective #4 A***: Create a database identifying those SMI individuals who are "frequent flyers" in the criminal justice system; including criminal charges they are facing, length of time incarcerated, whether on COT status, and last contact with the primary treatment agency prior to arrest. (The intent, in part, is to identify those who may need more services/oversight as evidenced by frequent encounters with the criminal justice system.)	This is being addressed in the Olmstead Plan under Strategy #3 (*Reach-in justice settings*), Objective #4, Sub-Objectives A, B, C, & D.
99	Provider	*We also recommend the following, and in summary, additional elements be considered to create effective permanent supportive housing, allowing members with a diagnosis of A/I/DD to successfully reside in the community:* 2. Establish objectives and performance targets. Law enforcement, homeless service programs and emergency rooms all report increased numbers of individuals with A/I/DD entering their systems. We know from AHCCCS' work with individuals with SMI that overall costs can be reduced by developing an integrated approach. Forty-two percent of individuals with autism are enrolled in the Arizona Complete Care Plans. Explore ways to improve data collection, monitoring and coordination with law enforcement on behalf of ALTCS members with A/I/DD. This is particularly important as a distinct set of individuals with A/I/DD often have multiple interactions with law enforcement but are not part of the Justice Reach-In program. Consequently, there is a lack of data related to their interactions and coordination of care on their behalf. AHCCCS already collaborates with law enforcement on behalf of individuals with SMI. As the new 988 number and new crisis contracts are implemented, AHCCCS and its MCOs must be prepared to capture data from those calls.	AHCCCS will utilize this input to revisit and consider changes to contract/policy requirements for Managed Care Organizations (MCOs) related to justice reach-in responsibilities. AHCCCS has already worked with DES/DDD to expand reach-in efforts to include conducting outreach and specialized training to local law enforcement regarding accommodating, interacting and communicating with individuals with I/DD.
100	Provider	The provision of integrated or coordinated services in the community to address physical and behavioral health care needs allows more members to access these services. One important aspect of the Health and Housing Opportunities Waiver Amendment helps to address the growing problem of homelessness in our State. The Arizona Olmstead Plan builds and extends on	Thank you for your comment.

		previous accomplishments to address the gaps in care that move people towards greater independence and support self-sufficiency. The Plan provides specific, measurable strategies to attain each objective.	
101	Health Plan	Page 10 - C. Utilize the Level of Care Utilization System (LOCUS)..."Identify and implement a new housing screening tool." Feedback - Question: Does the LOCUS align with PSH Fidelity and Housing First? Recommendation: Utilize the tool that is adopted by the housing community and Continuum of Care.	AHCCCS does not intend to make this change without stakeholder input and ample notice to providers and stakeholders. Currently AHCCCS is considering the use of the Level of Care Utilization System (LOCUS) tool in order to align with the integrated care and meet the need of the Continuum of Care (COC).
102	Advocate	**Additions and/or Clarifications**: AHCCCS should add to or clarify the following strategies and objectives. ***Objective 1***: Concerns that it'll be until July 2024 before the baseline data 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.	In order to ensure AHCCCS can collect the referenced data, the AMPM and ACOM policies referenced in Strategy #1 (*Housing*), Objective #1, Sub-Objectives A & B must first be updated then be allowed sufficient time to develop the data structures necessary including time to collect service utilization data.
103	Advocate	**Additions and/or Clarifications**: AHCCCS should add to or clarify the following strategies and objectives. ***Objective 3***: What specific actions or steps will AHCCCS outline to increase housing capacity by 10% or reduce waiting times? Based on the current use of LOCUS, is there data available that can be show the effectiveness of this tool? Who will be providing the necessary training for staff on the use of LOCUS?	There are a number of AHCCCS strategies being used in an attempt to increase housing options for members, including landlord incentives, utilizing the Serious Mental Illness (SMI) Housing Trust Funds for capital expenses, and partnering with the Arizona Department of Housing (ADOH) for gap funding. Progress on these strategies will be shared as part of the ongoing updates to the Olmstead Plan.
104	Health Plan	The ways in which the Division of Developmental Disabilities ADOH, AHCCCS, and HUD have come together to provide qualified persons affordable housing opportunities and step away from traditional silos is very impressive and a credit to the leadership of these organizations. Unfortunately, the resources needed to carry out the goals of the Olmstead plan are very limited. For example, there are only twenty-four public housing authorities in the entire state that are responsible for the housing voucher programs and project-based rental assistance. AHCCCS reports that about 2,800 members with SMI are on the waiting list for permanent supportive housing. The average amount of time it takes for designated SMI to find appropriate housing is four months if they have a case manager's assistance. For the DD and SMI communities, the reality of these long waiting lists for appropriate housing is deeply troubling. Being homeless is simply not conducive to effective treatment or receipt of services.	Thank you for your comment.

105	Health Plan	We need to increase accountability for proper allocation of housing trust funds. One of our health homes submitted the requisite 21-page request for capital expenditure nearly three years ago and despite frequent follow-up requests has received no feedback on their application. Proper allocation of these funds must be made to ensure that those with SMI receive ample opportunity to find supportive, stable housing.	AHCCCS recently worked to streamline and enhance the Serious Mental Illness (SMI) Housing Trust Fund application. This new application will be posted to the AHCCCS website by November 2023.
106	Health Plan	Housing programs for SMI members should not be restricted as to the proximity of housing units designated for members with SMI. Clearly, we do not want to pull ourselves back to a pre-Arnold, pre-Olmstead reality, but it is important nevertheless that close proximity housing options would fill a hole in the current continuum of care. It should not be a binary choice between complete institutionalization and complete integration. We need to increase housing options for those with SMI that allows them to stabilize, provides for more cost effective onsite wraparound service availability, and prevents rising rates of homelessness. This will likely positively impact individuals wellbeing and decrease justice involvement.	Thank you for your comment.
107	Health Plan	We need improved coordination between housing programs. The Arizona Behavioral Health Corporation (ABC) administers a portion of the rental assistance and housing programs. Their Permanent Supportive Housing program is dedicated to providing rental assistance to over 1,600 individuals. For someone to be considered qualified, they must have SMI, be enrolled in AHCCCS, be Title XIX eligible, and be considered homeless under the HUD's definition of homelessness. The Continuums of Care provide housing solutions, too, but these systems are siloed causing individuals to have to be waitlisted in multiple programs.	Thank you for your comment.
108	Advocate	***Objective 1C***: It is imperative that AHCCCS works with the city to address zoning issues to permit the most integrated settings. If left unattended, these facilities will be placed in areas that are not conducive to easy access to food, jobs, or entertainment. Better locations within communities may need to start with a zoning assessment.	Thank you for your comment.
109	Advocate	***Objective 2A***: Refer to housing is a healthcare ASU study Morrison released on SMI housing.	Thank you for your comment.
110	Advocate	***Objective 2A***: We need more housing across the continuum of care. Use the waitlist and understand which areas are most deficient.	Thank you for your comment.
111	Advocate	***Objective 2A***: De silo the information on SMI stakeholders (criminal justice and healthcare systems should readily pass information about clients), Persons with SMI are present in each environment, jails, streets, hospitals, and	Thank you for your comment.

		housing,	
112	Advocate	***Objective 2A***: Make sure that the waitlist is eliminated. A reduction of 10% of wait time if currently 400 hrs. from approval of a voucher to move in is not that much better.	Thank you for your comment.
113	Advocate	***Objective 2A***: Ensure there is a warm hand-off between all settings.	Thank you for your comment.
114	Advocate	***Objective 2B***: The real need is to access the housing needs and eliminate the waitlist.	Thank you for your comment.
115	Advocate	***Objective 3A***: Provide a list of agencies with a number of patients at each type of housing (BHTF, Scattered, Flex, Secure, Specialty homes, streets, jail) and plans to house them in PSH appropriately	Thank you for your comment.
116	Advocate	***Objective 3A***: Provide appropriate care for the aging smi population.	This is being addressed in the Olmstead Plan under Strategy #4 (*Expansion of HCBS*), Objective #1.
117	Advocate	***Objective 3A***: Provide length of stay on each treatment/ housing type.	AHCCCS tracks average length-of-stay for treatment settings, though, does not implement strict time frame requirements as AHCCCS values member voice and choice, as well as recognizes the need for individualization of treatment goals and service plans.
118	Family Member	Objectives 2 and 3: I am an architect working on a variety of related projects – behavioral health residential facilities, recovery/treatment, transitional housing, etc. We are constantly confronted with zoning and use challenges with cities in Maricopa County. I would add as an additional barrier to housing not included in the current plan – ZONING AND USE CLASSIFICATION. This also applies statewide. * Often, zoning ordinances in communities want to locate these types of residential/other facilities in industrial zones. This is not appropriate as we strive for “most integrated setting”. * Many cities do not understand the uses and end up categorizing the uses in ways that seem to unnecessarily lengthen the process quite a bit, require more public meetings, delaying appropriate care or housing, etc. My recommendation is to add a comment to Strategy 1/Objectives 2 and 3 – Establish baseline understanding of current zoning and uses (starting with Maricopa County municipalities) and recommend most appropriate zoning and uses (for the existing bridge options and the to be determined bridge options). This will require working with each municipality. I also have 2 immediate family members who are SMI in Arizona, and we are	Zoning is outside the scope of AHCCCS, however there are other entities addressing this issue.

		caregiver to one.	
119	Advocate	***Objective #2***: Critical to the provision of appropriate community-based housing is Arizonans' ability to obtain eligibility for the services for which they are lawfully qualified under DDD and ALTCS. Too frequently, Arizonans are denied eligibility for DDD services, or ALTCS services, though they are plainly eligible for the same. Often, the applicants have relocated to Arizona after years or decades of eligibility for other states' sister programs.	Thank you for your comment.
120	Advocate	***Objective #2***: The plan should include a timeline for reviewing, seeking community input, and revising, regulatory framework, and for eliminating all non-regulatory administrative barriers that prevent properly diagnosed Arizonans from obtaining eligibility for these critical services.	Please see the "*Evaluation and Transparency*" section in the introduction of the Olmstead Plan. This section was expanded to include more information about seeking community input. Also, for more information on how to stay informed of opportunities for input on the Olmstead Plan, please visit the AHCCCS Olmstead web page.
121	Advocate	***Objective #2***: In addition, the plan should include a timeline for identifying significant gaps in the range of housing currently offered to our population. This analysis should include, for example, gaps in housing available to members who are dually diagnosed, including those who are diagnosed with both developmental and behavioral health disabilities.	AHCCCS has procured a contractor to complete an in-depth review of specialty providers across the state and their related capacity to serve members with complex conditions, such as polydipsia, substance use disorder, sexually maladaptive behavior, and others. This Contractor will evaluate member needs, provider specialties/capacity, and potential gaps between the two. It is anticipated that the evaluation will be completed within 2024 and that implementation of system improvements will begin immediately thereafter.
122	Advocate	***Objective #2***: In addition, ACDL would like to see this objective provide a plan to more regularly promote the availability of HCBS, and to educate MCOs, case managers, and community members about the broad range of community-based housing opportunities for those who are qualified, but who currently reside in more restrictive settings.	AHCCCS Policy AMPM 1620-D states the Case Manager is responsible for facilitating placement and services based primarily on the member's choice with additional input in the decision-making process from the member/Health Care Decision Maker(HCDM)/Designated Representative (DR), the Case Manager's assessment, the Pre-Assessment Screening, and other members of the Planning Team. In determining the most appropriate service placement, the Case Manager and the member/HCDM/DR are required to discuss services necessary to meet the member's needs in the most integrated/least restrictive setting, including Home and Community Based Services (HCBS).

123	Advocate	***Objective #2 A & B***: Track individually and in aggregate the housing status of clients/patients at each level of care such as DD homes, BHRFs, residential drug rehabilitation programs, Level I facilities, jails/prisons, unlicensed boarding homes, etc. Incorporate as policy the fact that “Housing is Healthcare.”	AHCCCS has made a post-public comment change to the plan in response to your feedback to add a new strategy in the Olmstead Plan related to population data. Please see the "*Strategy #8: Aggregated Population Data*" section. Regarding recidivism rates, this is being addressed in the Olmstead Plan under Strategy #3 (*Reach-in justice settings*), Objective #4, Sub-Objective B.
124	Advocate	***Objective #2 A & B***: Create more housing units with a varied continuum of care.	This is being addressed in the Olmstead Plan under Strategy #1 (*Housing*), Objective #2, Sub-Objectives A and B.
125	Advocate	***Objective #2 A & B***: On a quarterly basis bring together the stakeholders such as from health, justice, housing, education and the like to review progress, etc.	Please see the "Evaluation and Transparency" section in the introduction of the Olmstead Plan. This section was expanded to include more information about seeking community input. Also, for more information on how to stay informed of opportunities for input on the Olmstead Plan, please visit the AHCCCS Olmstead web page.
126	Advocate	***Objective #2 A & B***: When transitioning individuals from a more secure higher level of care to a lesser restrictive and less secure program/facility mandate a “warm” handoff” (by a case manager or the like) to the responsible receiving agency/site/individual.	This is being addressed in the Olmstead Plan under Strategy #1 (Housing), Objectives A and B.
127	Advocate	***Objective #3 A & B***: Records/reports to be maintained by the respective agencies of patients/clients (as well as aggregate numbers) at each level of care such as BHRF, Level I facilities, jails/prisons, specialty homes, DD homes, unlicensed boarding homes, etc.	AHCCCS has made a post-public comment change to the Plan in response to some of your feedback to add a new strategy in the Olmstead Plan related to population data. Please see the "*Strategy #8: Aggregated Population Data*" section.
128	Advocate	***Objective #3 A & B***: Review, establish, and disseminate various housing options for those with special needs such as sex offenders, the elderly, DD, etc.	Housing options for individuals with an identified need for housing, including hard to house individuals, is outlined in ACOM Policy 448. Managed Care Organizations (MCOs) and their providers shall: * Identify and refer members with high need for housing, * Assist members to identify, apply, and qualify for housing options they may be eligible for, and * Require providers to participate and support pre-tenancy activities and continue with ongoing housing-related supports.

*** AHCCCS did not ask respondents to disclose their role when providing the public comments. These affiliations were derived from the manner in which the comments were provided and are simply intended to provide more context to the comment.***