Arizona Olmstead Plan

Arizona Olmstead Plan

Introduction:

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

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

In 2001 (and subsequently in 2003), AHCCCS worked with the Arizona Department of Health Services (ADHS) and the Arizona Department of Economic Security (ADES) to develop and update the state's Olmstead Plan. For more information on the Olmstead Planning history and the historical version of the Olmstead Plan please visit www.azahcccs.gov/Olmstead.

Arizona's Practice of Advancing Olmstead:

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

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

whereby members receive physical and behavioral health care from one MCO and the LTSS are provided by ADES. Designed to support members to live and receive services in community-based settings, the ALTCS program has supported members to reside either in their own home or an alternative residential setting (e.g., assisted living facilities, group home, etc.). Over a decade ago (2009), the proportion of members residing in their own homes was as low as 49 percent and has currently grown to maintain a rate of 72 percent (in 2020 and 2021), while the proportion of the members residing in institutions declined from 31 percent (2009) to the current rate of 9 percent (in 2020 and 2021). The proportion of members residing in alternative residential settings remains stable at 19 percent for the past five years. More information about the specific program elements employed by AHCCCS and the MCOs to support community-based care for ALTCS members may be found in the Home and Community Based Services Report provided to CMS on an annual basis and posted to the AHCCCS website.

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

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

Arizona Olmstead Plan

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

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

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

Housing and Health Opportunities (H2O) Waiver Amendment - AHCCCS is requesting an amendment to the 1115 Research and Demonstration Waiver to seek waiver and expenditure authority to implement the AHCCCS Housing and Health Opportunities (H2O) demonstration. The goal of the AHCCCS H2O demonstration is to enhance and expand housing services and interventions for AHCCCS members who are homeless or at risk of becoming homeless. It is anticipated that AHCCCS will receive a response to the waiver amendment request by 10/1/2022. This request is an example of AHCCCS' drive to innovate community-based care for targeted populations by providing transitional housing and/or expanding access to supportive services to ensure housing stability.

Behavioral Health Continuum of Care - AHCCCS facilitated an extensive stakeholder engagement process in May 2019 to assess and provide recommendations to enhance the service delivery system. The focus was on ensuring an array of options available to members on the continuum aimed at supporting individuals to receive treatment in the clinically appropriate least restrictive environment, creating opportunities for members to elect voluntary treatment. In addition to the original six monthly meetings whereby roughly 90 stakeholders contributed, stakeholders continued to participate in workgroups focusing on implementing recommendations specific to membership populations (children, adults experiencing General Mental Health/Substance Use challenges, and individuals with an SMI designation). In 2022, AHCCCS published a report of the progress of the recommendations proposed by the stakeholders, including

changes that have been implemented, planned, or are under further review by the agency. This effort is a testament of AHCCCS' engagement with the community of stakeholders impacted by the delivery system to assess needs and make recommendations, while also providing transparency into the progress of implementation.

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

Home and Community Based Settings (HCBS) Rules - AHCCCS utilized the HCBS Rules to establish new standards by which to measure residential and non-residential settings in their efforts to support members to integrate into their community of choice and have full access to the benefits of community living. AHCCCS views the HCBS Rules as the equivalent of basic rights afforded to the ALTCS membership. The HCBS Rules will continue to reinforce Arizona's priority to support members to live and receive services in the most integrated setting. Given Arizona's residential placement rates, the main opportunity, under the HCBS Rules, is to focus attention on ensuring that members are actively engaged and participating in their communities to the same degree as any other Arizonan through employment, education, volunteerism, and social and recreational activities. The residential and non-residential providers must come into compliance by March 2023 in order to continue to receive Medicaid reimbursement for services. This is an example whereby AHCCCS is not just satisfied with simply providing community-based care, but rather advancing the system to support members in fundamental human experiences of making meaningful contributions, relationships, and community engagement that lead to better health outcomes.

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

Arizona Olmstead Plan

Focus Area	2003 Plan Accomplishments	Present Day Practices/Initiatives
Member Voice and Choice	Establishment of ALTCS Member/Provider Councils within each MCO contract.	Establishment of an Office of Individual and Family Affair (OIFA) within each MCO contract.
Placement Rates	Offer financial incentives to MCOs to continue improving HCBS placement rates for in-home and alternative residential placements.	Established performance targets in contract for MCOs to work towards moving people from alternative residential placements into their own homes.
Network Adequacy	Annual Network Development and Management Plans are required of MCOs.	Annual Workforce Development Plans are required of MCOs to ensure providers have enough competent staff to provide care.
Employment Services	Transition coordination and payment of long-term employment services from the ADES/Rehabilitation Services Administration to Medicaid coordinated by the MCOs.	Instituted policy for MCOs pertaining to the expectations for the provision of employment services.
Person-Centered Planning	Enhancement of the Person-Centered Planning process by ADES/DDD.	A new Person-Centered Service Planning process and standardized tool is being used by all ALTCS MCOs and focuses on personal goals and community integration.
Discharge Planning	Cross-agency Arizona State Hospital (ASH) discharge planning coordination.	MCOs are required to have policies and procedures, provide high-touch care management and behavioral health services, and status reports on discharged members.

Arizona Olmstead Plan

Focus Area	2003 Plan Accomplishments	Present Day Practices/Initiatives
Assertive Community Treatment (ACT)	Establishment of ACT teams.	ACT teams continue to grow statewide, including specialty forensic and medical ACT teams. Specialty teams are being considered for members with intellectual and developmental disabilities.
Consumer-Run Agencies	Expand consumer-run agencies.	Criteria and processes established for identifying new consumer- and family-run agencies.
Child and Family Teams (CFT)	Development of CFT practice and training.	Creation of protocols in policy, training competencies, and verification of competencies of facilitators and MCO monitoring standards.
Service Delivery Model Expansion	Implementation of Spouse as Paid Caregiver and Self-Directed Attendant Care ALTCS in-home care service delivery models.	Implemented Agency with Choice model to afford members an opportunity to direct their care while also receiving support from the agency.

In addition to these practices and initiatives noted above, the AHCCCS Olmstead web page presents a timeline and description of efforts like these that have been undertaken to advance the spirit and intention of Olmstead principles in order to provide community-based treatment and care. The list is presented within system-related, contracts/policy, initiatives, and upcoming categories. AHCCCS will continue to keep the Olmstead web page updated to keep stakeholders informed about initiatives that may not be expressly addressed in the Olmstead plan, but does support mitigation of institutionalization and the successful transition of members from institutional settings into community-based living and service delivery. For more information on the historical and upcoming initiatives, please visit the AHCCCS web page and the section entitled, "*A Recent History of Olmstead Activities.*"

Arizona's 2022 Olmstead Plan In Development:

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

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

Evaluation and Transparency:

The intent of the design of the Olmstead Plan is for it to be both an actionable and "living" plan. The plan contains specific timelines for objectives that are directed at completing a specified process while also including, as applicable, specific performance targets, when applicable, to measure positive change resulting from the objectives. AHCCCS plans to post updates to the plan, when available, as well as available data on outcomes, ensuring the protection of member health information. 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 www.azahcccs.gov/Olmstead. Lastly, under each strategy listed, AHCCCS

will include a section to record a running list of major accomplishments that have occurred based on activities listed within the objectives and performance targets in order to track the successes of each strategy.

Arizona Olmstead Plan - Summary Overview

#	Strategy
1	**Effective Permanent Supportive Housing (PSH) for members to successfully reside in the community** – Increase housing choice and opportunities for individuals and ensure necessary support services are available to assist members to obtain and maintain the least restrictive, most integrated community setting possible.
2	**Reach-in discharge planning for hospital settings** – Increase the ease of access for care coordination and discharge planning for members in hospital settings, while reducing outpatient service barriers.
3	**Reach-in discharge planning for correctional settings** – Improve discharge planning, reach-in care coordination, and service delivery for members exiting correctional settings.
4	**Expansion of Home and Community-Based Services (HCBS) for aging individuals with Serious Mental Illness (SMI) determinations** – Explore options to provide medically-necessary HCBS services to the aging SMI population who do not meet institutional level of care criteria to become eligible for the Arizona Long Term Care System (ALTCS).
5	**Workforce Development initiatives** – Implement programs and systems that will enhance the capacity, capability, and commitment of the health care workforce.
6	**High quality network to ensure members are served in the most effective and least restrictive manner** – Ensure services are provided by high quality network providers in a timely manner.
7	**Person-centered planning enhancements** - Improve monitoring with service and treatment planning standards for Managed Care Organizations (MCOs).

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

Objective #1	Target Date	Performance Targets	Progress Summary
Address barriers to the financing and delivery of supportive housing support and wrap-around services.			
A. Review and update the AHCCCS Medical Policy Manual (AMPM) Title XIX/XXI Behavioral Health Service Benefit policy (AMPM 310-B) to clarify expectations on housing support and wrap-around services and benefits related to Medicaid funding.	3/31/2023		
B. Modify the AHCCCS Contractor Operations Manual (ACOM) Housing policy (ACOM 448) to clearly outline how Medicaid services may be used to help members obtain and maintain housing.	3/31/2023		
C. Establish baseline data on current utilization of existing housing support and wrap-around services to determine how services are being utilized to meet members' housing needs and to strategize opportunities for improvement.	7/1/2024		
Objective #2	**Target Date**	**Performance Targets**	**Progress Summary**
Expand access and range of housing settings for all eligible populations.			

A. Develop new bridge options to facilitate transition from residential, inpatient, correctional, and housing instability to the least restrictive, community-based settings.	3/31/2023 6/30/2023	• Increase the number of bridge units to 50. • Maintain or exceed 95% occupancy across all units each month.	
B. Use covered Medicaid housing support services to partner with housing providers (e.g., Public Housing Authorities, 811 Project Rental Assistance, etc.) to expand permanent, community-based housing options.	12/31/2022 10/1/2024	• Establish baseline data for scattered site and Community Living Program (CLP) capacity. • Once capacity baseline data is established, increase the number of housing units by 10%.	
Objective #3	**Target Date**	**Performance Targets**	**Progress Summary**
Increase speed with which appropriate housing options can be identified and provided.			
A. Strengthen screening, assessment, in-reach, outreach, member provider choice, and service coordination processes.	10/1/2023	• Reduce time from housing waitlist placement to move-in by 10%.	
B. Improve PSH stability for members in AHCCCS Housing Programs (AHPs).	11/1/2022	• Establish baseline data for length-of-stay in AHCCCS housing units in order to determine subsequent strategies.	
C. Utilize the *Level of Care Utilization System* (LOCUS) standardized assessment tool being used by the Provider network to evaluate the most appropriate and least restrictive housing settings and supportive services.	10/1/2023	• Identify and implement a new housing screening tool.	

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

Objective #1	Target Date	Performance Targets	Progress Summary
Develop contract, policy, or other guidance document changes for Managed Care Organizations (MCOs) to strengthen provider oversight and compliance with care coordination and discharge planning.			
A. Increase usage of *Child and Adolescent Level of Care Utilization System* (CALOCUS) as standardized assessment tools used by the Provider network to determine service level needs across all MCOs.	10/1/2023	• Increase completed CALOCUS assessments by 5% each month by the target date. • Ongoing utilization to be monitored and evaluated on organization/ provider usage and staff training to identify opportunities for technical assistance.	
B. Require *Level of Care Utilization System* (LOCUS) standardized assessment tool by the Provider network to evaluate the most appropriate and least restrictive services and level of care across all MCOs.	4/1/2024	• At least 50 providers will be using the LOCUS within 6 months of the target roll-out date of 10/1/2023. • Ongoing utilization to be monitored and evaluated on organization/provider usage and staff training to identify opportunities for technical assistance.	

Objective #2	Target Date	Performance Targets	Progress Summary
Use CommunityCares, the statewide Closed-Loop Referral System (CLRS), for members exiting hospital settings to increase member access to community resources addressing social risk factors of health.			
A. Monitor usage of CommunityCares by hospital/inpatient providers to community resources using the CLRS.	9/30/2023	• 30% of hospitals/inpatient providers will be facilitating at least 10 member referrals (on average) per month using CommunityCares after the go-live date.	

Strategy #3: Reach-in discharge planning for correctional settings

Objective #1	Target Date	Performance Targets	Progress Summary
Develop relationships with counties/correctional settings currently not participating in data sharing with AHCCCS to support enrollment suspense.	7/1/2023	• Add two new counties/ correctional settings that participate in data sharing with AHCCCS, prioritizing outreach to counties with higher population density.	• As of July 2022, there are currently five counties that are participating in data sharing with AHCCCS.
Objective #2	**Target Date**	**Performance Targets**	**Progress Summary**
Monitor enrollment suspense/pre-release inmate applications for care coordination.	12/31/2023	• Collaborate with the Arizona Department of Corrections, Rehabilitation & Reentry (ADCRR) to ensure at least 55% of all inmates releasing from ADC have a pre-release application submitted prior to release.	• As of July 2022, approximately 50% of all inmates released from ADC have a pre-release application submitted prior to release.
Objective #3	**Target Date**	**Performance Targets**	**Progress Summary**
Develop a discharge planning process which ensures inmates obtain medically-necessary Durable Medical Equipment (DME) immediately upon release.	7/1/2023	• 75% of inmates with medically necessary DME needs obtain DME the same day of release.	

Objective #4	Target Date	Performance Targets	Progress Summary
Use the Justice Reach-In Monitoring Report to analyze member-level data for justice-involved members with chronic and/or complex physical and/or behavioral health needs.			
A. Identify a cohort of members who have received a reach-in care coordination service in recent years and verify service delivery following release.	1/01/2023		
B. Perform utilization analysis to evaluate services provided post-release as compared to individuals being released who have not received a reach-in service to determine trends on: ○ Emergency Department usage, ○ Crisis Utilization, ○ Inpatient Stays, and ○ Rates of members returning to correctional settings (recidivism).	6/30/2023		
C. Develop a baseline for desired outcomes and use the data to inform performance criteria/goals for Managed Care Organization (MCO) requirements.	7/31/2023		

D. Review and update contract, policy, or other guidance document changes to enhance MCO oversight and compliance with care coordination and discharge.	10/1/2023		
Objective #5	**Target Date**	**Performance Targets**	**Progress Summary**
Explore the use of CommunityCares, the statewide Closed-Loop Referral System (CLRS), in correctional settings to increase member access to community resources addressing social risk factors of health.	3/31/2023		

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

Objective #1	Target Date	Performance Targets	Progress Summary
Explore options to provide medically-necessary HCBS to the aging SMI population who do not meet institutional level of care criteria to become eligible for the Arizona Long Term Care System (ALTCS).			
A. Identify a cohort of individuals 65 years and older with an SMI designation who were denied ALTCS eligibility for medical reasons.	10/31/2022		
B. Conduct fiscal impact analysis for the utilization of HCBS by the cohort.	12/31/2022		
C. Research health outcomes and service utilization of the cohort including hospitalizations, inpatient stays and crisis utilization, and rehabilitation services.	2/1/2023		
D. Explore potential Medicaid authority and/or funding options.	6/30/2023		

Strategy #5: Workforce Development initiatives

Objective #1	Target Date	Performance Targets	Progress Summary
Improve hiring and retention of Direct Care Workers (DCWs) and behavioral health technician (BHT)/behavioral health paraprofessional (BHPP) staff			
A. Develop and implement a Provider Workforce Database and System to track and monitor the following: ● Retention rates (rates of keeping staff) ● Turnover rates (rates of staff leaving positions) ● Time-to-fill (length of time to fill positions)	4/2023	● Initiate collection of baseline data for retention, turnover, and time-to-fill metrics.	
B. Enhance basic competencies, and create new specialized competencies, that support career development opportunities to support members with complex needs and support provider agency leadership with expertise around workforce development management practices. ● For example, new competencies and training requirements for behavioral health providers serving Arizona Long Term Care System (ALTCS) members.	4/2024		

C. Create and implement an interactive Caregiver Career Pathway (CCP) planning tool into the Pipeline AZ platform for prospective health care staff to explore Arizona health care jobs, including their eligibility requirements, and map the career ladders and frameworks connected to actual job openings.	4/2024		

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

Objective #1	Target Date	Performance Targets	Progress Summary
Use Electronic Visit Verification (EVV) to monitor access to care for Home and Community-Based Services (HCBS).			
A. Develop reporting criteria for AHCCCS and Managed Care Organizations (MCOs) to monitor and report the following access to care data: ● Percentage of visits scheduled, ● Percentage of missed appointments being rescheduled in accordance with the member's contingency plan, and ● Timeframes from when services were determined medically necessary to when services were actually provided.	12/31/2022		
B. Develop and implement access to care performance targets for providers and require MCOs to monitor those requirements.	9/2023		

Objective #2	Target Date	Performance Targets	Progress Summary
Monitor timeliness of appointments available for prescribers of psychotropic meds, general behavioral health providers, and children in legal custody of the Arizona Department of Child Safety (DCS) and adopted children per A.R.S. § 8-512.01.	Ongoing (review every six months)	Using AHCCCS' Appointment Availability standards, maintain or exceed current network access to appointments.	
Objective #3	**Target Date**	**Performance Targets**	**Progress Summary**
Increase network adequacy for behavioral health services, including members with developmental disabilities and behavioral health needs and children/adolescents with behavioral health needs.			
A. MCOs to implement at least one Center of Excellence (COE) for children at risk of/with Autism Spectrum Disorder (ASD).	12/31/2022	• 100% of MCOs to implement at least one COE for children at risk of/with ASD.	• As of July 2022, six of the eight MCOs have at least one contracted provider with a COE.
B. MCOs to develop consistent definitions and requirements aligned with national standards for COEs to allow for expansion of the network of COEs available and competency to serve the population of children and adolescents at risk of/with ASD.	10/1/2023		
C. Increase and enhance the network of available service providers across all levels of care who are certified, or have completed specific coursework or training, in service provision to	12/2022	• In collaboration with the Department of Economic Security, Division of Developmental Disabilities (ADES/DDD), identify certification and training programs	

children and adolescents with complex behavioral health needs and co-occurring disorders, including those at risk/with ASD.	4/2023	that will be endorsed by both entities. ● Establish baseline data for the number of available service providers with specific training or expertise in service provision.	
D. Purchase and implement training for use of the *Early Childhood Service Intensity Instrument* (ECSII), a stand-alone assessment tool, which allows for assessment of children birth through five.	3/2023	● Implement training for 3,000 provider, AHCCCS, and MCO staff on the ECSII tool.	

Strategy #7: Person-centered planning enhancements

Objective #1	Target Date	Performance Targets	Progress Summary

Implement performance measurements and targets for Arizona Long Term Care System (ALTCS) Managed Care Organizations' (MCOs), including Tribal ALTCS Programs, case management chart audits for more frequent performance monitoring and to ensure MCO compliance with the federally mandated Person-Centered Service Plan (PCSP) process and requirements.	10/1/2022
	
	10/1/2023
	
	10/1/2023
		• Work with the Centers for Medicare & Medicaid Services (CMS) to finalize performance measurements and targets.
		• Modify ALTCS contracts to initiate MCO and Tribal ALTCS Program compliance reporting with performance targets, including adding a formal deliverable to the Chart of Deliverables.
		• MCOs and the Tribal ALTCS Programs to maintain 86% compliance in ensuring the PCSP process and documentation include:
		  ○ Member choice of services and providers.
		  ○ Member needs and progress towards personal goals and desired outcomes.
		  ○ Verification that PCSPs were reviewed with members/ guardians and revised at least annually.
		  ○ Services, including the type, scope, amount, duration, and frequency specified in the PCSPs, as well as verification of service delivery.	

Objective #2	Target Date	Performance Targets	Progress Summary
Increase the utilization of *Supplemental Security Income/Social Security Disability Insurance Outreach, Access, and Recovery (SOAR)* services provided to eligible members.			
Identify a position within AHCCCS that would be partially responsible for SOAR efforts, to include, but not limited to: ● Becoming a SOAR Co-State Lead for Arizona, ● Developing a network of SOAR Local Leads across the state, ● Tracking completed SOAR online trainings for individuals becoming SOAR-certified, ● Providing education and training to expand and promote SOAR, and ● Monitoring utilization of SOAR services through Medicaid funding.	10/1/2023		