A	
ABSENT PARENT	An individual who is absent from the home and is legally responsible for providing financial and/or medical support for a dependent child, as specified by AAC R9-22-1001.
ABUSE	The infliction of, or allowing another individual to inflict, or cause, physical pain or injury, impairment of bodily function, disfigurement or serious emotional damage which may be evidenced by severe anxiety, depression, withdrawal, or untoward aggressive behavior. Such abuse may be caused by acts or omissions of an individual having responsibility for the care, custody or control of a client receiving behavioral health services or community services. Abuse shall also include sexual misconduct, assault, molestation, incest, or prostitution of, or with, a client under the care of personnel of a mental health agency as specified in AAC R9-21-101(B).
ABUSE - OF A CHILD	The infliction or allowing of physical injury, impairment of bodily function or disfigurement or the infliction of or allowing another individual to cause serious emotional damage as evidenced by severe anxiety, depression, withdrawal, or untoward aggressive behavior and which emotional damage is diagnosed by a medical doctor or psychologist and is caused by the acts or omissions of an individual who has the care, custody, and control of a child. As specified in ARS 8-201(2), abuse includes: 1. Inflicting or allowing sexual abuse, sexual conduct with a minor, sexual assault, molestation of a child, commercial sexual exploitation of a minor, sexual exploitation of a minor, incest, or child sex trafficking as those acts are described in the ARS Title 13, Chapter 14. 2. Physical injury that results from permitting a child to enter or remain in any structure or vehicle in which volatile, toxic, or flammable chemicals are found, or equipment is possessed by any individual for the purpose of manufacturing a dangerous drug as specified in ARS 13-3401. 3. Unreasonable confinement of a child.
ABUSE - OF A VULNERABLE ADULT ***Revised: 09/2024***	As specified in ARS 46-451(A)(1), (i) An intentional infliction of physical harm, (ii) Injury caused by negligent acts or omissions, (iii) Unreasonable confinement, or (iv) Sexual abuse or sexual assault as specified in ARS 46-451(A)(1).
ABUSE - OF MEMBER	Abuse of a Vulnerable Adult or the Abuse of a Child who is a member as specified in ARS 46-451(A)(1), ARS 8-201(2), and ARS 46-451(A)(9).
ABUSE - OF THE AHCCCS PROGRAM	Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the AHCCCS program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care, noncompliance with licensure standards, misuse of billing numbers, or misuse or abuse of billing privileges. It also includes beneficiary practices that result in unnecessary cost to the AHCCCS Program [42 CFR 455.2].

ACCESS	The timely use of services to achieve optimal outcomes, as evidenced by managed care plans successfully demonstrating and reporting on outcome information for the availability and timeliness elements specified in 42 CFR 438.68, 42 CFR 438.206, and 42 CFR 438.320.
ACCESS TO PROFESSIONAL SERVICE INITIATIVE (APSI)	A program to preserve and promote access to medical services through a uniform percentage increase to the Contractor's rates for professional services provided by qualified physicians and non-physician professionals affiliated with designated hospitals as specified in Contract and Policy . Federal regulation mandates that these payments be prior approved by Centers for Medicare and Medicaid Services (CMS) before they shall be implemented.
ACTION	The denial or limited authorization of a requested behavioral health service. This includes: 1. Type or level of service. 2. Reduction, suspension, or termination of a previously authorized service. 3. Denial, in whole or in part, of payment for a service. 4. Failure to provide covered services in a timely manner. 5. Failure to act within established timeframes for resolving an Appeal or complaint and providing notice to affected parties, and 6. Denial of the Title XIX/XXI eligible individual's request to obtain covered services outside the network.
ACTIVE TREATMENT	A current need for treatment. The treatment is identified on the member's service plan to treat a serious and chronic physical, developmental, or behavioral condition requiring medically necessary services of a type or amount beyond that generally required by members that lasts, or is expected to last one year or longer, and requires ongoing care not generally provided by a primary care provider.
ACTIVE TREATMENT - CHILDREN'S REHABILITATION SERVICES (CRS)	A current need for treatment of the CRS qualifying condition(s) or it is anticipated that treatment or evaluation for continuing treatment of the CRS qualifying condition(s) will be needed within the next 18 months from the last date of service for treatment of any CRS qualifying condition as specified in AAC R9-22-1301.
ACTIVITIES OF DAILY LIVING	Activities a member shall perform daily for the member's regular day-to-day necessities, including but not limited to mobility, transferring, bathing, dressing, grooming, eating, and toileting.
ACTUAL ACQUISITION COST	The purchase price of a drug paid by a pharmacy net of all discounts, rebates, chargebacks, and other adjustments to the price of the drug, not including professional fees.
ACTUARY	An individual who meets the qualification standards established by the American Academy of Actuaries for an actuary and follows the practice standards established by the Actuarial Standards Board. An actuary develops and certifies the capitation rates as specified in 42 CFR 438.2.

ACUTE	Symptoms that are characterized by sharpness or severity, have a sudden onset, have arisen quickly, and are short-lived.
ACUTE CARE HOSPITAL	A general hospital that provides surgical services and emergency services.
ACUTE CARE ONLY (ACO)	1. The enrollment status of a member who is otherwise financially and medically eligible for Arizona Long Term Care Services (ALTCS) but who: a. Refuses Home and Community Based Services (HCBS) offered by the Case Manager. b. Has made an uncompensated transfer that makes the individual ineligible. c. Resides in a setting in which Long Term Services and Supports (LTSS) cannot be provided, or d. Has equity value in a home that exceeds $713,000. These ALTCS enrolled members are eligible to receive acute medical services but not eligible to receive Long Term Care (LTC) institutional, alternative residential or Home and Community Based Services (HCBS).
ADJUDICATED CLAIM	A claim that has been received and processed by the Contractor which resulted in a payment or denial of payment.
ADMINISTRATIVE APPEAL	An appeal to AHCCCS of a decision made by a contractor as the result of a grievance.
ADMINISTRATIVE OFFICE OF THE COURTS (AOC)	The Arizona Constitution authorizes an administrative director and staff to assist the Chief Justice with administrative duties. Under the direction of the Chief Justice, the administrative director, and the staff of the AOC provide the necessary support for the supervision and administration of all State courts.
ADMINISTRATIVE SERVICES SUBCONTRACT/SUBCONTRACTOR	An agreement that delegates any of the requirements of the Contract with AHCCCS, including, but not limited to the following: a. Claims processing, including pharmacy claims, b. Pharmacy Benefit Manager (PBM), c. Dental Benefit Manager, d. Credentialing, including those for only primary source verification (i.e., Credential Verification Organization [CVO]), e. Medicaid Accountable Care Organization (ACO), f. Service Level Agreements with any Division or Subsidiary of a corporate parent owner, and g. Comprehensive Health Plan (CHP) and DES DDD Subcontracted Health Plan. A person (individual or entity) who holds an Administrative Services Subcontract is an Administrative Services Subcontractor. Providers are not Administrative Services Subcontractors.

ADOPTIVE PARENT(S)	Any adult(s) who is a resident of Arizona, whether married, unmarried, divorced or legally separated, who has adopted a child who is eligible under Title XIX or Title XXI of the Social Security Act.
ADULT	An individual 18 years of age or older, unless the term is given a different definition by statute, rule, or policies adopted by AHCCCS.
ADULT DAY HEALTH SERVICES	A program that provides planned care, supervision and activities, personal care, personal living skills training, meals, and health monitoring in a group setting during a portion of a continuous 24-hour period. Adult day health services may also include preventive, therapeutic and restorative health-related services that do not include behavioral health services as specified in ARS 36-401.
ADULT DEVELOPMENTAL HOME (ADH)	An Alternative Home and Community Based Services (HCBS) Setting for adults (18 or older) with Developmental Disabilities (DD) which is licensed by Department of Economic Securities (DES) to provide room, board, supervision and coordination of habilitation and treatment for up to three residents as specified in ARS 36-551.
ADULT FOSTER CARE (AFC) HOME	An Alternative Home and Community Based Services (HCBS) Setting that provides room and board, supervision, and coordination of necessary adult foster care services within a family type environment for at least one and no more than four adult residents who are ALTCS members.
ADULT GROUP ABOVE 106% FEDERAL POVERTY LEVEL (ADULTS > 106%)	Adults aged 19-64, without Medicare, with income above 106% through 133% of the Federal Poverty Level (FPL).
ADULT GROUP AT OR BELOW 106% FEDERAL POVERTY LEVEL (ADULTS </= 106%)	Adults aged 19-64, without Medicare, with income at or below 106% of the Federal Poverty Level (FPL).
ADULT PROTECTIVE SERVICES (APS)	A Program within the Arizona Department of Economic Security (DES) that investigates allegations and provides service referrals to protect vulnerable adults from abuse, neglect, or exploitation.
ADULT RECOVERY TEAM (ART)	A group of individuals that, following the Nine Guiding Principles for Recovery-Oriented Adult Behavioral Health Services and Systems, work in collaboration and are actively involved in a member's assessment, service planning, and service delivery. At a minimum, the team consists of the member, member's Health Care Decision Maker (HCDM) (if applicable), advocates (if assigned), and a qualified behavioral health representative. The team may also include the member's family, physical health, behavioral health or social service providers, other agencies serving the member, professionals representing various areas of expertise related to the member's needs, or other individuals identified by the member.

ADVANCE	Includes but is not limited to payment to a provider or affiliate by a Contractor which is based on an estimate of Received but Unpaid Claims (RBUCs), an estimate of the value of erroneous claim denials (including underpayments), a loan, or as otherwise defined by the Contractor.
ADVANCE CARE PLANNING	A part of the End-of-Life care concept and is a billable service that is a voluntary face-to-face ongoing discussion between a qualified health care professional and the member/ Health Care Decision Maker (HCDM) to: 1. Educate the member/HCDM and Designated Representative (DR) about the member's illness and the health care options that are available to them. 2. Develop a written plan of care that identifies the member/HCDMs choices for treatment, and 3. Share the member/HCDMs wishes with family, friends, and his or her physicians.
ADVANCE DIRECTIVE	A document by which an individual makes provision for health care decisions in the event that, in the future, he/she becomes unable to make those decisions.
ADVANCED LIFE SUPPORT (ALS)	Refer to the term Transportation - Advanced Life Support.
ADVERSE BENEFIT DETERMINATION ***Revised: 10/2022***	1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit. 2. The reduction, suspension, or termination of a previously authorized service. 3. The denial, in whole or in part, of payment for a service. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a "clean claim" at ARS 447.45(b) of this chapter is not an adverse benefit determination. 4. The failure to provide services in a timely manner, as defined by the State. 5. The failure of an MCO, PIHP, or PAHP to act within the timeframes provided in ARS 438.408(B)(1) and (2) regarding the standard resolution of grievances and appeals. 6. For a resident of a rural area with only one MCO, the denial of an enrollee's request to exercise his or her right, under ARS 438.52(b)(2)(ii), to obtain services outside the network. 7. The denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.
ADVERSE DRUG EVENT (ADE)	An injury resulting from medical intervention related to a drug including harms that occur during medical care that are directly caused by the drug including but not limited to medication errors, adverse drug reactions, allergic reactions, and overdose.

AFFILIATE (RELATED PARTY) TRANSACTIONS	Transactions with a party that has, or may have, the ability to control or significantly influence a Contractor, or a party that is, or may be, controlled or significantly influenced by the Contractor. Control, for purposes of this definition, means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of an enterprise through ownership, by contract, or otherwise. “Related parties” or “Affiliates” include, but are not limited to, agents, managing employees, individuals with an ownership or controlling interest in the disclosing entity, and their immediate families, subcontractors, wholly owned subsidiaries or suppliers, parent companies, sister companies, holding companies, and other entities controlled or managed by any such entities or individuals.
AFFILIATE (RELATED PARTY)	A party that has, or may have, the ability to control or significantly influence a Contractor, or a party that is, or may be, controlled or significantly influenced by a Contractor. "Related parties" include, but are not limited to, agents, managing employees, individuals with an ownership or controlling interest in the Contractor and their immediate families, subcontractors, wholly owned subsidiaries or suppliers, parent companies, sister companies, holding companies, and other entities controlled or managed by any such entities or individuals.
AFFILIATED ORGANIZATION	A party that, directly or indirectly through one or more intermediaries, controls, is controlled by, or is under common control with an entity.
AFFORDABLE CARE ACT (ACA)	Federal statute signed into law in March 2010 as part of comprehensive health insurance reforms that will, in part, expand health coverage, expand Medicaid eligibility, establish health insurance exchanges, and prohibit health insurers from denying coverage due to pre-existing conditions. The Affordable Care Act is also referred to as the Patient Protection and Affordable Care Act (ACA).
AGENCY WITH CHOICE (AWC)	An option offered to ALTCS members who reside in their own home. This option is elective as a member or the member’s Individual Representative (IR) may choose to participate in AWC. Under the AWC option, the provider agency and the member/IR enter into a partnership agreement. The provider agency serves as the legal employer of the Direct Care Worker (DCW) and the member/IR serves as the day-to-day managing employer of the DCW.
AGENT	Any individual who has been delegated the authority to obligate or act on behalf of a provider as specified in 42 CFR 455.101.
AGGREGATE LIFETIME DOLLAR LIMIT	A dollar limitation on the total amount of specified benefits that may be paid under a Managed Care Organization (MCO), Prepaid Inpatient Health Plan (PIHP), or Prepaid Ambulatory Health Plan (PAHP).
AHCCCS AMERICAN INDIAN HEALTH PROGRAM (AIHP)	A Fee-For-Service (FFS) program administered by AHCCCS for Title XIX/XXI eligible American Indians which reimburses for physical and behavioral health services provided by and through the Indian Health Service (IHS), tribal health programs operated under 638 or any other AHCCCS registered provider.

AHCCCS CLAIMS DASHBOARD REPORTING GUIDE	A document designed to assist the Contractor in submitting a monthly report to address claim requirements, including billing rules and documentation requirements, and submit a report to AHCCCS that will include the rationale for specific requirements.
AHCCCS COMPLETE CARE (ACC) CONTRACTOR	A contracted Managed Care Organization (also known as a health plan) that is responsible for the provision of specific physical and behavioral health services to certain Title XIX/XXI populations as specified in Contract No. YH19-0001 and which does not have the expanded contractual responsibilities of an ACC-RBHA under Competitive Contract Extension (CCE) No. YH20-0002.
AHCCCS COMPLETE CARE-REGIONAL BEHAVIORAL HEALTH AGREEMENT (ACC-RBHA) OR (RBHA) CONTRACTOR	An AHCCCS Complete Care (ACC) Contractor with expanded contractual responsibilities, as specified in Competitive Contract Extension (CCE) No. YH20-0002, for the provision of Non-Title XIX/XXI services for Title XIX/XXI and Non-Title XIX/XXI members and comprehensive Title XIX/XXI physical health and behavioral health services to eligible individuals with a Serious Mental Illness (SMI) designation.
AHCCCS CONTRACTOR OPERATIONS MANUAL (ACOM) ***Revised: 08/2023, 10/2024***	The ACOM provides Administrative, Claims, Financial, and Operational Policies of the AHCCCS Administration. The ACOM also provides information to Contractors and subcontractors who have delegated responsibilities under the contract.
AHCCCS DRUG LIST	A list of federally and state reimbursable behavioral health and physical health care medications that is to be used by AHCCCS Fee-For-Service (FFS) Programs and all Contractors responsible for the administration of acute and long-term care pharmacy benefits. This drug list identifies specific federally and state reimbursable medications and related products, which are supported by current evidence-based medicine. The AHCCCS Drug List includes preferred drugs and was developed to encourage the use of safe, effective, clinically appropriate, and the most cost-effective medications.
AHCCCS ELIGIBILITY DETERMINATION	The process of determining, through an application and required verification, whether an applicant meets the criteria for Title XIX/XXI funded services.
AHCCCS FEE-FOR-SERVICE (FFS) PROGRAM	An AHCCCS program administered by the AHCCCS/Division of Fee-For-Service Management (DFSM) using the original Medicaid payment model, where a fee is paid for each medically necessary service provided (e.g., office visit, test, procedure). Members enrolled in an FFS program may receive AHCCCS-covered services from any AHCCCS-registered provider. Note: Providers do not need to separately contract with any FFS program to render and bill for Medicaid Title XIX/XXI services provided to FFS members. Providers can bill FFS after they enter into a provider participation agreement with AHCCCS Provider Registration. Providers with active registration with AHCCCS Provider Registration serve as the FFS provider network.

AHCCCS GRIEVANCE AND APPEAL SYSTEM GUIDE ***Revised 07/2023***	A document that provides instructions to the Contractors on how to complete the Grievance System Report for submission to, and review by the Division of Health Care Services (DHCS), as required by contract.
AHCCCS HOUSING ACQUISITION, CONSTRUCTION, AND/OR RENOVATION PROGRAMS	A housing program that provides state funding (including the Serious Mental Illness (SMI) Housing Trust Fund per ARS 41-3955.01) for the acquisition, construction and/or renovation of properties (house, condominium, duplex, apartment, new construction etc.) to provide permanent supportive housing for individuals with an SMI designation. The property is held for use of AHCCCS eligible members for an extended period of time through the use of filed Covenants, Conditions, and Restrictions (CC&Rs).
AHCCCS HOUSING PROGRAM	A permanent supportive housing program, eligible members receive a housing subsidy funded through State general funds paired with Medicaid covered supportive services to support eligible persons with achieving housing stability in the community.
AHCCCS MANAGED CARE ORGANIZATION (MCO)	An organization or entity that has a prepaid capitated Contract with AHCCCS pursuant to ARS 36-2904, 36-2940, or 36-2944 to provide goods and services to members either directly or through subcontracts with providers, in conformance with contractual requirements, AHCCCS Statutes and Rules, and Federal law and regulations.
AHCCCS MEDICAL POLICY MANUAL (AMPM) ***Revised: 08/2023***	The AMPM provides information to Contractors and Providers regarding services that are covered within the AHCCCS program. The AMPM is applicable to both Managed Care Organizations (MCOs) and Fee-For-Service (FFS) Programs and Providers.
AHCCCS POLICY COMMITTEE (APC)	A group of individuals comprised of Agency Management and Subject Matter Experts (SME)s within AHCCCS along with external stakeholder and tribal representatives who review and approve new and revised Policies found in both the AHCCCS Contractor Operations Manual (ACOM) and AHCCCS Medical Policy Manual (AMPM).
AHCCCS REGIONAL BEHAVIORAL HEALTH AGREEMENT (ACC-RBHA) or (RBHA) CONTRACTOR	An AHCCCS Complete Care (ACC) Contractor with expanded contractual responsibilities, as specified in Competitive Contract Extension (CCE) No. YH20-0002, for the provision of Non-Title XIX/XXI services for Title XIX/XXI and Non-Title XIX/XXI members and comprehensive Title XIX/XXI physical health and behavioral health services to eligible individuals with a Serious Mental Illness (SMI) designation.
AHCCCS OFFICE OF THE INSPECTOR GENERAL (OIG)	The AHCCCS Office of Inspector General (AHCCCS OIG) is the division of AHCCCS that has the authority to conduct preliminary and full investigations relating to fraud, waste, and abuse involving the programs administered by AHCCCS.

AHCCCS DIVISION OF FEE-FOR-SERVICE MANAGEMENT (DFSM)	The division responsible for the clinical, administrative and claims functions of the Fee-For-Service (FFS) members. This includes American Indians enrolled in the American Indian Health Program (AIHP) for acute care, members enrolled with the Tribal Regional Behavioral Health Authorities for behavioral health services and Tribal long term care programs, and individuals in the Federal Emergency Service population (FES). DFSM pays FFS provider claims, prior authorizes certain medical and behavioral health services, provides ongoing training, completes clinical claims reviews, provides customer services to FFS providers, and completes care coordination activities for the FFS population. The DFSM also acts as the Third-Party Administrator for the School Based Claiming program.
AHCCCS DIVISION OF FEE-FOR-SERVICE MANAGEMENT (DFSM) QUALITY MANAGEMENT (QM)	A unit within the AHCCCS Division of Fee-For-Service Management (DFSM) that oversees Fee-For-Service (FFS) Quality Management (QM) activities, including but not limited to, Quality of Care (QOC) investigations and Health and Safety inspections.
AHCCCS DIVISION OF MANAGED CARE SERVICES (DMCS), QUALITY IMPROVEMENT (QI) TEAM ***Revised:07/2023, 09/2024***	AHCCCS staff who provide oversight of the Contracted Health Plans in the provision of Quality of Care (QOC) investigations, onsite visits, audits and reviews while ensuring compliance with the requirements outlined in Contract and AMPM policies including: provide oversight of Contractor credentialing and delegation processes; monitor compliance with required quality standards and Contractor Quality Management (QM) Corrective Action Plans (CAPs); and provide technical assistance for QM related matters.
AHCCCS DIVISION OF MANAGED CARE SERVICES (DMCS), QUALITY MANAGEMENT (QM) TEAM ***Revised: 07/2023***	AHCCCS staff who provide oversight to Contracted Health Plans in the provision of Quality of Care (QOC) perform investigations, onsite visits, audits and reviews while ensuring compliance with requirements outlined in Contract and AMPM Policies including: provide oversight of contractor credentialing and delegation processes; monitor compliance with required quality standards and Contractor Quality Management (QM) Corrective Action Plans (CAPs); and provide technical assistance for QM related matters.
AHCCCS OFFICE OF INDIVIDUAL AND FAMILY AFFAIRS	The Office of Individual and Family Affairs (OIFA) promotes recovery, resiliency, and wellness for individuals with mental health and substance use challenges.
AHCCCS PROVIDER ENROLLMENT PORTAL (APEP)	The electronic system where providers apply to be enrolled with AHCCCS to qualify themselves to be reimbursed for services provided to AHCCCS members. The system is also used by providers to report changes and complete required revalidations.
AHCCCS REGISTERED PROVIDER	A contracted provider or non-contracting provider who enters into a provider agreement with AHCCCS and meets licensing or certification requirements to provide AHCCCS-covered services.
AIR AMBULANCE	Refer to the term Transportation - Air Ambulance.

ALLOCATION LETTER	Communication provided by AHCCCS to identify funding not otherwise included in the "Original" Allocation Schedule and specific terms and conditions for receipt of Non-Title XIX/XXI funding.
ALLOCATION SCHEDULE ***Revised: 09/2022***	The schedule prepared by AHCCCS that specifies the Non-Title XIX/XXI non-capitated funding sources by program including Mental Health Block Grant (MHBG) and Substance Abuse Block Grant (SABG) Federal Block Grant funds, discretionary grant funds, State General Fund appropriations, County, and other funds, which are used for services not covered by Title XIX/XXI funding and for populations not otherwise covered by Title XIX/XXI funding.
ALTERNATE ELECTRONIC VISIT VERIFICATION (EVV) SYSTEM	Refer to the term Electronic Visit Verification (EVV) System – Alternate.
ALTERNATIVE HOME AND COMMUNITY BASED SERVICES (HCBS) SETTING	A living arrangement where a member may reside and receive HCBS. The setting shall be approved by the director, and either 1. Licensed or certified by a regulatory agency of the state. 2. Operated by the Indian tribe or tribal organization, or an urban Indian organization, and has met all the applicable standards for state licensure, regardless of whether it has actually obtained the license. The possible types of settings include: 1. For an individual with an intellectual/developmental disability: a. Community residential setting, b. Group home, c. State-operated group homes, d. Group foster homes, e. Adult Behavioral Health Therapeutic Homes (ABHTH), and f. Behavioral health respite homes. 2. For an individual who is Elderly and/or have a Physical Disabled (E/PD): a. Adult foster care homes, b. Assisted living homes or assisted living centers, units only, c. Adult Behavioral Health Therapeutic Homes (ABHTH), and d. Behavioral health respite homes.
AMBULANCE	Refer to the term Transportation – Ambulance.
AMBULATORY CARE	Preventive, diagnostic, and treatment services provided on an outpatient basis by physicians, nurse practitioners, physician assistants and/or other health care providers.

AMBULATORY TRANSPORTATION	Refer to the term Transportation – Ambulatory.
AMERICAN INDIAN HEALTH PROGRAM (AIHP)	A Fee-For-Service (FFS) program administered by AHCCCS for Title XIX/XXI eligible American Indians which reimburses for physical and behavioral health services provided by and through the Indian Health Service (IHS), tribal health programs operated under 638 or any other AHCCCS registered provider.
AMERICAN INDIAN MEDICAL HOME (AIMH)	A program for American Indian/Alaska Native (AI/AN) members enrolled in the American Indian Health Program (AIHP). The AIMH Program supports Primary Care Case Management (PCCM), diabetes education, and care coordination for its AIHP enrolled members.
AMERICANS WITH DISABILITIES ACT (ADA)	The ADA prohibits discrimination on the basis of disability and ensures equal opportunity for individuals with disabilities in employment, State and local government services, public accommodations, commercial facilities transportation, and telecommunications as specified in the Americans with Disabilities Act of 1990, as amended, in 42 USC 126 and 47 USC 5.
ANNIVERSARY DATE	The anniversary date is 12 months from the date the member is enrolled with the Contractor and annually thereafter. In some cases, the anniversary date will change based on the last date the member changed Contractors or the last date the member was given an opportunity to change.
ANNUAL DOLLAR LIMIT	Total amount of specified benefits that may be paid in a fiscal year 12-month period under a Managed Care Organization (MCO), Prepaid Inpatient Health Plan (PIHP), or Prepaid Ambulatory Health Plan (PAHP).
ANNUAL ENROLLMENT CHOICE (AEC)	The opportunity for an individual to change Contractors every 12 months.
APPEAL **(As required by CMS 42 CFR 457.1207, 42 CFR 438.10(c)(i)** ***Revised: 07/2023, 09/2024***	To ask for review of a decision that denies or limits a service.
APPEAL RESOLUTION	The written determination by the Contractor concerning an appeal.
APPEAL- SERIOUS MENTAL ILLNESS (SMI)	A request for review of an adverse decision by a Contractor or AHCCCS.
APPLICANT ***Revised: 08/2023***	An individual who: 1. Submits an application for behavioral health services as specified in AAC Title 9, Chapter 21, or on whose behalf an application has been submitted, or 2. Is referred for a determination of eligibility for behavioral health services, as specified in AAC R9-21-101, or 3. Is under the age of 18 and requests, or is referred for, a Serious Emotional Disturbance (SED) Eligibility Determination.

APPOINTMENT	A scheduled day and time for an individual to be evaluated, treated, or receive a service by a healthcare professional or service provider, within their scope of practice.
APPROVED DIRECT CARE WORKER (DCW) TRAINING AND TESTING PROGRAM (APPROVED PROGRAM OR PROGRAM)	Any entity that is approved by AHCCCS to provide training and testing of Direct Care Workers (DCWs. These Approved Programs can be an AHCCCS registered agency that provides Direct Care Services, a private vocational program, or an educational institution (e.g., high school, college, or university).
ARIZONA – NATIONAL BREAST AND CERVICAL CANCER EARLY DETECTION PROGRAM (AZ-NBCCEDP)	An Arizona program that provides breast and cervical cancer screening and diagnosis as specified in AAC R9-22-2001.
ARIZONA ADMINISTRATIVE CODE (AAC)	The official publication of Arizona's codified Rules and published by the Administrative Rules Division.
ARIZONA ASSOCIATION OF HEALTH PLANS (AzAHP)	The AzAHP is an organization dedicated to working with elected officials, AHCCCS Health Care Plans, health care providers, and consumers to keep quality health care available and affordable for all Arizonans. AzAHP is involved in administration of the chart audit process for physical health plan sites and they collaborate with the Contractors with regard to the behavioral health chart audit process.
ARIZONA DEPARTMENT OF HEALTH SERVICES (ADHS)	The State agency that has the powers and duties set forth in ARS 36-104 and ARS Title 36, Chapters 5 and 34.
ARIZONA DEPARTMENT OF JUVENILE CORRECTION (ADJC)	The State agency responsible for all juveniles adjudicated as delinquent and committed to its jurisdiction by the county juvenile courts.
ARIZONA DISABILITY BENEFITS 101 (AZ DB101)	AZ DB101 provides information about employment, health coverage, and benefits to assist individuals with disabilities in making informed decisions about work and self-sufficiency. AZ DB101 is the Arizona-specific website of DB101.
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)	Arizona's Medicaid Program, approved by the Centers for Medicare and Medicaid Services (CMS) as a Section 1115 Waiver Demonstration Program and described in ARS Title 36, Chapter 29.
ARIZONA LONG TERM CARE SYSTEM (ALTCS) ***Revised: 08/23***	An AHCCCS program which delivers long-term, acute, behavioral health and Case Management services as authorized by ARS 36-2931 et seq., to eligible members who are either Elderly and/or have Physical Disabilities (E/PD), and to members with Developmental Disabilities (DD), through contractual agreements and other arrangements. REFER TO "LINE OF BUSINESS"
ARIZONA LONG TERM CARE SYSTEM (ALTCS) LOCAL OFFICE ***Revised: 11/2024***	The Arizona Long Term Care System (ALTCS) local office is currently responsible for the member's financial and medical eligibility determination for ALTCS.

ARIZONA LONG TERM CARE SERVICES (ALTCS) TRANSITIONAL PROGRAM	A program available for eligible Arizona Long Term Care System (ALTCS) members who, at the time of medical reassessment, have improved either medically, functionally, or both, to the extent that they no longer need institutional care, but who still need significant Long-Term Services and Supports (LTSS). The eligible member will continue to require some LTSS, but at a lower level of care. The ALTCS Transitional program allows those members who meet the lower level of care, as determined by the Pre-Admission Screening (PAS), to continue to receive all ALTCS covered services that are medically necessary. Refer to 9 AAC 28, Article 3.
ARIZONA REVISED STATUTE (ARS)	Laws of the State of Arizona.
ARIZONA STATE HOSPITAL (ASH)	Provides long-term inpatient psychiatric care to Arizonans with mental illnesses who are under court order for treatment.
ARIZONA STATE PLAN	The written agreements between the State and Centers for Medicare and Medicaid Services (CMS), which describes how the AHCCCS program meets CMS requirements for participation in the Medicaid program and the State Children's Health Insurance Program (CHIP).
ASSERTIVE COMMUNITY TREATMENT (ACT) TEAM ***Revised: 07/2023***	A team-based service delivery system available 24 hours per day, seven days per week for members with a Serious Mental Illness (SMI) designation who have been assigned to an ACT team. ACT teams provide individualized, flexible services to those living in the community, and each team includes no less than 10 professional health care workers with varied experience for every 100 members on the team, including: a psychiatrist, nurse, social worker, substance abuse specialist, vocational rehabilitation specialist, and a peer specialist.
ASSESSMENT	An analysis of a patient's needs for physical health services or behavioral health services to determine which services a health care institution shall provide to the patient as specified in AAC R9-10-101.
ASSESSMENT - BEHAVIORAL HEALTH	The ongoing collection and analysis of an individual's medical, psychological, psychiatric, and social conditions in order to initially determine if a health disorder exists, if there is a need for behavioral health services, and on an ongoing basis ensure that the individual's service plan is designed to meet the individual's (and family's) current needs and long-term goals.
ASSISTED LIVING CENTER (ALC) ***Revised: 10/2021***	An assisted living facility that provides resident rooms or residential units to eleven or more residents (ARS 36-401).
ASSISTED LIVING FACILITY (ALF)	A residential care institution that provides supervisory care services, personal care services or directed care services on a continuing basis. All approved residential settings in this category are required to meet Arizona Department of Health Services (ADHS) licensing criteria as specified in AAC R9-10 Article 8.

ASSISTED LIVING HOME (ALH)	An Alternative Home and Community Based Services (HCBS) Setting that provides room and board, supervision, and coordination of necessary services to 10 or fewer residents.
ARIZONA LONG TERM CARE SYSTEM (ALTCS)	An AHCCCS program which delivers long-term, acute, behavioral health and Case Management services as authorized by ARS 36-2931 et seq., to eligible members who are either Elderly and/or have a Physical Disability (E/PD), and to members with Developmental Disabilities (DD), through contractual agreements and other arrangements. REFER TO "LINE OF BUSINESS."
AUTHORIZED REPRESENTATIVE	An individual who is authorized to apply for medical assistance or act on behalf of another individual as specified in AAC R9- 22-101, AAC R9-28-401.
AUTO-ASSIGNMENT	The process by which members who do not exercise their right to choose a Contractor, and members who are not assigned a Contractor based on family continuity rules are assigned to a Contractor through an auto-assignment algorithm. The algorithm is a mathematical formula used to assign members to the various Contractors in a manner that is predictable and consistent with AHCCCS goals. Members who do not exercise their right to choose a Contractor and those who are not assigned a Contractor based on family continuity rules are assigned to a Contractor through an auto-assignment algorithm.
AVERAGE MANUFACTURER PRICE (AMP)	The average price paid by wholesalers for drugs distributed to the retail class of trade, net of customary prompt pay discounts.
AVERAGE SPEED OF ANSWER (ASOA)	The average online wait time in seconds that the member/ provider waits from the moment the call is connected in the Contractor's phone switch until the call is picked up by a contractor's representative or Interactive Voice Recognition System (IVR).

B	
BASELINE DATA	Data collected at the beginning of a Performance Improvement Project that is used as a starting point for measurement and the basis for comparison with subsequent remeasurement(s) in demonstrating significant and sustained improvement.
BASIC LIFE SUPPORT (BLS)	Refer to the term Transportation - Basic Life Support (BLS).
BED HOLD	A 24 hour per day unit of service that is authorized by an Arizona Long Term Care System (ALTCS) member's Case Manager or the behavioral health Case Manager or a subcontractor for an acute care member, which may be billed despite the member's absence from the facility for the purposes of short-term hospitalization leave and therapeutic leave. Refer to the Arizona State Plan Amendment (SPA), 42 CFR 447.40 and 42 CFR 483.12, 9 AAC 28.
BEHAVIOR ANALYSIS SERVICES	The use of behavior analysis to assist an individual to learn new behavior, increase existing behavior, reduce existing behavior, and emit behavior under precise environmental conditions as specified in ARS 32-2091.
BEHAVIOR ANALYSIS TRAINEE	An individual who has met the credentialing requirements of a nationally recognized behavior analyst certification board as a board-certified behavior analyst, assistant behavior analyst, or a matriculated graduate student or trainee whose activities are part of a defined behavior analysis program of study, practicum, intensive practicum, or supervised independent fieldwork. The practice under this role requires direct and ongoing supervision consistent with the standards set by a nationally recognized behavior analyst certification board as determined by the Arizona Board of Psychologist Examiners, and as specified in ARS 32-2091.08.
BEHAVIOR ANALYST	An individual who is licensed to practice behavior analysis. As specified in ARS 32-2091.
BEHAVIORAL HEALTH ASSESSMENT	Refer to the term Assessment - Behavioral Health.
BEHAVIORAL HEALTH	Mental health and substance use collectively.
BEHAVIORAL HEALTH CONDITION	Mental, behavioral, or Neurodevelopmental Disorder diagnosis defined by International Classification of Diseases, Tenth Revision, Clinical Modification.
BEHAVIORAL HEALTH DIAGNOSIS	Diagnoses listed in the Standard Service Set in AHCCCS Reference File (RF) 724.
BEHAVIORAL HEALTH DISORDER	Any behavioral, mental health, and/or substance use diagnoses found in the most current version of the Diagnostic and Statistical Manual of Mental Disorders excluding those diagnoses such as intellectual disability, learning disorders and dementia, which are not typically responsive to mental health or substance use treatment.

BEHAVIORAL HEALTH ENTITY	The entity with which the member is enrolled/assigned for the provision of and/or coordination of behavioral health services.
BEHAVIORAL HEALTH FACILITY	A health care institution, as specified in AAC R9-10-101, that provides continuous treatment to an individual experiencing a behavioral health issue that causes the individual to: 1. Have a limited or reduced ability to meet the individual's basic physical needs. 2. Suffer harm that significantly impairs the individual's judgment, reason, behavior, or capacity to recognize reality. 3. Be a danger to self. 4. Be a danger to others. 5. Be an individual with a persistent or acute disability as specified in ARS 36-501, or 6. Be an individual with a grave disability as specified in ARS 36-501.
BEHAVIORAL HEALTH INPATIENT FACILITIES (BHIF)	A health care institution, as specified in AAC R9-10-101, that provides continuous treatment to an individual experiencing a behavioral health issue that causes that individual to: 1. Have a limited or reduced ability to meet the basic physical needs. 2. Suffer harm that significantly impairs the judgment, reason, behavior, or capacity to recognize reality. 3. Be a danger to self. 4. Be a danger to others. 5. Be persistently or acutely disabled as specified in ARS 36-501, or 6. Be gravely disabled.
BEHAVIORAL HEALTH OUT-OF-HOME TREATMENT	Highly individualized treatment services and support interventions to meet the needs of each child and his or her family. When community-based services are not effective in maintaining the child in their home setting, or safety concerns become critical, the use of out of home treatment services can provide essential behavioral health interventions to stabilize the situation. The primary goal of out of home treatment intervention is to prepare the child and family, as quickly as possible, for the child's safe return to their home and community settings.
BEHAVIORAL HEALTH PARAPROFESSIONAL (BHPP) ***Revised: 09/2024***	As specified in AAC R9-10-10O et seq, an individual who is not a Behavioral Health Professional who provides behavioral health services at or for an Arizona Department of Health Safety (ADHS) licensed health care institution according to the health care institution's policies and procedures that: 1. If the behavioral health services were provided in a setting other than an ADHS licensed health care institution, the individual would be required to be licensed as a behavioral health professional under ARS Title 32, Chapter 33. 2. Are provided under supervision by a Behavioral Health Professional (BHP).

BEHAVIORAL HEALTH PROFESSIONAL (BHP) ***Revised: 11/2024***	1. An individual licensed under ARS 32, Chapter 33, whose scope of practice allows the individual to: a. Independently engage in the practice of behavioral health as specified in ARS 32-3251, or b. Except for a Licensed Addiction Technician, engage in the practice of behavioral health as specified in ARS 32-3251 under direct supervision as specified in AAC R4-6-101, 2. A psychiatrist as specified in ARS 36-501, 3. A psychologist as specified in ARS 32-2061, 4. A physician, 5. A behavior analyst as specified in ARS 32-2091, 6. A registered nurse practitioner licensed as an adult psychiatric and mental health nurse, or 7. A registered nurse with: a. A psychiatric-mental health nursing certification, or b. One year of experience providing behavioral health services.
BEHAVIORAL HEALTH RESIDENTIAL FACILITY (BHRF)	As specified in AAC R9-10-101, a health care institution that provides treatment to an individual experiencing a behavioral health issue that: 1. Limits the individual's ability to be independent, or 2. Causes the individual to require treatment to maintain or enhance independence.
BEHAVIORAL HEALTH RESIDENTIAL FACILITY (BHRF) - SECURED	As specified in ARS 36-425.06 (B) and AAC R9-10-101 (36), "secure" means premises that limit a patient's egress in the least restrictive manner consistent with the patient's court-ordered treatment plan and is a healthcare institution that provides treatment to an individual experiencing a behavioral health issue that limits the individual's ability to receive treatment in an independent setting.
BEHAVIORAL HEALTH RESIDENTIAL FACILITY (BHRF) STAFF	An employee of the behavioral health residential facility agency including but not limited to administrators, behavioral health professionals and behavioral health technicians.
BEHAVIORAL HEALTH SERVICES	Physician or practitioner services, nursing services, health-related services, or ancillary services provided to an individual to address the individual's behavioral health issue.
BEHAVIORAL HEALTH TECHNICIAN (BHT) ***Revised: 09/2024***	An individual who is not a Behavioral Health Professional (BHP) who provides the following services to a patient to address the patient's behavioral health issue: 1. With clinical oversight by a BHP, services that, if provided in a setting other than an Arizona Department of Health Services (ADHS) licensed health care institution, would be required to be provided by an individual licensed as specified in ARS 32, Chapter 33, and 2. Health-related services.

BENEFIT PACKAGE	All benefits provided to a specific population group or targeted residents (e.g., individuals with a Serious Mental Illness [SMI] designation) regardless of the Health Care Delivery System.
BEREAVEMENT COUNSELING	Emotional, psychosocial, and spiritual support and services provided before and after the death of a member to assist the family with issues related to grief, loss, and adjustment.
BIOSIMILAR	A biological drug approved by the Food and Drug Administration (FDA) based on a showing that it is highly similar to an FDA-Approved biological drug, known as the reference product, and has no clinically meaningful differences in terms of safety and effectiveness from the reference product.
BOARD CERTIFIED	An individual who has successfully completed all prerequisites of the respective specialty board and successfully passed the required examination for certification and when applicable, requirements for maintenance of certification.
BORDER COMMUNITIES ***Revised: 09/2022***	Cities, towns, or municipalities located in Arizona and within a designated geographic service area whose residents typically receive primary or emergency care in adjacent Geographic Service Areas (GSA) or neighboring States, excluding neighboring countries, due to service availability or distance.
BREAST AND CERVICAL CANCER TREATMENT PROGRAM (BCCTP)	Eligible individuals under the Title XIX expansion program for women with income up to 250% of the Federal Poverty Level (FPL), who are diagnosed with and need treatment for breast and/or cervical cancer or cervical lesions and are not eligible for other Title XIX programs providing full Title XIX services. Qualifying individuals cannot have other creditable health insurance coverage, including Medicare.
BROADCAST	Video, Audio, or text transmitted through Social Networking Applications, via internet, cellular or wireless network for display on any device (e.g., comments, podcasts, blogs).
BUSINESS DAY	Refer to the term Day – Business/Working.

C	
CALENDAR DAY	Includes every day of the week including weekends and holidays.
CARE MANAGEMENT ***Revised: 09/2022***	A group of activities performed by the Contractor to identify and manage clinical interventions or alternative treatments for identified members to reduce risk, cost, and help achieve better health care outcomes. Distinct from Case Management, Care Management does not include the day-to-day duties of service delivery.
CARE MANAGEMENT PROGRAM (CMP) ***Revised: 09/2022***	Activities to identify the top tier of high need/high-cost Title XIX members receiving services within an AHCCCS contracted health plan; including the design of clinical interventions or alternative treatments to reduce risk, cost, and help members achieve better health care outcomes. Care Management is an administrative function performed by the health plan. Distinct from Case Management, Care Managers should not perform the day-to-day duties of service delivery.
CARE PLAN ***Revised: 07/2023***	A documented guide for providing physical health services and behavioral health services expected to be provided to a member, based on the member's comprehensive assessment that includes measurable objectives and the methods for meeting the objectives.
CAREGIVER	A caregiver is an adult who is providing for the physical, emotional, and social needs (i.e., caring for) a child who is under the care, custody, and contractor. Examples of caregivers can include birth parents(s), foster parent(s), adoptive parent(s), kin or relative(s), group home staff. Caregivers can be licensed or unlicensed.
CASE MANAGEMENT ***Revised: 07/23***	A collaborative process, which assess, plans, implements, coordinates, monitors, and evaluates options and services to meet an individual's health needs and goals through communication, education services, and available resources to promote quality, cost-effective outcomes.
CASE MANAGEMENT EXPERIENCE	Human service-related experience requiring care coordination across service delivery systems and work involving assessing, evaluating, and monitoring services for individuals with special health care needs related but not limited to conditions such as physical and/or intellectual disabilities, aging, physical and/or behavioral health disorders, and substance use disorder.
CASE MANAGER	An individual assigned as responsible for locating, accessing, and monitoring the provision of services to individuals in conjunction with a clinical team as specified in AAC Title 9, Chapter 21 and Chapter 28, and Title 6, Chapter 6.
CASE MANAGER - ASSIGNED	The individual or team assigned by the Contractor who is responsible for locating, accessing, and monitoring the provision of all services as specified in contract for high-needs children and members with a Serious Mental Illness (SMI) designation.

CASE MANAGEMENT	A collaborative process, which assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet an individual's health needs through communication and available resources to promote quality, cost-effective outcomes.
CENTER FOR SUBSTANCE ABUSE TREATMENT (CSAT)	Substance Abuse and Mental Health Services Administration's (SAMHSA's) center to promote community-based substance abuse treatment and recovery services for individuals and families in every community. CSAT provides national leadership to improve access, reduce barriers, and promote high quality, effective treatment, and recovery services.
CENTER-BASED EMPLOYMENT (CBE)	A service that provides a controlled and protected work environment, additional supervision and other supports for individuals engaged in remunerative work either in a work center or in the community.
CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC)	A Federal agency under the Department of Health and Human Services (HHS), based in Atlanta, Georgia, that provides information and tools to promote health, prevent disease, injury and disability and prepare for new health threats.
CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)	The Federal agency within the United States Department of Health and Human Services (HHS), which administers the Medicare (Title XVIII) and Medicaid (Title XIX) programs and the State Children's Health Insurance Program (Title XXI).
CENTERS OF EXCELLENCE ***Revised: 09/2024***	A facility and/or program that is recognized as providing the highest levels of leadership, quality, and service. Centers of Excellence align physicians and other providers to achieve higher value through greater focus on appropriateness of care, clinical excellence, and patient satisfaction.
CERTIFICATE OF PARTNERSHIP	The basic legal instrument filed with a state to form partnership. A Certificate of Partnership is not required to form a partnership in the State of Arizona.
CERTIFIED NURSE MIDWIFE (CNM)	An individual certified by the American College of Nursing Midwives (ACNM) on the basis of a national certification examination and licensed to practice in Arizona by the State Board of Nursing. Certified Nurse Midwife (CNM) practice independent management of care for pregnant women and newborns, providing antepartum, intrapartum, postpartum, gynecological, and newborn care, within a health care system that provides for medical consultation, collaborative management, or referral.

CHANGE IN ORGANIZATIONAL STRUCTURE	Any of the following: 1. Acquisition. 2. Change in organizational documents (e.g., Amendments to Articles of Incorporation, Articles of Incorporation, Articles of Organization) or Certificate of Partnership. 3. Change in Ownership. 4. Change of Management Services Agreement (MSA) Subcontractor (to the extent management of all or substantially all plan functions have been delegated to meet AHCCCS contractual requirements). 5. Joint Venture. 6. Merger. 7. Reorganization. 8. State Agency reorganization resulting from an act of the Governor of the State of Arizona or the Arizona State Legislature. 9. Other applicable changes which may cause: a. A change in the Employer Identification (ID) Number/Tax ID Number (EIN/TIN), b. Changes in critical member information, including the website, member or provider handbook and member ID card, or c. A change in legal entity name.
CHANGE IN OWNERSHIP	Any change in the possession of ownership interests in equity, capital, stock, profits, or voting rights with respect to a business such that there is a change in the individuals or entities having the controlling interest of an organization, such as changes that result from a Merger or Acquisition, or, with respect to nonstock corporations (e.g., non-profit corporations, limited liability companies or partnerships), a change in the members or sponsors of the corporation or in the voting rights of the members, partners, or sponsors of the corporation.
CHEMICAL RESTRAINT	A drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition. Refer to 42 CFR 482.13 (e)(1)(I)(B). Chemical Restraints shall be interpreted and applied in compliance with the Center for Medicaid Services (CMS) State Operations Manual, for further Regulations and Interpretive Guidelines for Hospitals.
CHILD	An individual under the age of 18, unless the term is given a different definition by statute, rule or policies adopted by AHCCCS.
CHILD - KIDSCARE	An individual under the age of 19 years.

CHILD AND FAMILY TEAM (CFT) ***Revised: 09/2024***	A defined group of individuals that includes, at a minimum, the child and their family, or Health Care Decision Maker (HCDM), a behavioral health representative, and any individuals important in the child's life who are identified and invited to participate by the child and family. This may include teachers, extended family members, friends, family support partners, healthcare providers, coaches and community resource providers, representatives from churches, temples, synagogues, mosques, or other places of worship/faith, agents from other service systems like the Arizona Department of Child Safety (DCS) or the Department of Economic Security Division of Developmental Disabilities (DES DDD). The size, scope, and intensity of involvement of the team members are determined by the objectives established for the child, the needs of the family in providing for the child, and by who is needed to develop an effective service plan and can therefore expand and contract as necessary to be successful on behalf of the child.
CHILD DEVELOPMENTAL CERTIFIED HOMES	An Alternative Home and Community Based Services (HCBS) residential setting for members who are under age 18 with intellectual/developmental disabilities which is licensed by Department of Economic Security (DES) and provide room and board, supervision and coordination of habilitation and treatment for up to three residents as specified in ARS 36-593.01.
CHILDREN'S REHABILITATIVE SERVICES (CRS)	Program that provides covered medical services and covered support services in accordance with AAC R9-22-1303 and ARS 36-2912.
CHILDREN'S REHABILITATIVE SERVICES (CRS) APPLICATION	A submitted form with additional documentation required by the AHCCCS Division of Member and Provider Services (DMPS)in order to make a determination whether an AHCCCS member is medically eligible for a CRS Designation.
CHILDREN'S REHABILITATIVE SERVICES (CRS) CONDITION	Any of the covered medical conditions in AAC R9-22-1303 which are referred to as covered conditions in ARS 36-2912.
CHRONIC	A health-related state that is not acute.
CLAIM DISPUTE	A dispute, filed by a provider or Contractor, whichever is applicable, involving a payment of a claim, denial of a claim, imposition of a sanction or reinsurance.
CLAIMS - RECOUPMENT	The process a Contractor takes to recover all or part of a previously paid claim(s). Recoupments include Contractor initiated/requested repayments, as well as overpayments identified by the Provider where the Contractor seeks to actively withhold or withdraw funds to correct the overpayment from the Provider.
CLAIMS – REFUND	An action initiated by a Provider to return an overpayment to a Contractor. In these instances the Provider writes a check or transfers money to the Contractor directly.

CLEAN CLAIM	A claim that may be processed without obtaining additional information from the provider of service or from a third party but does not include claims under investigation for fraud or abuse or claims under review for medical necessity, as specified in ARS 36-2904.
CLIENT ASSESSMENT AND TRACKING SYSTEM (CATS)	A component of AHCCCS' data management information system that supports the Arizona Long Term Care System (ALTCS) and that is designed to provide key information to and receive key information from ALTCS Contractors.
CLINICAL BREAST EXAM	A physical examination of the breasts by a health care provider used as a primary diagnostic procedure for early detection of breast cancer.
CLINICAL LABORATORY IMPROVEMENT ACT (CLIA)	A certificate issued on the basis of the laboratory's accreditation by an organization approved by Centers for Medicare and Medicaid (CMS) in accordance with 42 CFR 493.61.
CLINICAL OVERSIGHT ***Revised: 02/2024***	Monitoring the behavioral health services provided by a Behavioral Health Technician (BHT) to ensure that the BHT is providing the behavioral health services according to the health care institution's policies and procedures and, if applicable: 1. A patient's treatment plan. 2. Providing on-going review of a BHTs skills and knowledge related to the provision of behavioral health services. 3. Providing guidance to improve a BHTs skills and knowledge related to the provision of behavioral health services. 4. Recommending training for a BHT to improve the BHTs skills and knowledge related to the provision of behavioral health services.
CLINICAL RECORD	Refer to the term Medical Record.
CLOSED-LOOP REFERRAL SYSTEM	The AHCCCS-approved statewide technology platform for screening and referring members to address their health-related social needs.
CODE OF FEDERAL REGULATIONS (CFR)	The general and permanent rules published in the Federal Register by the departments and agencies of the Federal Government.
COMMERCIAL ORAL SUPPLEMENTAL NUTRITION	Nourishment available without a prescription that serves as sole caloric intake or additional caloric intake.

COMMUNITY RESIDENTIAL SETTING	A residential setting in which individuals with intellectual/developmental disabilities live and are provided with appropriate supervision by the service provider responsible for the operation of the residential setting. Community residential settings include a child developmental home or an adult developmental home operated or contracted by Division of Developmental Disabilities (DDD) or DDDs contracted vendor or a group home operated or contracted by DDD.
COMMUNITY INTERVENER (CI)	Intercede between the member and the environment, allowing access to information usually gained through vision and hearing, and facilitates learning and the development of skills to lead self-determined lives (e.g., interact with others, express preferences, make choices, solve problems, and develop self-esteem). Community Interveners are extensively trained, unlicensed personnel that shall be employed/contracted by an AHCCCS registered provider and are required to complete a specialized, competency based, training and testing program designed for CIs.
COMMUNITY REINVESTMENT	A strategy that requires the Contractor to reinvest a designated portion of profits into the local community.
COMMUNITY RESOURCE GUIDE	A handbook with listings of local community resources that help address Health-Related Social Needs (HRSN) and Social Determinants of Health (SDOH). The Guide contains referral resources that are specific to the region in which members are served. It is to be used by providers and health plans who are not using the Closed-Loop Referral System (CLRS). The Community Resource Guide serves as a supplement to the CLRS for members who are not actively engaged with health care providers that utilize the system. The Guide can be custom-made by a provider or health plan, or it can be publicly available regional handbook of resources.
COMMUNITY TRANSITION SERVICE PROVIDER	A provider that facilitates the purchase and delivery of the allowable pre-determined goods and services needed to support the member to transition into the community as authorized by the case manager.
COMPANION MEDICARE ADVANTAGE ORGANIZATION (MAO)	A public or private entity organized and licensed or certified by a State as a risk-bearing entity (with the exception of provider sponsored organizations receiving waivers) that is also certified by Centers for Medicare and Medicaid (CMS) as meeting Medicare Advantage program contract requirements and is an Affiliated Organization (companion) of a Contractor.
COMPETENCY	Worker's demonstrated ability to intentionally, successfully, and efficiently perform the basic requirements of a job multiple times, at or near the required standard of performance.
COMPETENCY DEVELOPMENT	A systematic approach for ensuring that workers are adequately prepared to perform the basic requirements of their jobs. Competency based Work Force Development (WFD).
COMPETENT MEMBER	An individual who is oriented, exhibits evidence of logical thought, and can provide directions as specified in AAC R9-28-508.

COMPETITIVE INTEGRATED EMPLOYMENT	Work that is performed on a full-time or part-time basis for which an individual is compensated at or above minimum wage and comparable to the customary rate paid to individuals without disabilities performing similar duties and with similar training and experience; receiving the same level of benefits provided to other employees without disabilities in similar positions; at a location where the employee interacts with other individuals without disabilities; and presented opportunities for advancement similar to other employees without disabilities in similar positions. Self-employment, in many cases, is also considered Competitive Integrated Employment.
COMPREHENSIVE HEALTH PLAN (CHP)	A Contractor that is responsible for the provision of covered, medically necessary AHCCCS services for foster children in Arizona. Previous to April 1, 2021, CHP was the Comprehensive Medical and Dental Program (CMDP) (ARS 8-512).
COMPREHENSIVE RISK CONTRACT	A risk Contract between the State and a Managed Care Organization (MCO) that covers comprehensive services, that is, inpatient hospital services and any of the following services, or any three or more of the following services [42 CFR 438.2]: 1. Outpatient hospital services. 2. Rural health clinic services. 3. Federally Qualified Health Center (FQHC) services. 4. Other laboratory and X-ray services. 5. Nursing facility services. 6. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services. 7. Family planning services. 8. Physician services. 9. Home health services.
CONCURRENT REVIEW	The process of reviewing an institutional stay at admission and throughout the stay to determine medical necessity for an institutional Level of Care (LOC). Reviewers assess the appropriate use of resources, LOC, and service, according to professionally recognized standards of care. Concurrent review validates the medical necessity for admission and continued stay and evaluates Quality Of Care (QOC).
CONDITION REQUIRING INVESTIGATION	An incident or condition that appears to be dangerous, illegal, or inhumane, including the death of an individual with a Serious Mental Illness (SMI) designation.

CONDITIONAL RELEASE PLAN (CRP)	If the psychiatric security review board finds that the individual still suffers from a mental disease or defect or that the mental disease or defect is in stable remission, but the individual is no longer dangerous, the board shall order the individual's conditional release. The individual shall remain under the board's jurisdiction. The board in conjunction with the state mental health facility and behavioral health community providers shall specify the conditions of the individual's release. The board shall continue to monitor and supervise an individual who is released conditionally. Before the conditional release of an individual, a supervised treatment plan shall be in place, including the necessary funding to implement the plan as specified in ARS 13-3994.
CONSCIENTIOUS OBJECTIONS	Refusal to perform a legal role or responsibility because of moral or other personal beliefs. Involves practitioners providing or not providing certain care or treatment to their patients based on reasons of morality or conscience.
CONTINUING EDUCATION AND ONGOING LEARNING	Activities of professional development intended to enhance relevant knowledge and build skills within a given practice. These activities may involve, but are not limited to, acquiring traditional Continuing Education Units (CEUs).
CONTINUITY OF CARE	The continuous flow of integrated health care services in a timely and appropriate manner. It is the process by which the patient and their health care team are cooperatively involved in ongoing health care management toward the shared goal of high-quality, cost-effective care. For continuity to exist, care must be experienced by the patient as connected and coherent.
CONTINUITY OF OPERATIONS PROGRAMS (COOP)	An effort within the individual executive departments and agencies to ensure that essential functions continue to be performed during a wide range of emergencies.
CONTINUOUS HOME CARE	Services provided during periods of crisis for a minimum of eight hours per 24-hour day (the hours do not have to be continuous) to maintain residence in their own home as specified in 42 CFR 418.204(a). Care shall be predominantly nursing care, provided by a Registered Nurse (RN) or a Licensed Practical Nurse (LPN). Homemaker and home health aide services may also be provided to supplement the care.

CONTINUUM OF CARE (CoC)	Both a planning process and an application required for funding from U.S. Department of Housing and Urban Development (HUD). The CoC brings together service providers in a geographic area to plan for providing housing and services for people who are homeless. The CoC controls funding for programs that target people who are homeless, specifically, Shelter Plus Care (S+C), Supportive Housing Program (SHP), and Section 8 Single Room Occupancy governed by the McKinney-Vento Homeless Assistance Act as amended by the Homeless Emergency Assistance, Rapid Transition to Housing Act (HEARTH Act) as specified in 24 CFR 91, 576, 582, and 583 and administered through the U.S. Department of Housing and Urban Development (HUD)Agency. A regional or local planning body that coordinates housing and services funding for individuals and families experiencing homelessness as required by the U.S. Housing and Urban Development (HUD) Agency.
CONTRACT	A written agreement entered into between an individual, an organization, or other entity and the Administration to provide health care services to a member as specified in ARS Title 36, Chapter 29.
CONTRACT EXPIRATION	The ending of the Contract pursuant to its terms without any action by a party to the agreement.
CONTRACT TERMINATION	The cancellation of the Contract, in whole or part (e.g., by Geographical Service Area [GSA]), as a result of an action taken by AHCCCS or the Contractor.
CONTRACT AMENDMENT	A written document signed by the Procurement Officer that is issued for the purpose of making changes in the Contract.
CONTRACT YEAR	For AHCCCS Contractors and Fee-For-Service (FFS) Programs, the contract year runs from October 1 through September 30.
CONTRACTOR	An organization or entity that has a prepaid capitated Contract with AHCCCS pursuant to ARS 36-2904, ARS 36-2940, ARS 36-2944, or Chapter 34 of ARS Title 36, to provide goods and services to members either directly or through subcontracts with providers, in conformance with contractual requirements and Federal and State law, rule, regulations, and policies.
CONTRACTOR - RECEIVING	The Contractor with which the member will become enrolled as a result of annual enrollment choice, open enrollment, a Contractor change or a change in eligibility.
CONTRACTOR - RELINQUISHING	The Contractor in which the member will be leaving as a result of annual enrollment choice, open enrollment, a Contractor change or a change in eligibility.
CONTROLLED SUBSTANCE	Drugs and other substances that are defined as controlled substances under the Controlled Substance Act (CSA).
CONTROLLED SUBSTANCES PRESCRIPTION MONITORING PROGRAM (CSPMP)	An electronic central repository of all prescriptions dispensed for Controlled Substances Schedules II, III, IV and V in Arizona, which grants access to prescribing clinicians and pharmacists who are mandated to review controlled substances as specified in ARS 36-2606. prior to ordering or dispensing medications to individuals.

CONVICTED	A judgment of conviction has been entered by a Federal, State, or local court, regardless of whether an appeal from that judgment is pending.
COORDINATION OF BENEFITS (COB)	The activities involved in determining Medicaid benefits when a member has coverage through an individual, entity, insurance, or program that is liable to pay for health care services.
COPAYMENT LEVELS	Copayment requirements are indicated via a member specific copayment level found in all AHCCCS eligibility verification processes other than Interactive Voice Response (IVR). Every member is assigned a copayment level which reflects whether they are exempt from copayments, subject to non-mandatory (nominal/optional) copayments, or subject to mandatory copayments.
COPAYMENT(S) **(Defined per CMS)** ***Revised: 09/2022***	Money a member is asked to pay for a covered health service, when the service is given.
CORPORATE COMPLIANCE OFFICER ***Revised: 01/2022***	An individual located in Arizona and who implements and oversees the Contractor's Compliance Program. The Corporate Compliance Officer shall be a management official, available to all employees, with designated and recognized authority to access records and make independent referrals to the AHCCCS Office of the Inspector General. The Corporate Compliance Officer shall not hold any other position other than the Contract Compliance Officer position. The Corporate Compliance Officer shall be an onsite management official who reports directly to the Contractor's Chief Executive Officer (CEO) and Board of Directors, if applicable. The Corporate Compliance Officer shall be responsible for developing and implementing policies, procedures and practices designed to ensure compliance with the requirements of the Contract as specified in 42 CFR 438.608.
CORRECTIONAL FACILITY	Any place used for the confinement or incarceration of a person such as jails, prisons, and detention facilities.
CORRECTIVE ACTION PLAN (CAP) ***Revised: 09/2024***	A written improvement plan used to improve performance of the Contractor and/or its providers, enhance QM/PI activities and the outcomes of those activities, or resolve a deficiency. The improvement plan includes the root cause(s) of a deficiency, goals and objectives, actions to be taken to facilitate an expedient return to compliance, methodologies to be used to accomplish the goals and objectives, and staff responsible to carry out the activities within established timelines.
COST AVOIDANCE	The process of identifying and utilizing all confirmed sources of first or third-party benefits before payment is made by the Contractor.
COUNTY OF FISCAL RESPONSIBILITY ***Revised: 09/2022***	The County of fiscal responsibility is the Arizona County that is responsible for paying the State's funding match for the member's ALTCS Service Package. The County of physical presence (the county in which the member physically resides) and the County of fiscal responsibility may be the same County or different Counties.

COURSE OF CARE	A period of time determined by a healthcare professional for the completion of treatment.
COURT ORDERED EVALUATION (COE)	The evaluation ordered by the court as specified in AAC R9-21-101.
COURT ORDERED TREATMENT (COT)	The treatment ordered by the court as specified in AAC R9-21-101.
COURT-ORDERED ALCOHOL TREATMENT	Detoxification services or treatment provided as specified in ARS 36-2027.
CREDENTIALED PARENT/PEER/FAMILY SUPPORT PARTNER (CPPFSP) ***Revised: 09/2022***	An individual who is qualified under this policy and has passed an AHCCCS/DCAIR, OIFA approved CPPFSP Training Program to deliver Credentialed Family Support Services.
CREDENTIALED PARENT/PEER/FAMILY SUPPORT PARTNER (CPPFSP) TRAINING PROGRAM ***Revised: 09/2022***	Approved credentialing program in compliance with competencies and requirements put in place by AHCCCS Office of Individual and Family Affairs (OIFA).
CREDIBLE ALLEGATION OF FRAUD	A credible allegation of fraud may be an allegation, which has been verified by the State, from any source, including but not limited to the following: 1. Fraud hotline complaints. 2. Claims data mining, and 3. Patterns identified through provider audits, civil false claims cases, and law enforcement investigations. Allegations are considered to be credible when they have indicia of reliability and the State Medicaid agency has reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis [42 CFR 455.2].
CRISIS	An acute, unanticipated, or potentially dangerous behavioral health condition, episode, or behavior.
CRISIS PLAN	A written plan established by the member that is designed to prevent or reduce the effects of a behavioral health crisis. This Plan identifies what is or is not helpful in crisis prevention through the identification of contacts and resources, and actions to be taken by the member, family, parents, guardians, friends, or others.
CRISIS SERVICES	Services that are community based, recovery-oriented, and member focused that shall work to stabilize members as quickly as possible so as to assist them in returning to their baseline of functioning.
CRISIS STABILIZATION FACILITY	An inpatient facility or outpatient treatment center licensed as specified in 9 AAC 10 that provides crisis intervention services (stabilization).

CRITICAL SERVICES	Include Attendant Care, Personal Care, Homemaker and Respite care, and is inclusive of, but not limited to, tasks such as bathing, toileting, dressing, feeding, transferring to or from bed or wheelchair, and assistance with similar daily activities.
CHILDREN'S REHABILITATIVE SERVICES (CRS) APPLICATION	A submitted form with additional documentation required by the AHCCCS Division of Member and Provider Services (DMPS) in order to make a determination whether an AHCCCS member is medically eligible for a CRS Designation.
CHILDREN'S REHABILITATIVE SERVICES (CRS) CONDITION	Any of the covered medical conditions as specified in AAC R9-22-1303 which are referred to as covered conditions as specified in ARS 36-2912.
CRYOTHERAPY	The destruction of abnormal tissue using an extremely cold temperature.
CONTROLLED SUBSTANCE PRESCRIPTION MONITORING PROGRAM (CSPMP)	An electronic central repository of all prescriptions dispensed for Controlled Substances Schedules II, III, IV and V in Arizona which grants access to prescribing clinicians and pharmacists who are mandated to review controlled substances as specified in ARS 36-2606. prior to ordering or dispensing medications to individuals.
CREDIBLE ALLEGATION OF FRAUD ***Revised: 04/2022***	An allegation, which has been verified by the State, from any source, including but not limited to the following: 1. Fraud hotline complaints. 2. Claims data mining, and 3. Patterns identified through provider audits, civil false claims cases, and law enforcement investigations. Allegations are considered to be credible when they have indicia of reliability and the State Medicaid agency has reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis [42 CFR 455.2].
CULTURAL COMPETENCY ***Revised: 09/2024***	A set of congruent behaviors, attitudes and policies that come together in a system, agency, or among professionals, which enables that system, agency, or those professionals to work effectively in cross-culture situations. Culture refers to integrated patterns of human behavior that include language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethic, religious, or social groups. Competence implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities. This includes consideration of health status, national origin, sex, gender, gender identity, sexual orientation, and age.
CULTURE	The integrated pattern of human behavior that includes language, thought, communication, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious, or social group. Culture defines the preferred ways for meeting needs and may be influenced by factors such as geographic location, lifestyle, and age.

CUMULATIVE FINANCIAL REQUIREMENTS	Financial requirements that determine whether or to what extent benefits are provided based on accumulated amounts and included deductibles, and out-of-pocket maximums. Cumulative Financial Requirements do not include aggregate lifetime or Annual Dollar Limits because these two terms are excluded from the meaning of financial requirements.
CURATIVE CARE	Health care practices that treat patients with the intent of curing them, not just reducing their pain or stress. An example is chemotherapy, which seeks to cure cancer patients.
CUSTOMIZED EMPLOYMENT	An individualized approach to employment planning and job development that is based on an individual match between the strengths, conditions, and interests of a job candidate and the identified business needs of an employer. Examples of customized employment include task reassignment and job sharing.
CUSTOMIZED MEDICAL EQUIPMENT	Equipment that has been altered or built to specifications unique to an individual's medical needs and which, most likely, cannot be used or reused to meet the needs of another individual.

D	
DAILY FIRST CONTACT CALL RESOLUTION RATE (DFCCR)	The number of calls received in a 24-hour period for which no follow-up communication or internal phone transfer is needed, divided by the total number of calls received in the 24-hour period.
DAY	A calendar day unless otherwise specified.
DAY – BUSINESS/WORKING	Monday, Tuesday, Wednesday, Thursday, or Friday unless a legal holiday falls on Monday, Tuesday, Wednesday, Thursday, or Friday.
DECERTIFICATION - SERIOUS MENTAL ILLNESS (SMI)	The process that results in the removal of the SMI behavioral health category designation from the individual's record.
DELEGATED AGREEMENT	A type of subcontract agreement with a qualified organization or individual to perform one or more functions required to be performed by the Contractor.
DENIAL	The decision to deny a request made by, or on behalf of, an individual for the authorization and/or payment of a covered service.
DENTAL HOME ***Revised: 07/2023***	The ongoing relationship between the dentist and the member, inclusive of all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated, and family-centered way. The dental home should be established no later than 12 months of age for FFS members. Members enrolled with a Contractor shall be established with a dental home by 6 months of age or upon enrollment. A dental home addresses anticipatory guidance and preventive, acute, and comprehensive oral health care and includes referral to dental specialists when appropriate according to the American Academy of Pediatric Dentistry (AAPD).
DENTAL PROVIDER	An individual licensed as specified in ARS Title 32, Chapter 11, whose scope of practice allows the individual to: a. Independently engage in the practice of dentistry as specified in ARS 32-1202, 2. A dentist as specified in ARS 32-1201, 3. A dental therapist as specified in ARS 32-1201, 4. A dental hygienist as specified in ARS 32-1201, 5. An affiliated practice dental hygienist as specified in ARS 32-1201.
DEPARTMENT OF CHILD SAFETY (DCS)	The department established as specified in ARS 8-451 to protect children and to perform the following: a. Investigate reports of abuse and neglect. b. Assess, promote, and support the safety of a child in a safe and stable family or other appropriate placement in response to allegations of abuse or neglect. c. Work cooperatively with law enforcement regarding reports that include criminal conduct allegations. d. Without compromising child safety, coordinate services to achieve and maintain permanency on behalf of the child, strengthen the family and provide prevention, intervention, and treatment services.

ARIZONA DEPARTMENT OF CHILD SAFETY (DCS) COMPREHENSIVE HEALTH PLAN (DCS CHP) ***Revised: 08/2023***	Responsible for a dependent child who is in the legal custody of the DCS and is placed in an out-of-home placement as specific in ARS 8-512. CHP assists in providing medical, dental, and behavioral health services for children in foster care.
DEPARTMENT OF ECONOMIC SECURITY DIVISION OF DEVELOPMENTAL DISABILITIES (DES DDD)	The Division of a State agency, as specified in A.R.S. Title 36, Chapter 5.1, which is responsible for serving eligible Arizona residents with an intellectual/developmental disability. AHCCCS contracts with DES/DDD to serve Medicaid eligible individuals with an intellectual/developmental disability.
DEPARTMENT OF ECONOMIC SECURITY DIVISION OF DEVELOPMENTAL DISABILITIES (DES DDD) TRIBAL HEALTH PROGRAM (THP) ***Revised: 02/2024, 09/2024***	The Fee-For-Service (FFS) health plan which administers physical health, behavioral health, and Long-Term care Services and Supports (LTSS) for DDD THP enrolled American Indian/Alaska Native (AI/AN) members. Effective April 01, 2022, responsibility for managing acute Physical/Behavioral Health/Children's Rehabilitative Services (CRS), and THP members with a Serious Mental Illness (SMI) designation was transitioned to AHCCCS.
DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT (HUD)	A U.S. government agency created in 1965 to support community development and home ownership. HUD does this by improving affordable home ownership opportunities, increasing safe and affordable rental options, reducing chronic homelessness, fighting housing discrimination by ensuring equal opportunity in the rental and purchase markets, and supporting vulnerable populations.
DESIGNATED RECORD SET (DRS)	A group of records maintained by the provider. The Designated Record Set (DRS) may include the following: 1. Medical and billing records maintained by a provider, 2. Case/medical management records, or 3. Any other records used by the provider to make medical decisions about the member.
DESIGNATED REPRESENTATIVE (DR) ***Revised: 02/2024***	An individual parent, guardian, relative, advocate, supporter, friend, or other individual, designated orally or in writing by a member or guardian who, upon the request of the member, assists the member in protecting the member's rights and voicing the member's service needs.

DEVELOPMENTAL DISABILITY (DD)	A strongly demonstrated potential that a child under six years of age has an intellectual/developmental disability or will become a child with an intellectual/developmental disability, as determined by a test performed as specified in ARS 36-551 and ARS 36-694 or by other appropriate tests, or a severe, chronic disability that: 1. Is attributable to Cognitive Disability, Cerebral Palsy, Epilepsy, Autism, or Down Syndrome. 2. Is manifested before age eighteen. 3. Is likely to continue indefinitely. 4. Results in substantial functional limitations in three or more of the following areas of major life activity: a. Self-care, b. Receptive and expressive language, c. Learning, d. Mobility, e. Self-direction, f. Capacity for independent living, and g. Economic self-sufficiency. 5. Reflects the need for a combination and sequence of individually planned or coordinated special, interdisciplinary, or generic care, treatment or other services that are of lifelong or extended duration.
DEVELOPMENTAL SCREENING	The administration of a brief standardized tool aiding the identification of children at risk of a developmental disorder. Developmental Screening that targets the area of concern is indicated whenever a problem is identified during Developmental Surveillance.
DEVELOPMENTAL SURVEILLANCE	The process of recognizing children who may be at risk of developmental delays. Developmental Surveillance is a flexible, longitudinal, continuous, and a cumulative process whereby knowledgeable health care professionals identify children who may have developmental problems. There are five components of Developmental Surveillance: 1. Eliciting and attending to the parents' concerns about their child's development. 2. Documenting and maintaining a developmental history. 3. Making accurate observations of the child. 4. Identifying the risk and protective factors. 5. Maintaining an accurate record and documenting the process and findings.
DIAGNOSTIC	The determination of the nature or cause of a condition, illness, or injury through the combined use of health history, physical, developmental, psychological examination, laboratory tests, and X-rays, when appropriate.
DIMINISHED SCOPE OF SERVICE	Indicates when a provider has decreased its capacity or eliminated a service previously provided.

DIRECT CARE SERVICES	The services provided by Direct Care Workers DCW are collectively known as Direct Care Services. There are three types of services within ALTCS that are provided by Direct Care Workers (DCWs); these include Attendant Care, Personal Care, and Homemaker services.
DIRECT CARE WORKER (DCW)	An individual who assists an elderly individual or an individual with a disability with activities necessary to allow them to reside in their home. These individuals, also known as Direct Support Professionals, must be employed/contracted by DCW Agencies or, in the case of member-directed options, employed by ALTCS members in order to provide services to ALTCS members.
DIRECT CARE WORKER (DCW) - AGENCY	An agency that registers with AHCCCS as a service provider of Direct Care Services that include Attendant Care, Personal Care, Homemaker or Habilitation. The agency, by registering with AHCCCS, warrants that it has a workforce (employees or contractors) with the abilities, skills, expertise, and capacity to perform services as specified in AHCCCS policy.
DIRECT CARE WORKER (DCW) - TRAINER	Individuals designated by an Approved Program and qualified to conduct training and testing of Direct Care Worker (DCWs).
DIRECT CARE WORKER (DCW) - ONLINE DATABASE	The online database maintains the testing records of Direct Care Workers (DCWs) serving Arizona Long Term Care System (ALTCS) members living in their own homes.
DIRECT SERVICE CLAIMING (DSC)	Claiming for medical services provided by or through a Local Education Agency (LEA) participating in the School Based Claiming Program to Title XIX Medicaid enrolled student beneficiaries that require medical or mental/behavioral health services identified as medically necessary in an Individualized Education Program (IEP), Individualized Family Service Plan (IFSP), 504 Plan, other individualized health or behavioral health plan, or where medical necessity has been otherwise established.
DISCRETIONARY GRANT	A grant (or cooperative agreement) for which the Federal awarding agency generally may select the recipient from among all eligible recipients, may decide to make or not make an award based on the programmatic, technical, or scientific content of an application, and can decide the amount of funding to be awarded.
DISENROLLMENT	The discontinuance of a member's eligibility to receive covered services through a Contractor as specified in 42 CFR 438.56.
DISPENSE	To deliver a controlled substance to an ultimate user by, or pursuant to, the lawful order of, a practitioner, including the prescribing and administering of a controlled substance, as specified in 42 CFR 8.2.

DOMESTIC VIOLENCE (DV)	The relationship between the victim and the perpetrator is one of marriage or former marriage or individuals residing or having resided in the same household. The perpetrator inflicts physical harm, bodily injury, or sexual assault, or inflicting the fear of imminent physical harm, bodily injury, or sexual assault on a family member as specified in ARS 13-3601, and 25 CFR 11.454.
DRIVING UNDER THE INFLUENCE (DUI)	Driving, operating, or being in control of a vehicle while impaired by alcohol or other drugs (including recreational drugs and those prescribed by physicians), to a level that renders the driver incapable of operating a motor vehicle safely.
DRIVING UNDER THE INFLUENCE (DUI) EDUCATION	A program in which an individual participates in at least 16 hours of classroom instruction relating to alcohol or other drugs.
DRIVING UNDER THE INFLUENCE (DUI) SCREENING	A preliminary interview and assessment of an offender to determine if the offender requires alcohol or other drug education or treatment as specified in ARS 28-1301.
DRIVING UNDER THE INFLUENCE (DUI) SERVICES	DUI Screening, education, or treatment.
DRIVING UNDER THE INFLUENCE (DUI) TREATMENT	A program consisting of at least 20 hours of participation in a group setting dealing with alcohol or other drugs in addition to the 16 hours of education as specified in ARS 28-1301.
DRUG DIVERSION	Redirection of prescription drugs for illicit purposes.
DRUG UTILIZATION REVIEW (DUR)	A systematic, ongoing review of the prescribing, dispensing, and use of medications. The purpose is to assure efficacious, clinically appropriate, safe, and cost-effective drug therapy to improve member health status and quality of care.
DUAL ELIGIBLE MEMBER	A member who is eligible for both Medicare and Medicaid. There are two types of Dual Eligible Members: A Qualified Medicare Beneficiary (QMB) Dual Eligible Member (a QMB Plus or a QMB Only), and a Non-QMB Dual Eligible Member (a Special Low-Income Beneficiary [SLMB] Plus or an Other Full Benefit Dual Eligible).
DUAL ELIGIBLE SPECIAL NEEDS PLAN (D-SNP)	A type of health benefits plan offered by a Centers for Medicare and Medicaid Services (CMS) - contracted Medicare Advantage Organization (MAO) that limits its enrollment to those beneficiaries who are entitled to both Medicare (Title XVIII) program covered health benefits and full Medicaid (Title XIX) program covered health benefits.
DUAL MARKETING	Marketing efforts specifically targeting a contractor's member who is eligible for Medicare and Medicaid.

DURABLE MEDICAL EQUIPMENT (Defined per CMS) ***Revised: 07/2023***	Equipment that provides therapeutic benefits; is designed primarily for a medical purpose; is ordered by a physician/ provider; is able to withstand repeated use; and is appropriate for use in the home. Refer to "MEDICAL EQUIPMENT AND APPLIANCES" Equipment, furnished by a supplier or a human health agency that meets the following conditions: 1. Can withstand repeated use. 2. Effective with respect to items classified as DME after January 1, 2012, has an expected life of at least 3 years. 3. Is primarily and customarily used to serve a medical purpose. 4. Generally is not useful to an individual in the absence of an illness or injury. 5. Is appropriate for use in the home.

E	
EARLY AND PERIODIC SCREENING, DIAGNOSTIC, AND TREATMENT (EPSDT) ***Revised: 01/2022, 09/2024***	A comprehensive child health program of prevention, treatment, correction, and improvement of physical and behavioral health conditions for members under the age of 21 The EPSDT services include screening services, vision services, dental services, hearing services and all other medically necessary mandatory and optional services as specified in Federal Law 42 USC 1396d(a) to correct or ameliorate defects and mental illnesses and conditions identified in an EPSDT screening whether or not the services are covered under the AHCCCS State Plan. Limitations and exclusions, other than the requirement for medical necessity and cost effectiveness, do not apply to EPSDT services.
EARLY SERIOUS MENTAL ILLNESS (ESMI) ***Revised: 09/2024***	A first onset of diagnostic and functional criteria consistent with a Serious Mental Illness as specified in ARS 36-550 (that may include a First Episode of Psychosis) and of an individual 18 years of age or older.
ELECTRONIC SIGNATURE	An electronic signature, including digital signatures, shall meet the standards as described in ARS 18-106 and includes signatures that are executed or adopted by a person with the intent to be bound by or to authenticate a record. An electronic signature shall be unique to the person using it, shall be capable of reliable verification and shall be linked to a record in a manner so that if the record is changed the electronic signature is invalidated.
ELECTRONIC VISIT VERIFICATION (EVV)	A computer-based system that electronically verifies the occurrence of authorized service visits by electronically documenting the precise time a service delivery visit begins and ends, the individuals receiving and providing a service, and type of service performed.
ELECTRONIC VISIT VERIFICATION (EVV) SYSTEM - ALTERNATE	Any EVV system(s) chosen by a provider as an alternate to the AHCCCS procured system.
ELECTRONIC VISIT VERIFICATION (EVV) – DESIGNEE	An individual who is 12 years of age or older and who is delegated by the member or Health Care Decision Maker (HCDM) the responsibility of verifying service delivery on behalf of the member.
ELECTRONIC VISIT VERIFICATION (EVV) - DIRECT CARE WORKER (DCW)	Refer to the term Direct Care Worker (DCW) - Electronic Visit Verification (EVV).
ELECTRONIC VISIT VERIFICATION (EVV) SYSTEM	The AHCCCS procured system or an AHCCCS approved alternate EVV system.
ELECTRONIC VISIT VERIFICATION (EVV) – VENDOR	The AHCCCS selected State-Wide EVV vendor to comply with the 21st Century Cures Act (Cures Act).
ELIGIBILITY DESIGNATION – SERIOUS MENTAL ILLNESS (SMI)	A determination as to whether or not an individual meets the diagnostic and functional criteria established for the purpose of determining an individual's eligibility for SMI services.

EMERGENCY	Medical or behavioral health services provided for the treatment of an emergency medical condition. Refer to the term Emergency – Medical Condition.
EMERGENCY - AMBULANCE TRANSPORTATION	Refer to the term Transportation – Emergency.
EMERGENCY - AMBULANCE SERVICES (Defined per CMS) ***Revised: 07/2023***	Transportation by an ambulance for an emergency condition.
EMERGENCY - CONDITION FOR NON-FES MEMBERS	Refer to the term Emergency Medical Condition.
EMERGENCY - MEDICAL CARE TECHNICIAN (EMCT)	As defined in AAC R9-25-101(18).
EMERGENCY MEDICAL CONDITION (Defined per CMS) ***Revised: 09/2022***	An illness, injury, symptom or condition (including severe pain) that a reasonable person could expect that not getting medical attention right away would: a. Put the person's health in danger; or b. Put a pregnant woman's baby in danger; or c. Cause serious damage to bodily functions; or d. Cause serious damage to any body organ or body part.
EMERGENCY - MEDICAL OR BEHAVIORAL HEALTH CONDITION FOR A FEDERAL EMERGENCY SERVICE (FES) PROGRAM MEMBER	Refer to the term Emergency - Medical Condition.
EMERGENCY - SERVICES (Defined per CMS) ***Revised: 07/2023***	Services to treat an emergency condition

EMERGENCY - TRANSPORTATION	Ground and air ambulance services that are medically necessary to manage an emergency physical or behavioral health condition and which provide transport to the nearest appropriate facility capable of treating the individual's condition. Emergency transportation is needed when due to a sudden onset of a physical or behavioral health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could be expected to result in: 1. Placing the member's health in serious jeopardy, or 2. Serious impairment of bodily functions, or 3. Serious dysfunction of any bodily organ or part, or 4. Serious physical harm to self or another individual.
EMERGENCY ROOM CARE **(Defined per CMS)** ***Revised: 07/2023***	Care you get in an emergency room.
EMERGENCY TRIAGE, TREAT, AND TRANSPORT (ET3)	A program designed to allow greater flexibility for ambulance providers registered as provider type 06 to address health care needs following a 9-1-1 call. It permits ambulance providers to transport a member to an Alternative Destination Partner (such as a primary care doctor's office, an urgent care clinic or a community mental health partner), and to initiate and facilitate a members' receipt of medically necessary covered service(s) by a Qualified Health Care Partner at the scene of a 9-1-1 response either in-person on the scene or via telehealth (Treatment in Place).
END-OF-LIFE (EOL) CARE	A concept of care, for the duration of the member's life, that focuses on Advance Care Planning, the relief of stress, pain, or life limiting effects of illness to improve quality of life for a member at any age who is currently or is expected to experience declining health, or is diagnosed with a chronic, complex, or terminal illness.
ENGAGEMENT	Activities designed to establish a trusting relationship, rapport and therapeutic alliance based on personal attributes, including empathy, respect, genuineness, and warmth.
ENHANCED SHELTER	A congregate setting with no more than 100 beds at the physical location or a non-congregate setting with individual rooms and no limit to the number of rooms at one physical location (e.g., hotel). Services are available 24/7 and include food, storage, access to hygiene and supportive services to support independent living and transition to a permanent housing destination.
ENROLLEE	A Title XIX/XXI or Non-Title XIX/XXI eligible individual who is enrolled in an AHCCCS program or AHCCCS, as specified in ARS 36-2901, 36-2981, 36-2901.10 and recorded in the AHCCCS Information System.
ENROLLED ENTITY	The entity, which may be a Contractor or AHCCCS FFS provider, with which the member is enrolled for the provision of physical health services.

ENROLLMENT	The process by which an eligible individual becomes a member of a Contractor's plan.
ENROLLMENT TRANSITION INFORMATION (ETI)	Member specific information the Relinquishing Contractor must complete and transmit to the Receiving Contractor or Fee-For-Service (FFS) Program for those members requiring coordination of services as a result of transitioning to another Contractor or FFS Program.
ENTERAL NUTRITION	Liquid nourishment provided directly to the digestive tract of a member who cannot ingest an appropriate number of calories to maintain an acceptable nutritional status. Enteral Nutrition is commonly provided by Jejunostomy Tube (J-Tube), Gastrostomy Tube (G-Tube) or Nasogastric (N/G) Tube.
EQUITY PARTNERS	The sponsoring organizations or parent companies of the Managed Care Organization (MCO) that share in the returns generated by the organization, both profits and liabilities.
ESTABLISHED PATIENT	A member who has received professional services from the physician/qualified health care professional or another physician/qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.
EVALUATION ***Revised: 09/2022***	The process of analyzing current and past treatment information including assessment, treatment other medical records and documentation for purposes of making a decision as to an individual's eligibility for Serious Emotional Disturbance (SED) or Serious Mental Illness (SMI) services.
EVALUATION AGENCY	A health care agency licensed by the Arizona Department of Health Services (ADHS) that has been approved as pursuant in ARS 36-501 Chapter 5 Title 36, providing those services required of such agency.
EVALUATION - SERIOUS MENTAL ILLNESS (SMI)	The process of analyzing current and past treatment information including assessment, treatment other medical records and documentation for purposes of making a determination as to an individual's serious mental illness eligibility.
EVALUATION - VOLUNTARY	An inpatient or outpatient professional multidisciplinary service based on analysis of data describing the individual's identity, biography and medical, psychological, and social conditions that is provided after a determination that an individual willingly agrees to consent to receive the service and is unlikely to present a danger to self or others until the service is completed. A voluntary evaluation is invoked after the filing of a pre-petition screening but before the filing of a court ordered evaluation and requires the informed consent of the individual. Additionally, the individual must be able to manifest capacity to give informed consent.
EVIDENCE BASED PRACTICES AND PROGRAMS (EBPPS)	An intervention that is recognized as effective in treating a specific health-related condition based on scientific research; the skill and judgement of health care professionals; and the unique needs, concerns, and preferences of the individual receiving services.

EVIDENCE-BASED MEDICINE	The judicious use of the best scientific evidence including clinical expertise and member values when making decisions about healthcare. The scientific evidence is limited to peer-reviewed articles in medical journals published in the United States.
EVIDENCE-BASED PRACTICE	An intervention that is recognized as effective in treating a specific health-related condition based on scientific research; the skill and judgment of health care professionals; and the unique needs, concerns and preferences of the individual receiving services.
EXCLUDED **(Defined per CMS)** ***Revised: 07/2023***	1. Services that AHCCCS does not cover. Examples are services that are: a. Above a limit, b. Experimental, or c. Not medically needed.
EXCLUSIVE PHARMACY	Individual pharmacy, which is chosen by the member or assigned by the Contractor to provide all medically necessary federally reimbursable pharmaceuticals to the member.
EXPERIMENTAL SERVICES	A service which is not generally and widely accepted as a standard of care in the practice of medicine in the United States and is not a safe and effective treatment for the condition for which it is intended or used as specified in AAC R9-22-203.
EXPLOITATION (OF A VULNERABLE ADULT)	The illegal or improper use of a vulnerable adult or their resources for another's profit or advantage as specified in ARS 46-451(A)(5).
EXTERNAL QUALITY REVIEW (EQR) ***Revised: 09/2024***	The analysis and evaluation by an External Quality Review Organization (EQRO), of aggregated information on quality, timeliness, and access to the health care services that a Contractor (or their subcontracted health plans) furnish to Medicaid members as specified in 42 CFR 438.320.
EXTERNAL QUALITY REVIEW ORGANIZATION (EQRO) ***Revised: 07/2023, 09/2024***	An organization that meets the competence and independence requirements as specified in 42 CFR 438.354 and performs External Quality Review (EQR) and other EQR-related activities as specified in 42 CFR 438.358, and 42 CFR 438.320.

F	
FAMILY CONTINUITY	A situation where the member's household includes individuals who are also members as reflected in the eligibility case file.
FAMILY MEMBER - ADULT SYSTEM	An individual who has lived experience as a primary natural support for an adult with emotional, behavioral health and/or Substance Use Disorders (SUD).
FAMILY MEMBER - CHILDREN'S SYSTEM	A parent or primary caregiver with lived experience who has raised or is currently raising a child with emotional, behavioral health and/or Substance Use Disorders (SUD).
FAMILY OR FAMILY MEMBER	A biological, adoptive, or custodial parent of a child, or an individual who has been appointed as a legal guardian or custodian of a child by a court of competent jurisdiction, or other member representative responsible for making health care decisions on behalf of the member. Family members may encompass family of choice for adult members, which includes informal supports.
FAMILY PLANNING PROVIDER	Individuals who are involved in providing family planning services to individuals and may include physicians, physician assistants, nurse practitioners, nurse midwives, midwives, nursing staff and health educators.
FAMILY PLANNING SERVICES AND SUPPLIES	The provision of accurate information, counseling, and discussion with a health care provider to allow members to make informed decisions about the specific family planning methods available that align with the member's lifestyle and provision of indicated supplies.
FAMILY-CENTERED	Care that recognizes and respects the pivotal role of the family in the lives of members. It supports families in their natural care-giving roles, promotes normal patterns of living, and ensures family collaboration and choice in the provision of services to the member. When appropriate the member directs the involvement of the family to ensure person-centered care.

FAMILY-RUN ORGANIZATION (FRO)	Family-Operated Services that are: 1. Independent and autonomous - Governed by a board of directors of which 51% or more are family members who: a. Have or had primary responsibility for the raising of a child, youth, adolescent or young adult with an emotional, behavioral, mental health or substance use need, or b. Have lived experience as a primary natural support for an adult with emotional, behavioral, mental health or substance use need, or c. An adult who had lived experience of being a child with emotional, behavioral, mental health or substance use needs. 2. Employs Credentialed Family Support Partner (CPPFSP) providers whose primary responsibility is to provide parent/family support.
FEDERAL EMERGENCY SERVICES (FES)	A program specified in AAC R9-22-217, to treat an emergency condition for a member who is determined eligible as specified in ARS 36-2903.03(D).
FEDERAL EMERGENCY SERVICES (FES) PROGRAM MEMBER	An eligible individual enrolled in the FES Program through AHCCCS
FEDERAL SUPPLY SCHEDULE (FSS)	The collection of multiple award contracts used by Federal agencies, U.S. territories, Indian tribes, and other specified entities to purchase supplies and services from outside vendors. FSS prices for the pharmaceutical schedule are negotiated by the Veterans Affairs (VA) and are based on the prices that manufacturers charge their “most-favored” non-Federal customers under comparable terms and conditions.
FEDERALLY QUALIFIED HEALTH CENTER (FQHC)	A public or private non-profit healthcare organization that has been identified by the Health Resources and services Administration (HRSA) and certified by Centers for Medicare and Medicaid Services (CMS) as meeting criteria as specified in Sections 1861(aa)(4) and 1905(l)(2)(B) of the Social Security Act.
FEDERALLY QUALIFIED HEALTH CENTER (FQHC) LOOK-ALIKE	A public or private non-profit healthcare organization that has been identified by the Health Resources and services Administration (HRSA) and certified by Centers for Medicare and Medicaid Services (CMS) as meeting the definition of “health center” as specified in Section 330 of the Public Health Service Act but does not receive grant funding under Section 330.
FEE-FOR-SERVICE (FFS)	A method of payment to an AHCCCS registered provider on an amount-per-service basis for services reimbursed directly by AHCCCS for members not enrolled with a managed care Contractor.
FEE-FOR-SERVICE (FFS) – MEMBER	A Title XIX or Title XXI eligible individual who is not enrolled with an AHCCCS Contractor.
FEE FOR SERVICE (FFS) - PROVIDER	Any AHCCCS registered provider who provides services to FFS members.

FIELD CLINIC	A "clinic" consisting of single specialty health care providers who travel to health care delivery settings closer to members and their families than the Multi-Specialty Interdisciplinary Clinics (MSICs) to provide a specific set of services including evaluation, monitoring, and treatment for Children's Rehabilitation Services (CRS)-related conditions on a periodic basis.
FINANCIAL SPONSOR	Any monies or in-kind contributions provided to an organization other than attendance fees or table fees, to help offset the cost of an event.
FIRST EPISODE PSYCHOSIS (FEP) PROGRAM ***Revised: 09/2024***	A program focused on the early identification and provision of evidence-based treatment and support services to adults and adolescents who have experienced an FEP within the past two years. Evidence-based FEP programs have been shown to improve symptoms, reduce relapse, and lead to better outcomes. A commonly used evidenced based model is Coordinated Specialty Care, which is a recovery-based approach that uses shared decision making and offers case management, psychotherapy, medication management, family education and support, and supported education or employment.
FISCAL AGENT	A Contractor that processes or pays vendor claims on behalf of the Medicaid agency as specified in 42 CFR 455.101.
FISCAL AND EMPLOYER AGENT (FEA)	The entity(ies) providing fiscal management services to members.
FOOD AND DRUG ADMINISTRATION (FDA)	A federal agency of the United States Department of Health and Human which is responsible for protecting the public health by ensuring the safety, efficacy, and security of human and veterinary drugs, biological products, and medical devices; and by ensuring the safety of our nation's food supply, cosmetics and products that emit radiation.
FORMULA GRANT ***Revised: 09/2022***	Allocations of Federal funding to States, territories, or local units of government determined by distribution formulas in the authorizing legislation and regulations. To receive a formula grant, the entity shall meet all the eligibility criteria for the program, which are pre-determined and not open to discretionary funding decisions.
FOSTER CAREGIVER	The caregiver providing consent for a child in the Arizona Department of Child Safety system (DCS), including a DCS case manager, a foster parent, kinship caregiver, group home staff member, foster home staff member, relative or other individual or agency in whose care the child is currently placed pursuant to ARS 8-514.05.
FOUNDATION FOR THE ACCREDITATION OF CELLULAR THERAPY (FACT)	A non-profit corporation co-founded by the International Society for Cellular Therapy (ISCT) and the American Society of Blood and Marrow Transplantation (ASBMT) for the purposes of voluntary inspection and accreditation in the field of cellular therapy.

FEDERALLY QUALIFIED HEALTH CENTERS (FQHC)/RURAL HEALTH CLINIC (RHC) SERVICES	The services of specific licensed professionals, services provided incident to those professional services, and any other ambulatory services offered by the FQHC/RHC that are otherwise included in the State Medicaid Plan.
FEDERALLY QUALIFIED HEALTH CENTERS (FQHC)/RURAL HEALTH CLINIC (RHC) VISIT	A face-to-face encounter with a licensed AHCCCS registered practitioner during which an AHCCCS-covered ambulatory service is provided when that service is not incident to another service. Multiple encounters with more than one practitioner within the same discipline (i.e., dental, physical, behavioral health) or with the same practitioner and which take place on the same day and at a single location, constitute a single visit unless the patient, subsequent to the first encounter, suffers illness or injury requiring additional diagnosis or treatment. In this circumstance, the subsequent encounter is considered a separate visit. A service which is provided incident to another service, whether or not on the same day or at the same location, is considered to be part of the visit and is not reimbursed separately. Services “incident to” a visit means: (a) Services and supplies that are an integral, though incidental, part of the physician’s or practitioner's professional service (examples: medical supplies; venipuncture; assistance by auxiliary personnel such as a nurse or medical assistant); or (b) Diagnostic or therapeutic ancillary services provided on an outpatient basis as an adjunct to basic medical or surgical services (examples: x-ray; medication; laboratory test).
FORMULA GRANT	Allocations of federal funding to states, territories, or local units of government determined by distribution formulas in the authorizing legislation and regulations. To receive a formula grant, the entity shall meet all the eligibility criteria for the program, which are pre-determined and not open to discretionary funding decisions.
FRAUD	An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to themself or some other person. It includes any act that constitutes fraud under applicable Federal or State law, as defined in 42 CFR 455.2.
FREEDOM OF CHOICE	The opportunity given to each member who does not specify a Contractor preference at the time of enrollment to choose between the Contractors available within the Geographic Service Area (GSA) in which the member is enrolled.
FREE STANDING BIRTHING CENTERS	Out-of-hospital, outpatient obstetrical facilities, licensed by the Arizona Department of Health Services (ADHS) and certified by the Commission for the Accreditation of Free-Standing Birthing Centers. These facilities are staffed by registered nurses and maternity care providers to assist with labor and delivery services and are equipped to manage uncomplicated, low-risk labor and delivery. These facilities shall be affiliated with, and in close proximity to, an acute care hospital for the management of complications, should they arise.

FULL BENEFIT DUAL ELIGIBLE MEMBER (FBDE)	An individual who is enrolled with an AHCCCS Contractor for full Medicaid services and is also a Medicare beneficiary receiving Medicare Part A and Part B services. A Full Benefit Dual Eligible Member does not include those individuals who are enrolled with AHCCCS in the following population categories only through a Medicare Savings Program (and receive from AHCCCS only Medicare cost sharing assistance): Qualified Medicare Beneficiary only (QMB only), Specified Low-income Medicare Beneficiary only (SLMB only) or Qualified Individual-1 (QI-1).

G	
GAP IN CRITICAL SERVICES	The difference between the number of hours of critical services scheduled in each member's Service Plan and the hours of the scheduled type of critical services that are actually delivered to the member.
GENERAL CONSENT	A one-time agreement to receive certain behavioral or physical health services that shall be obtained from a member or the member's Health Care Decision Maker (HCDM) prior to the provision of any physical or behavioral health services. General Consent is usually obtained during the intake process at the initial appointment.
GENERAL FUND	The primary fund of a government used to record all assets and liabilities not assigned to a fund used for some specific purpose. AHCCCS receives specific appropriations of the General Fund for Non-Title XIX/XXI behavioral health services from the Arizona State Legislature.
GENERAL MENTAL HEALTH (GMH)	A behavioral health category assignment for members who are over the age of 18, are not designated as Serious Mental Illness (SMI), and do not have only a qualifying Substance Use Disorder (SUD).
GENERAL MENTAL HEALTH/SUBSTANCE USE (GMH/SU)	Behavioral health services provided to adult members age 18 and older who have not been determined to have a Serious Mental Illness (SMI).
GENERIC DRUG	A drug that contains the same active ingredient(s) as a brand name drug and the Food and Drug Administration (FDA) has approved it to be manufactured and marketed after the brand name drugs patent expires. Generic drug substitution shall be completed in accordance with Arizona State Board of Pharmacy rules and regulations.
GENETIC TESTING	Genetic testing is the sequencing of human Deoxyribonucleic Acid (DNA) obtained from of a small sample of body fluid or tissue in order to discover genetic differences, anomalies, or mutations.
GEOGRAPHIC SERVICE AREA (GSA)	An area designated by AHCCCS within which a Contractor of record provides, directly or through subcontract, covered health care services to a member enrolled with that Contractor of record, as specified in 9 AAC 22, Article 1 and 9 AAC 28, Article 1.
GLOBAL OBSTETRICAL (OB) PACKAGE	Includes all OB visits prior to delivery, the delivery, postpartum visits, and all services associated with admission to and discharge from a hospital.
GRANT	A sum of money given by an organization or government for a particular purpose. Specific criteria must be followed to ensure funding.
GRATUITY	A payment, loan, subscription, advance, deposit of money, services, or anything of more than nominal value, present or promised, unless consideration of substantially equal or greater value is received.

GRIEVANCE **(Defined per CMS)** ***Revised: 07/2023***	A complaint that the member communicates to their health plan. It does not include a complaint for a health plan's decision to deny or limit a request for services.
GRIEVANCE OR REQUEST FOR INVESTIGATION - SERIOUS MENTAL ILLNESS (SMI) ***Revised: 09/2022***	A complaint that is filed by an individual with a Serious Mental Illness (SMI) designation or other concerned person alleging a violation of the rights of a member with an SMI designation or a condition requiring an investigation.
GRIEVANCE AND APPEAL SYSTEM	A system that includes a process for member grievances and appeals including, Serious Emotional Disturbance (SED) and Serious Mental Illness (SMI) grievances and appeals, provider claim disputes. The Grievance and Appeal system provides access to the State fair hearing process.
GROUP HOME ***Revised: 10/2021, 12/2024***	A community residential setting for not more than six individuals with intellectual/developmental disabilities that is operated by a service provider under contract with the department that provides room and board and daily rehabilitation and other assessed medically necessary services and supports to meet the needs of each person. It does not include an adult developmental home, a child development home, a behavioral-supported group home, a nursing-supported group home, or an intermediate care facility for individuals with intellectual disabilities.
GROUP SUPPORTED EMPLOYMENT (GSE)	A service that provides a group of members with on-site supervision and support in an integrated paid work environment within the community.
GUEST DOSING	A mechanism for patients who are not eligible for take-home medication to travel from their home clinic for business, pleasure, or family emergencies and which also provides an option for patients who need to travel for a period of time that exceeds the amount of eligible take-home doses.

H	
HABILITATION **(Defined by CMS)** ***Revised: 07/2023***	Services that help a person get and keep skills and functioning for daily living.
HEALTH AND SAFETY CONDITION	A situation in which a member receiving an AHCCCS covered service has suffered or is likely to suffer injury, harm, impairment, or death as a result of a Fee-For-Service (FFS) Provider's noncompliance with their AHCCCS Provider Participation Agreement (PPA).
HEALTH CARE ACQUIRED CONDITION (HCAC)	A Hospital Acquired Condition (HAC) which occurs in any inpatient hospital setting and is not present on admission (Refer to the current Centers for Medicare and Medicaid Services (CMS) list of Hospital-Acquired Conditions.)
HEALTH CARE DECISION MAKER (HCDM)	An individual who is authorized to make health care treatment decisions for the patient. As applicable to the situation, this may include a parent of an unemancipated minor or an individual lawfully authorized to make health care treatment decisions as specified in ARS Title 14, Chapter 5, Article 2 or 3; or ARS 8-514.05, 36-3221, 36-3231 or 36-3281.
HEALTH CARE DELIVERY SYSTEM	The Health Care Delivery System refers to the structure and organization of covered services and Benefit Packages available to Contractor's members. Delivery systems can be fully integrated (all covered services administered by a single Contractor) or partially integrated (Members enrolled with a Contractor may receive covered services by multiple Contractors and/or via Fee-For-Service (FFS) arrangements).
HEALTH CARE POWER OF ATTORNEY	A written document that designates an individual who is allowed to make health care decisions for someone. The document shall specify if there are any health care decisions the Power of Attorney is not allowed to make, otherwise it is assumed all decisions are permissible. The document shall include the name and signature of the individual and the name of the Power of Attorney. It shall be dated and explain whether it is in operation always, or only if the individual is incapacitated as specified in ARS 8-514.05, 36-3221 and Mental Health Care Power of Attorney as specified in ARS 8-514.05, 36-3281. Examples of forms for a durable power of attorney can be found on the Arizona Attorney General's website.
HEALTH CARE PROFESSIONAL ***Revised: 07/2023***	A physician, podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist, therapist assistant, speech language pathologist, audiologist, registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist and certified nurse midwife), licensed social worker, licensed behavior analyst, registered respiratory therapist, licensed marriage and family therapist and licensed professional counselor.

HEALTH CARE SERVICE ***Revised: 04/2022***	A Medicaid service provided by a Contractor under contract with the State Medicaid agency in any setting, including but not limited to physical and behavioral health care, and long-term services and supports as specified in 42 CFR 438.320.
HEALTH CARE ACQUIRED CONDITION (HCAC)	A condition which occurs in any inpatient hospital setting and is not present on admission. (Refer to the current Centers for Medicare and Medicaid Services (CMS) list of Hospital Acquired Conditions).
HEALTH HOME	A provider that either provides or coordinates and monitors the provision of all primary, physical health, behavioral health and services and supports to treat the whole person. A Health Home can be an Outpatient Behavioral Health Clinic, a Federally Qualified Health Center (FQHC) or an Integrated Care Provider. Members may or may not be formally assigned to a health home.
HEALTH INFORMATION EXCHANGE (HIE)/HEALTH INFORMATION ORGANIZATION (HIO)	A State designated non-profit Health Information Organization (HIO), that provides the statewide exchange of patient health information among disparate health care organizations and providers not owned, operated, or controlled by the Health Information Exchange (HIE) organization as defined in ARS 36-3801. Pursuant to AAC R9-22-701.
HEALTH INFORMATION TECHNOLOGY FOR ECONOMIC AND CLINICAL HEALTH ACT (HITECH)	Enacted as part of the American Recovery and Reinvestment Act of 2009, was signed into law on February 17, 2009, to promote the adoption and meaningful use of health information technology. Subtitle D of the HITECH Act addresses the privacy and security concerns associated with the electronic transmission of health information, in part, through several provisions that strengthen the civil and criminal enforcement of the Health Insurance Portability and Accountability Act (HIPAA) rules.
HEALTH INFORMATION SYSTEM	A primary data system that collects, analyzes, integrates, and reports data to achieve the objectives outlined as specified in 42 CFR Part 438. Data system composed of the resources, technology, and methods required to optimize the acquisition, storage, retrieval, analysis and use of data. The systems shall provide information on areas including, but not limited to, utilization, claims, grievances and appeals, and disenrollment's for other than loss of Medicaid eligibility as specified in 42 CFR 438.242.
HEALTH INFORMATION TECHNOLOGY (HIT)	The application of information process involving both computer hardware and software that deals with the storage, retrieval, sharing, and use of health care information, data, and knowledge for communication and decision making.
HEALTH INSURANCE **(Defined per CMS)** ***Revised: 07/2023***	Coverage of costs for health care services.
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)	Also known as the Kennedy-Kassebaum Act, signed August 21, 1996, as amended, and as reflected in the implementing regulations as specified in 45 CFR Parts 160, 162, and 164.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) - PRIVACY RULE	The Rule establishes national standards to protect individuals' medical records and other individual health information and applies to health plans, health care clearinghouses, and those health care providers that conduct certain health care transactions electronically. The Rule requires appropriate safeguards to protect the privacy of individual health information and sets limits and conditions on the uses and disclosures that may be made of such information without patient authorization. The Rule also gives patients' rights over their health information, including rights to examine and obtain a copy of their health records, and to request corrections.
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) - SECURITY RULE	Established national standards to protect individuals' electronic personal health information that is created, received, used, or maintained by a covered entity. The Security Rule requires appropriate administrative, physical, and technical safeguards to ensure the confidentiality, integrity, and security of electronic protected health information.
HEALTH PLAN	Refer to the term Contractor.
HEALTH-RELATED SOCIAL NEEDS (HRSN)	Non-medical factors that impact health outcomes including but not limited to increasing access to safe and affordable housing, nutritious food, utility assistance, education, employment, transportation, connection to others in the community, as well as physical, environmental, and interpersonal safety. Also known as Social Determinants of Health (SDOH) or Social Risk Factors Of Health (SRFOH).
HEALTH-E-ARIZONA PLUS (HEAPLUS)	A system through which to apply for AHCCCS Health Insurance, KidsCare, Nutrition Assistance and Cash Assistance benefits and to connect to the Federal Insurance Marketplace.
HIGH-RISK PREGNANCY ***Revised: 08/2023***	Refers to a condition in which the mother, fetus, or newborn is, or is anticipated to be, at increased risk for morbidity or mortality before or after delivery. High-risk is determined through the use of a standardized medical risk assessment tool using criteria as specified in standard guidelines such as those established by the American College of Obstetricians and Gynecologists (ACOG).
HOME	A residential dwelling that is owned, rented, leased, or occupied by a member, at no cost to the member, including a house, a mobile home, an apartment, or other similar shelter. A home is not a facility, a setting, or an institution, or a portion of any of these that is licensed or certified by a regulatory agency of the state as a: 1. Health care institution as specified in ARS 36-401. 2. Residential care institution as specified in ARS 36-401. 3. Community residential setting as specified in ARS 36-551, or 4. Behavioral health facility as specified in 9 AAC 20, Articles 1, 4, 5, and 6.
HOME – ALTCS	A residential dwelling that is owned, rented, leased, or occupied at no cost to the member, including a house, a mobile home, an apartment, or other similar shelter. A home is not a facility, a setting or an institution, or a portion of any of these, licensed or certified by a regulatory agency of the State as specified in AAC R9-28-101.

HOME AND COMMUNITY BASED SERVICES (HCBS)	Home and community-based services, as specified in ARS 36-2931 and ARS36-2939.
HOME DELIVERED MEAL	A service that provides a nutritious meal containing at least one-third of the Federal recommended daily allowance for the member, delivered to the member's own home.
HOME HEALTH AGENCY (HHA)	A public or private agency or organization, or part of an agency or organization, which is licensed by the state, that meets requirements for participation in Medicare, including the capitalization requirements as specified in 42 CFR 489.28 [42 CFR 440.70].
HOME HEALTH SERVICES (Defined per CMS) ***Revised: 07/2023***	Nursing, home health aide, and therapy services; and medical supplies, equipment, and appliances a member receives at homebased on a doctor's order.
HOMELESS	An individual is considered homeless only when they reside in one of the places described below: 1. A place not meant for human habitation, such as cars, parks, sidewalks, abandoned buildings (on the street). 2. In an emergency shelter. 3. In transitional or supportive housing for homeless individuals who originally came from the streets or emergency shelters. 4. In any of the above places but is spending a short time (up to 30 consecutive days) in a hospital or other institution. 5. Is being evicted within a week from a private dwelling unit and no subsequent residence has been identified and lacks resources and support networks needed to obtain housing. 6. Is being discharged within a week from an institution, such as a mental health or substance abuse treatment facility or a jail/prison, in which the individual has been a resident for more than 30 consecutive days and no subsequent residence has been identified and the individual lacks the resources and support networks needed to obtain housing for example: a. An individual being discharged from prison after more than 30 days is eligible ONLY IF no subsequent residence has been identified and the individual does not have money, family, or friends to provide housing, b. Is fleeing a domestic violence housing situation and no subsequent residence has been identified and lacks the resources and support networks needed to obtain housing.
HOSPICE SERVICE (Defined per CMS) ***Revised: 07/2023***	Comfort and support services for a member deemed by a Physician to be in the last stages (six months or less) of life.

HOSPITAL OUTPATIENT CARE (Defined per CMS)	Care in a hospital that usually does not require an overnight stay.
HOSPITALIZATION (Defined per CMS) ***Revised: 07/2023***	Being admitted to or staying (usually overnight) in a hospital.
HOUSING AND HEALTH OPPORTUNITIES (H2O) PROGRAM ADMINISTRATOR	The entity contracted with AHCCCS to provide administration of the Housing and Health Opportunities (H2O) program.
HOUSING AND HEALTH OPPORTUNITIES (H2O) PROVIDER	Entity skilled and trained in providing Targeted Outreach and/or Pre-Tenancy/Tenancy sustaining services that contracts directly with the H2O Program Administrator for the purpose of providing direct services to members.
HOUSING AND URBAN DEVELOPMENT (HUD) HOUSING CHOICE VOUCHER PROGRAM	The federal government's major program for assisting very low-income families, the elderly, and the disabled to afford decent, safe, and sanitary housing in the private market. Individuals free to choose any housing that meets the requirements of the program and is not limited to units located in subsidized housing projects. Housing choice vouchers are administered locally by Public Housing Agencies (PHAs). The PHAs receive federal funds from the U.S. Department of Housing and Urban Development (HUD) to administer the voucher program.
HOUSING APPLICATION	A written authorization from the Contractor or a provider to the AHCCCS Housing Administrator verifying that an individual is eligible for Permanent Supportive Housing (PSH) services and may be considered for PSH subsidies and programs. Form and format of housing applications shall be determined by the AHCCCS Housing Administrator.
HOUSING FIRST	A Housing approach that works to quickly and successfully connect individuals and families experiencing homelessness to permanent housing without preconditions and barriers to entry, such as sobriety, treatment, or service participation requirements. Supportive services are offered to maximize housing stability and prevent returns to homelessness as opposed to addressing predetermined treatment goals prior to permanent housing entry.
HOUSING SPECIALIST	A position, at the provider level, that serves as the subject matter expert for housing and homeless related services. Providing both in the office and in the field direct service to members to support them in achieving housing stability.
HUMAN IMMUNODEFICIENCY VIRUSES (HIV)	A Sexually Transmitted Infection (STI) that damages white blood cells that are very important in helping the body fight infection and disease.

HUMAN IMMUNODEFICIENCY VIRUS (HIV) EARLY INTERVENTION SERVICES	Appropriate pretest counseling, testing for HIV, including tests to confirm the presence of HIV, to diagnose the extent of the deficiency in the immune system, and to provide information on appropriate therapeutic measures for preventing and treating the deterioration of the immune system, and for preventing and treating conditions arising from the disease. Appropriate post-test counseling and Therapeutic measures will also be provided (42 USC 300x-24(b)(7).
HUMAN PAPILLOMAVIRUS (HPV)	A sexually transmitted infection for which a series of immunizations are available for both males and females.
HYSTERECTOMY	A medical procedure or operation for the purpose of removing the uterus as specified in 42 CFR 441.251.
HYSTEROSALPINGOGRAM	An X-ray procedure used to confirm sterility (occlusion of the fallopian tubes).

I	
ILLEGAL	An incident or occurrence that is or was likely to constitute a violation of a state or federal statute, regulation, court decision or other law.
IMMEDIATE JEOPARDY	A situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a member.
IMMUNIZATION	The administration of a vaccine to promote the development of immunity or resistance to an infectious disease.
IN-NETWORK PROVIDER (Defined per CMS) ***Revised: 07/2023***	A health care provider that has a contract with your health plan.
INCIDENT ***Revised: 09/2022***	An event or occurrence that causes harm to a member or serves as an indicator of risk to the health or welfare of the member such as abuse, neglect, and exploitation.
INCIDENT, ACCIDENT, AND DEATH (IAD) ***Revised: 07/2023***	A report entered into the AHCCCS Quality Management (QM) Portal by a provider to document an occurrence that caused harm or may have caused harm to a member and or to report the death of a member.
INCIDENT OF SECLUSION AND/OR RESTRAINT	An incident of seclusion and/or restraint: 1. Begins at the time a behavior necessitating seclusion or restraint begins, and 2. Ends when the behavior has resolved for more than ten minutes. All interventions used during each incident should be documented in a single individual report including all required components of each type of intervention used to manage the behavior.
INCURRED BUT NOT REPORTED (IBNR)	Liability for services rendered for which claims have not been received.
INDEPENDENT COMMUNITY HOUSING	A setting where an individual can live either alone or with a roommate in a home or apartment without ongoing daily supervision from behavioral health providers. Options include the Housing and Urban Development (HUD) Section 8 programs through local Public Housing Authorities to provide: 1. Low-income subsidized housing through local non-profit organizations. 2. Supportive Housing Programs funded with federal grants and administered by RBHA contracted housing providers. 3. State subsidized rental units, and 4. Permanent Houses and apartments purchased with state funding.

INDEPENDENT OVERSIGHT COMMITTEE (IOC)	A committee established by state statute to provide independent oversight and to ensure the rights of behavioral health members are protected. There is one Independent Oversight Committee established for each region as well as the Arizona State Hospital (ASH), with each committee providing independent oversight and review within its respective jurisdiction as defined in ARS 41-3803 and 41-3804, and AAC R9-21-105.
INDIAN HEALTH SERVICE (IHS)	The operating division within the U.S. Department of Health and Human Services, responsible for providing medical and public health services to members of federally recognized Tribes and Alaska Natives as specified in 25 USC 1661.
INDIRECT OWNERSHIP INTEREST ***Revised: 10/2021***	An ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity as specified in 42 CFR 455.101.
INDIVIDUAL RECOVERY PLAN (FORMERLY KNOWN AS THE INDIVIDUAL SERVICE PLAN)	Refer to the term Service Plan.
INDIVIDUAL WITH AN INTELLECTUAL/DEVELOPMENTAL DISABILITY (IID/DD) ***Revised: 08/2023, 09/2024***	An individual who meets the Arizona definition as specified in ARS 36-551 and is determined eligible for services through the Department of Economic Security Division of Developmental Disabilities (DES DDD). Services for AHCCCS enrolled members with Intellectual/Developmental Disabilities (IID/DD) determined eligible for services through DES DDD are managed through the DES DDD.
INDIVIDUALIZED EDUCATION PLAN (IEP)	A formal written document developed and implemented for the purposes of providing special education and related services to a child with a disability who is determined eligible under the Individuals with Disabilities Education Act (IDEA), Part B.
INDIVIDUALIZED FAMILY SERVICE PLAN (IFSP)	A formal written document developed and implemented for the purposes of obtaining special education services for eligible children from birth to three years of age.
INDIVIDUALIZED SERVICE PLAN (ISP)	A comprehensive written description of all covered health services and other informal supports which includes individualized goals, family support services, care coordination activities and strategies to assist the member in achieving an improved quality of life. The ISP is created and managed by the Child and Family Team (CFT). It is a dynamic document that is regularly updated to adequately match the strengths and needs of the member and family.
INDIVIDUALS WITH DISABILITIES EDUCATION ACT (IDEA)	Established in Part B of the IDEA, ensures that children with special education needs receive a free and appropriate public education.

INFORMAL SUPPORTS	Non-billable services provided to a member by a family member, friend, or volunteer to assist or perform functions such as, but not limited to: 1. Housekeeping, 2. Personal care, 3. Food preparation, 4. Shopping, 5. Pet care, or 6. Non-medical comfort measures.
INFORMATION SYSTEM	The component of the Contractor's organization which supports the Information Systems, whether the systems themselves are internal to the organization (full spectrum of systems staffing), or externally contracted (internal oversight and support).
INFORMED CONSENT	An agreement to receive physical or behavioral health services following the presentation of facts necessary to form the basis of an intelligent consent by the member or the member's Health Care Decision Maker (HCDM) with no minimization of known dangers of any procedures.
INHUMANE	An incident, condition, or occurrence that is demeaning to an individual with a Serious Mental Illness (SMI) designation or which is inconsistent with the proper regard for the right of the individual to humane treatment.
INSTITUTION	An establishment that furnishes (in single or multiple facilities) food, shelter, and some treatment or services to four or more individuals unrelated to the proprietor.
INSTITUTION FOR MENTAL DISEASE (IMD)	A hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of individuals with mental diseases (including substance use disorders), including medical attention, nursing care and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such. An institution for Individuals with Intellectual and Developmental Disabilities (IDD) is not an institution for mental diseases as specified in 42 CFR 435.1010.
INSTITUTION FOR MENTAL DISEASE (IMD) – STAY	The total number of calendar days of an inpatient stay in an institution for mental disease beginning with the date of admission through discharge, but not including the date of discharge unless the member expires.

INSTITUTIONAL SETTING	1. Institutional settings: a. A nursing facility as specified in 42 USC 1396 r(a), b. An Institution for Mental Diseases (IMD) for an individual who is either under age 21 or age 65 or older, c. An Intermediate Care Facility for the Mentally Retarded (ICF-MR) for an individual with intellectual/developmental disabilities, d. A hospice (free-standing, hospital, or nursing facility subcontracted beds) as specified in ARS 36-401. 2. Home and Community Based Services (HCBS) settings: a. An individual's home as specified in AAC R9-28-101(B), or b. Alternative HCBS settings as specified in AAC R9-28-101(B).
INTAKE	The initial evaluation and collection, by appropriately trained staff, of basic demographic information and preliminary identification of the member's needs.
INTEGRATED MEDICAL RECORD	A single document in which all of the medical information is recorded to facilitate the coordination and quality of care delivered by multiple providers serving a single patient in multiple locations and at varying times.
INTEGRATED RAPID RESPONSE	A process that occurs when a child enters into Department of Child Safety (DCS) custody. When this occurs, a behavioral health service provider is referred and then dispatched within 72 hours to assess a child's immediate behavioral health and physical health needs and to refer the child for additional assessments through the behavioral health system.
INTENSIVE OUTPATIENT PROGRAMS (IOP) ***Revised: 10/2022***	Treatment programs that operate at least three hours/day and at least three days/week used to address addictions, depression, eating disorders, or other dependencies that do not require detoxification or 24-hour supervision.
INTERAGENCY SERVICE AGREEMENT (ISA)	A binding contract between state government agencies whereby one agency provides reimbursement for services performed by another agency to carry out the objectives of the funding source. Refer to ARS 35-148.
INTER-FACILITY TRANSFER	Occurs when an individual is transferred from one nursing facility to another nursing facility, with or without an intervening hospital stay. Inter-facility transfers are subject to resident review rather than preadmission screening.
INTERDISCIPLINARY CARE	A meeting of the interdisciplinary team members or coordination of care among interdisciplinary treatment team members to address the totality of the treatment and service plans for the member based on the most current information available.
INTERDISCIPLINARY TEAM	A group of individuals consisting of a resident's attending physician, a Registered Nurse (RN) responsible for the resident, and other individuals as determined in the resident's comprehensive assessment.

INTERGOVERNMENTAL AGREEMENT (IGA) ***Revised: 09/2022***	When authorized by legislative or other governing bodies, two or more public agencies or public procurement units by direct Contract or agreement may contract for services or jointly exercise any powers common to the contracting parties and may enter into agreements with one another for joint or cooperative action or may form a separate legal entity, including a nonprofit corporation to contract for or perform some or all of the services specified in the Contract or agreement or exercise those powers jointly held by the contracting parties ARS Title 11, Chapter 7, Article 3 (ARS 11-952.A).
INTERMEDIATE CARE FACILITY FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES (ICF/IID)	A facility that primarily provides health and rehabilitative services to individuals with Developmental Disabilities (DD) that are above the service level of room and board or supervisory care services or personal care services as defined in section 36-401 but that are less intensive than skilled nursing services (ARS 36-551 (28)).
INTERMITTENT NURSING SERVICES	Skilled nursing services provided by either a Registered Nurse (RN) or Licensed Practical Nurse (LPN), for visits of two hours or less in duration, up to a total of four hours per day.
INTERNAL REFERRAL (IRF)	A report entered into the AHCCCS QM Portal by an employee of a health plan to document an occurrence that caused harm or may have caused harm to a member and or to report the death of a member.
INTERPRETATION	The conversion of oral communication from English into the member's preferred language while maintaining the original intent.
INVENTORY FOR CLIENT AND AGENCY PLANNING (ICAP)	A Department of Economic Security Division of Developmental Disabilities (DES DDD) standardized assessment tool which provides information regarding the member's medical condition and diagnoses, motor skills, social and communication skills, personal living skills, community living skills, social and leisure activities, and problem behaviors, if any.
IMMEDIATE JEOPARDY	A situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a member.

J	
JOINT VENTURE	A business arrangement in which two or more parties agree to pool their resources for the purpose of accomplishing a specific task. This task can be a new project or any other business activity. In a joint venture, each of the participants is responsible for profits, losses, and costs associated with it. However, the venture is its own entity, separate and apart from the participants' other business.
JUVENILE PROBATION OFFICER (JPO)	An officer within the Arizona Department of Juvenile Corrections (ADJC) assigned to a juvenile upon release from a secure facility. Having close supervision and observation over juvenile's who are ordered to participate in the intensive probation program including visual contact at least four times per week and weekly contact with the school, employer, community restitution agency or treatment program (A.R.S. § 8-353).

K

KIDSCARE ***Revised: 04/2024***	Federal and State Children's Health Insurance Program (CHIP) administered by AHCCCS. The KidsCare program offers comprehensive medical, preventive, treatment services, and behavioral health care services statewide to eligible children under the age of 19, in households with income between 133% and 225% of the Federal Poverty Level (FPL).

L	
LABORATORY	A facility for the biological, microbiological, serological, chemical, immunohematological, hematological, biophysical, cytological, pathological, or other examination of materials derived from the human body for the purpose of providing information for the diagnosis, prevention, or treatment of any disease or impairment of, or that otherwise describes the presence or absence of various substances or organisms in the body as specified in 42 CFR 493.2.
LANGUAGE ASSISTANCE SERVICE	Services as specified in 45 CFR 92.4 including, but not limited to: 1. Oral language assistance, including interpretation in non-English languages provided in-person or remotely by a qualified interpreter for an individual with limited English proficiency, and the use of qualified bilingual or multilingual staff to communicate directly with individuals with limited English proficiency, 2. Written translation, performed by a qualified translator, of written content in paper or electronic form into languages other than English, and 3. Taglines.
LEGAL HOLIDAY	Legal holiday as defined by the State of Arizona are: 1. New Year's Day – January 1. 2. Martin Luther King Jr./Civil Rights Day – 3rd Monday in January. 3. Lincoln/Washington Presidents' Day – 3rd Monday in February. 4. Memorial Day – Last Monday in May. 5. Independence Day – July 4. 6. Labor Day – 1st Monday in September. 7. Columbus Day – 2nd Monday in October. 8. Veterans Day – November 11. 9. Thanksgiving Day – 4th Thursday in November. 10. Christmas Day – December 25.
LIABLE PARTY	An individual, entity, or program that is or may be liable to pay all or part of the medical cost of injury, disease, or disability of an applicant or member as specified in AAC R9-22-1001.

LICENSED HEALTH AIDE (LHA) ***Revised: 11/2024***	Pursuant to ARS 32-1601, a person who is licensed to provide or assist in providing nursing-related services pursuant to ARS 36-2939: 1. Is the parent, guardian, or family member by affinity or consanguinity of the Arizona Long-Term Care System (ALTCS) member receiving services who may provide Licensed Health Aide (LHA) services only to that member and only consistent with that member's plan of care. 2. Has a scope of practice that is the same as a Licensed Nursing Assistant (LNA) and may also provide medication administration, tracheostomy care, and enteral care and therapy, routine ventilator care, and any other tasks approved by the State Board of Nursing in rule.
LICENSED MIDWIFE (LM)	An individual licensed by the Arizona Department of Health Services (ADHS) to provide maternity care as specified in ARS Title 36, Chapter 6, Article 7, and AAC R9-16 (This provider type does not include certified nurse midwives licensed by the Board of Nursing as a nurse practitioner in midwifery or physician assistants licensed by the Arizona Medical Board).
LICENSED NURSING ASSISTANT (LNA)	An individual who is licensed to provide or assist in the delivery of nursing or nursing-related services under the supervision and direction of a licensed nursing staff member as specified in ARS 32-1601. Licensed nursing assistant does not include an individual who: 1. Is a licensed healthcare professional. 2. Volunteers to provide nursing assistant services without monetary compensation, or 3. Is a certified nursing assistant.
LIEN ***Revised: 09/2022***	A legal claim filed with the County Recorder's office in which a member resides, and in the County an injury was sustained, for the purpose of ensuring that AHCCCS receives reimbursement for medical services paid. The lien is attached to any settlement the member may receive as a result of an injury.
LIMITED AUTHORIZATION	A service authorization that falls short of the original request, with respect to the duration, frequency, or type of service requested.
LIMITED ENGLISH PROFICIENCY (LEP)	Individuals who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English may have LEP and may be eligible to receive language assistance for a particular type of service, benefit, or encounter as specified in 42 CFR 457.1207, 42 CFR 438.10.
LINE OF BUSINESS (LOB)	AHCCCS Programs: AHCCCS Complete Care (ACC); AHCCCS Complete Care-Regional Behavioral Health Agreements (ACC-RBHA); Arizona Long Term Care Services Elderly and/or have a Physically Disability (ALTCS E/PD); Department of Child Safety Comprehensive Health Plan (DCS CHP); and Department of Economic Security Division of Developmental Disabilities (DES DDD).

LINGUISTIC NEED	The necessity of providing services in the member's primary or preferred language, including sign language, and the provision of interpretation and translation services.
LOCAL EDUCATION AGENCY (LEA)	Public school districts, charter schools not sponsored by a school district and the State School for the Deaf and Blind as specified in 34 CFR 300.28.
LONG-ACTING REVERSIBLE CONTRACEPTIVES (LARC)	Reversible methods for family planning that provide effective contraception for an extended period of time with little or no maintenance or user actions required, including intrauterine devices and subdermal and implantable contraceptives.
LONG-TERM SERVICES AND SUPPORTS (LTSS)	Services and supports provided to members of all ages who have functional limitations and/or chronic illnesses that have the primary purpose of supporting the ability of the member to live or work in the setting of their choice, which may include the individual's home, a provider-owned or controlled residential setting, a Nursing Facility (NF), or other institutional setting as specified in 42 CFR 438.2.
LOOP ELECTROSURGICAL EXCISION PROCEDURE (LEEP)	Procedure that passes an electric current through a thin wire loop as specified in AAC R9-22-2001.
LUNG VOLUME REDUCTION SURGERY (LVRS)	A surgical procedure that removes diseased lung tissue. This procedure reduces the size of an over-inflated lung and allows for the expansion of the remaining (healthy) lung. Also referred to as reduction pneumoplasty, lung shaving, or lung contouring.

M	
MACHINE READABLE	A digital representation of data or information in a file that can be imported or read into a computer system for further processing and is complaint with 42 CFR 438.10.
MAJOR UPGRADE	Any systems upgrade or change to a major business component that may result in a disruption to the following: loading of contracts, providers, or members, issuing Prior Authorizations (PA) or the adjudication of claims.
MAMMOGRAM	An x-ray of the breasts used to look for early signs of breast cancer.
MANAGED CARE	Systems that integrate the financing and delivery of health care services to covered individuals by means of arrangements with selected providers to furnish comprehensive services to members; establish explicit criteria for the selection of health care providers; have financial incentives for members to use providers and procedures associated with the plan; and have formal programs for quality, medical management, and the coordination of care.
MANAGED CARE ORGANIZATION (MCO) ***Revised: 08/2023***	An organization or entity that has a prepaid capitated Contract with AHCCCS pursuant to ARS 36-2904, 36-2940, or 36-2944 to provide goods and services to members either directly or through subcontracts with providers, in conformance with contractual requirements, AHCCCS Statutes and Rules, and Federal law and regulations.
MANAGED CARE PROGRAM	A managed care delivery system operated by a State as specified in section 1915(a), 1915(b), 1932(a), or 1115(a) of the Social Security Act [42 CFR 438.2].
MANAGEMENT SERVICES AGREEMENT (MSA)	A type of subcontract with an entity in which the owner of the Contractor delegates all or substantially all management and administrative services necessary for the operation of the Contractor.
MANAGING EMPLOYEE	A general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency as specified in 42 CFR 455.101.
MARKETING	Any communication from Contractors to a member not enrolled with the Contractor that can reasonably be interpreted as intended to influence the member to enroll with the Contractor, or to not enroll or disenroll with another Contractor's Medicaid product as specified in 42 CFR 438.104. Marketing does not include communication to any member about a Qualified Health Plan, as specified in 45 CFR 155.20.
MARKETING - HEALTH MESSAGE	A slogan or statement on marketing materials to promote healthy lifestyles, situations that affect or influence health status, behaviors that affect or influence health status, or methods or modes of medical treatment.

MARKETING - HEALTH-RELATED	An event that has a direct or indirect health care purpose, and/or it supports or contributes to any AHCCCS initiative or program goal. Giveaway items shall have a Health Message or a health care purpose to be considered health related.
MARKETING MATERIALS	Materials produced in any medium, by or on behalf of the Contractor that can reasonably be interpreted as intended for marketing purposes. This includes general audience materials such as general circulation brochures, Contractor's website and other materials that are designed, intended, or used to increase Contractor membership or establishing a brand.
MASTECTOMY	Removal of the entire breast through surgery.
MATERIAL CHANGE TO BUSINESS OPERATIONS	Any change in overall operations that affects, or can reasonably be foreseen to affect, the Contractor's ability to meet the performance standards as required in Contract including, but not limited to, any change that would impact or is likely to impact more than 5% of total membership and/or provider network in a specific Geographic Service Area (GSA). Changes to business operations may include, but are not limited to, policy, process, and protocol, such as Prior Authorization (PA) or retrospective review. Additional changes may also include the addition or change in: 1. Pharmacy Benefit Manager (PBM), 2. Dental Benefit Manager, 3. Transportation vendor, 4. Claims Processing system, 5. System changes and upgrades, 6. Change to Organization Name, 7. Member Identification (ID) Card vendor, 8. Call center system, 9. Covered benefits delivered exclusively through the mail, such as mail order pharmaceuticals or delivery of medical equipment, 10. Management Services Agreement (MSA), and 11. Any other Administrative Services Subcontract.

MATERIAL CHANGE TO PROVIDER NETWORK	Any change in composition of or payments to a contractor's provider network that affects, or can reasonably be foreseen to affect, the Contractor's adequacy of capacity and services necessary to meet the performance and/or provider network standards as specified in Contract. Changes to provider network may include but are not limited to: 1. A change that would cause or is likely to cause more than 5% of the members in a Geographic Service Area (GSA) to change the location where services are received or rendered. 2. Any change impacting 5% or less of the membership but involving a provider or provider group who is the sole provider of a service in a service area or operates in an area with limited alternate sources of the service.
MATERIAL OMISSION	A fact, data or other information excluded from a report, Contract, etc., the absence of which could lead to erroneous conclusions following reasonable review of such report, Contract, etc.
MATERIALS	All property, including equipment, supplies, printing, insurance, and leases of property but does not include land, a permanent interest in land or real property or leasing space.
MATERNITY CARE	Any covered services related to pregnancy to include, but not be limited to, medically necessary preconception counseling, identification of pregnancy, medically necessary education and prenatal services for the care of the pregnancy, treatment of pregnancy-related conditions, labor and delivery services, and postpartum care. Includes identification of pregnancy, prenatal care, labor/delivery services, and postpartum care.
MATERNITY CARE COORDINATION	Consists of the following maternity care related activities: determining the member's medical or social needs through a risk assessment evaluation; developing a plan of care designed to address those needs; coordinating referrals of the member to appropriate service providers and community resources; monitoring referrals to ensure the services are received; and revising the plan of care, as appropriate.
MATERNITY CARE PROVIDER	The following are provider types who may provide maternity care when it is within their training and scope of practice: 1. Arizona licensed allopathic and/or osteopathic physicians who are obstetricians or general practice/family practice providers. 2. Physician Assistants. 3. Nurse Practitioners. 4. Certified Nurse Midwives, and 5. Licensed Midwives.

MEASURABLE ***Revised: 07/2023***	The ability to determine definitively whether or not a quantifiable objective has been met, or whether progress has been made towards a positive outcome.
MECHANICAL RESTRAINT	Any device, article, or garment attached or adjacent to a member's body that the member cannot easily remove and that restricts the member's freedom of movement or normal access to the member's body, but does not include a device, article, or garment: 1. Used for orthopedic or surgical reasons, or 2. Necessary to allow a member to heal from a medical condition or to participate in a treatment program for a medical condition.
MEDICAID	A Federal and State funded health care coverage program authorized by Title XIX of the Social Security Act, as amended.
MEDICAID ACCOUNTABLE CARE ORGANIZATION (ACO) ***Revised: 11/2024***	An entity that enters into a Value-Based Purchasing (VBP) arrangement with a Contractor which: 1. Improves the health care delivery system by increasing the quality of care while managing and reducing costs. 2. Enters into VBP contracts with provider groups and/or networks of groups. 3. Coordinates provider accountability for the health of their patient population, often through shared savings, shared risk, or capitated Alternative Payment Models (APM), combined with quality incentives (to ensure both quality outcomes and cost containment). 4. Supports providers participating in APMs by providing services such as, but not limited to data analytics, technical assistance, provider education, care management, care coordination, and provider recruitment. 5. Operates as an intermediary between the Contractor and providers, is not a provider of direct services to members. 6. May or may not perform delegated administrative activities. Any delegated administrative activities to the Medicaid ACO are subject to prior approval by AHCCCS.
MEDICAID MANAGED CARE REGULATIONS	The Federal law mandating, in part, that States ensure the accessibility and delivery of quality health care by their managed care Contractors. These regulations were promulgated as specified in the Balanced Budget Act (BBA) of 1997.

MEDICAL EQUIPMENT AND APPLIANCES	Item as specified in 42 CFR 440.70, that is not a prosthetic or orthotic; and 1. Is customarily used to serve a medical purpose, and is generally not useful to an individual in the absence of an illness, disability, or injury, 2. Can withstand repeated use, and 3. Can be reusable by others or removable. Medical equipment and appliances may also be referred to as Durable Medical Equipment (DME).
MEDICAL MANAGEMENT (MM)	An integrated process or system that is designed to assure appropriate utilization of health care resources, in the amount and duration necessary to achieve desired health outcomes, across the continuum of care (from prevention to hospice).
MEDICAL PRACTITIONER	A physician, physician assistant or registered nurse practitioner.
MEDICAL RECORD	All communications related to a patient's physical or mental health or condition that are recorded in any form or medium and that are maintained for purposes of evaluation or treatment, including records that are prepared by a health care provider or by other providers. Records do not include materials that are prepared in connection with utilization review, peer review or quality assurance activities as specified in ARS 12-2291.
MEDICAL RECORD – INTEGRATED	A single document in which all of the medical information is recorded to facilitate the coordination and Quality of Care (QOC) delivered by multiple providers serving a single patient in multiple locations and at varying times.
MEDICAL SERVICES	Medical care and treatment provided by a Primary Care Provider (PCP), attending physician, or dentist or by a nurse or other health related professional and technical personnel at the direction/order of a licensed physician or dentist.
MEDICAL SUPPLIES	Health care related items that are consumable or disposable or cannot withstand repeated use by more than one individual, that are required to address an individual medical disability, illness or injury as specified in 42 CFR 440.70.
MEDICAL/SURGICAL (M/S) BENEFITS ***Revised: 09/2024***	Items or services for medical conditions or surgical procedures, as defined by the State and in accordance with applicable Federal and State law, but do not include mental health or Substance Use Disorder (SUD) Benefits. Any condition defined by the State as being or not being a M/S condition shall be defined to be consistent with generally recognized independent standards of current medical practice. The M/S Benefit includes long-term care services.

MEDICALLY NECESSARY (Defined per CMS) ***Revised: 07/2023***	A service given by a doctor, or licensed health practitioner that helps with health problem, stops disease, disability, or extends life.
MEDICALLY NECESSARY BEHAVIORAL HEALTH SERVICES	Those behavioral health services necessary, in the judgment of a qualified medical practitioner, to treat an existing behavioral health condition or illness and/or to prevent the patient from potentially harming themselves or others.
MEDICALLY NECESSARY SERVICES	Those covered services provided by qualified service providers within the scope of their practice to prevent disease, disability and other adverse health conditions or their progression or to prolong life.
MEDICALLY STABLE	As specified in AAC R9-28-508, the Member's skilled-care medical needs are routine and not subject to frequent change because of health issues.
MEDICARE	A Federal program authorized by Title XVIII of the Social Security Act, as amended.
MEDICARE ADVANTAGE	The Medicare managed care program (Part C) as administered by the Centers for Medicare and Medicaid Services (CMS).
MEDICARE ADVANTAGE – BENEFITS	Health care services that are intended to maintain or improve the health status of dual eligible members, for which the Medicare Advantage Organization (MAO) incurs a cost or liability under a Centers for Medicare and Medicaid Services (CMS) approved Plan Benefits package offered by the MAO (not solely an administrative processing cost).
MEDICARE ADVANTAGE – EQUITY PER MEMBER ***Revised:11/2024***	Net assets that are not designated or restricted for specific purposes divided by the number of Medicare Advantage Dual Eligible Members.
MEDICARE ADVANTAGE – STATE CERTIFICATION REQUEST FORM	A Form required by the Centers for Medicare and Medicaid Services (CMS) to be completed by the applicable State agency (either by AHCCCS or the Arizona Department of Insurance and Financial Institutions [IFI]) authorized to attest that a Medicare Advantage Organization (MAO) applicant's status as a public or private entity organized and licensed by the State as a risk-bearing entity. The Form is included in the annual Medicare Advantage application as published by CMS. The executed Form is to be returned to the Medicare Advantage applicant prior to CMS' due date for Medicare Advantage applications.
MEDICARE ADVANTAGE - SUPPLEMENTAL BENEFIT	Covered benefits offered by a Medicare Advantage Plan which are not covered services under Medicare Parts A and B. These benefits may include, but are not limited to, dental, hearing, and/or vision services.

MEDICARE ADVANTAGE PLAN	A private health insurance plan that has a contract with the Centers for Medicare and Medicaid Services (CMS) to provide all Medicare benefits covered under Parts A and B to Medicare beneficiaries who choose to enroll in their plan. Most Medicare Advantage plans include Medicare Part D prescription drug coverage and may also provide additional supplemental benefits as approved by CMS. Types of Medicare Advantage plans include Health Maintenance Organizations (HMOs), Dual Eligible Special Needs Plans (D-SNPs), and Local and Regional Preferred Provider Organizations (RPPOs).
MEDICARE ADVANTAGE CONTRACT YEAR	Centers for Medicare and Medicaid Services (CMS) Medicare Advantage program contracts with each approved Medicare Advantage Organization (MAO) for a one-year term beginning January 1 and ending December 31 of each calendar year.
MEDICARE ADVANTAGE ORGANIZATION (MAO)	A public or private entity organized and licensed or authorized by a State as a risk-bearing entity (with the exception of provider sponsored organizations receiving waivers) that is certified by Centers for Medicare and Medicaid Services (CMS) as meeting the Medicare Advantage contract requirements.
MEDICARE CERTIFIED HOME HEALTH AGENCY (HHA)	A Medicare certified Home Health Agency (HHA) is licensed by the Arizona Department of Health Services (ADHS). Under limited circumstances, home health services may be provided by either a state licensed Home Health Agency or by an Independent Registered Nurse (RN) when specific criteria are met.
MEDICARE COST SHARING	A Contractor's obligation for payment of applicable Medicare deductible, coinsurance and copayment amounts for Medicare Parts A and B covered services.
MEDICARE IMPROVEMENTS FOR PATIENTS AND PROVIDERS ACT (MIPPA) AGREEMENT	A formal written Agreement entered into by AHCCCS and a Contractor's companion Medicare Advantage Organization (MAO) to coordinate care for individuals in Arizona who are entitled to Medicare and receive full coverage of health services under Medicaid. The AHCCCS MIPPA Agreement outlines requirements which aim to improve care coordination and timely information sharing by both parties for dual eligible members enrolled in a contracted MAO's offered D-SNP as specified in 42 CFR 422.107, Section 164 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) and Section 3205 of the Affordable Care Act.
MEDICARE MANAGED CARE PLAN	A managed care entity that has a Medicare Contract with Centers for Medicare and Medicaid Services (CMS) to provide services to Medicare beneficiaries, including Medicare Advantage Plan (MAP), Medicare Advantage Prescription Drug Plan (MAPDP), MAPDP Special Needs Plan, or Medicare Prescription Drug Plan.
MEDICARE PART A	Medicare hospital insurance that provides coverage for hospice services, Skilled Nursing services, and inpatient hospital care.
MEDICARE PART B	Medicare coverage of medically necessary services such as doctors' appointments, outpatient care, home health services, and other outpatient or professional medical services.

MEDICARE PART D	Medicare prescription drug coverage program.
MEDICATIONS FOR OPIOID USE DISORDER (MOUD) ***Revised: 07/2023***	The use of medications in combination with counseling and behavioral therapies for the treatment of Substance Use Disorders (SUD).
MEDICATION ERROR	The Federal Drug Administration (FDA) defines a medication error as any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of a healthcare provider, patient, or consumer.
MEMBER	An eligible individual who is enrolled in AHCCCS, as specified in ARS 36-2931, 36-2901, 36-2901.01 and ARS 36-2981. Also referred to as Title XIX/XXI member or Medicaid member. When applicable, MEMBER may also or alternatively refer to an enrolled individual's health care decision maker (HCDM) or designated representative (DR). REFER TO HEALTH CARE DECISION MAKER; REFER TO DESIGNATED REPRESENTATIVE.
MEMBER CRITICAL SERVICE PREFERENCE LEVEL	Indication of the timeframe in which the member chooses to have a gap in critical services filled if the scheduled Direct Care Worker (DCW) of that critical service is not available.
MEMBER IDENTIFICATION CARD (ID CARD)	A Contractor-specific identification card that meets the formatting requirements and is issued by the Responsible Contractor to each member. The ID Card is used by the member when presenting for Medicaid services.
MEMBER IDENTIFICATION CARD (ID CARD) – CARD HOLDER	The document in which the ID Card is attached to or the sleeve in which the ID Card is provided to the member.
MEMBER INFORMATION MATERIALS	Any materials given to the Contractor's membership. This includes, but is not limited to member handbooks, member newsletters, provider directories, surveys, on hold messages and health related brochures/reminders and videos, form letter templates, and website content. It also includes the use of other mass communication technology such as email and voice recorded information messages delivered to a member's phone.
MEMBER INFORMATION - FILE AND USE	A process whereby the Contractor submits qualifying member information materials to AHCCCS prior to use and can proceed with distributing the materials without any expressed approval from AHCCCS.
MEMBER INFORMATION - INCENTIVE ITEM	Items that are used to encourage behavior changes in the Contractor's enrolled members or health promotion incentives to motivate members to adopt a healthy lifestyle and/or obtain health care services.
MEMBER INFORMATION - RETENTION MATERIALS	Member information materials sent to members prior to and during their Annual Enrollment Choice for the purposes of retaining members as an enrollee with the Contractor.

MEMBER INFORMATION - VITAL MATERIALS	Written materials that are critical to obtaining services which include, at a minimum, the following: 1. Member Handbooks 2. Provider Directories 3. Consent Forms 4. Appeal and Grievance Notices 5. Denial and Termination Notices
MEMBER TRANSITION	The process during which members change from one Contractor or Fee-For-Service (FFS) Program to another.
MEMBER-DIRECTED OPTIONS	Allows members to have more control over how certain services are provided, including services such as attendant care, personal care, homemaker, and habilitation. The options are not services, but rather define the way in which services are delivered. Member-directed options are available to ALTCS members who live in their own home. Member-directed options include Agency with Choice and Self-Directed Attendant Care and the Division of Developmental Disabilities' Independent Provider Network.
MEMBER-DIRECTED SERVICE DELIVERY OPTIONS	Models which allow Members to have more control over how certain services are provided, including services such as attendant care, personal care, homemaker, and habilitation. The options are not a service, but rather define the way in which services are delivered. Member-directed options are available to ALTCS Members who live in their own home. The options are not available to Members who live in an alternative residential setting or Nursing Facility (NF).
MEMORANDUM OF UNDERSTANDING (MOU) ***Revised: 07/2023***	A nonbinding agreement between two parties.
MENTAL DISORDER	A substantial disorder of the individual's emotional processes, thought, cognition, or memory as pursuant in ARS 36-501.
MENTAL HEALTH AGENCY	Includes a regional authority, service provider, inpatient facility, an agency that conducts screening and evaluation as specified in AAC Title 9, Chapter 21, Article 5. and AAC R9-21-101.B.47.
MENTAL HEALTH BENEFIT	Items or services for mental health conditions, as specified in the State and in accordance with applicable Federal and State law. Any condition defined by the State as being or not being a mental health condition shall be defined to be consistent with generally recognized independent standards of current medical practice. Mental Health Benefits include long-term care services.

MERGER	Two companies join together to form a single entity, using both companies' assets and stock, or, for non-stock entities (e.g., nonprofit corporations, limited liability companies, and partnership), the conversion of membership interests, sponsors, or their voting rights. Both companies cease to exist separately and new stock is issued for the resulting organization or, for non-stock corporations (e.g., non-profit corporations), memberships or sponsors are combined or their voting rights are transferred to the new corporation.
METABOLIC MEDICAL FOOD FORMULAS OR MEDICAL FOODS	Nutrition and specialized diets used to treat inherited metabolic disorders that are rare genetic conditions in which normal metabolic function is inhibited by a deficiency in a critical enzyme. Metabolic formula or modified low protein foods are produced or manufactured specifically for individuals with a qualifying metabolic disorder and are not generally used by individuals in the absence of a qualifying metabolic disorder. In order to avoid toxic effects, the treatment of the associated metabolic disorder depends on dietary restriction of foods containing the substances that cannot be metabolized by the member.
METHODOLOGY	The planned documented process, steps, activities, or actions taken by a Contractor to achieve a goal or objective, or to progress towards a positive outcome.
MID-LEVEL EXEMPTION REQUEST	An exemption process as specified in 42 CFR Part 8.11 for Opioid Treatment Programs (OTPs) to request the Single State Authority (SSA) and the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Treatment (CSAT) to provide approval to allow Mid-Level Practitioners to treat opioid-related withdrawal symptoms.
MID-LEVEL PRACTITIONER	An individual practitioner, other than a physician, dentist, veterinarian, or podiatrist, who is licensed, registered, or otherwise permitted by the United States or the jurisdiction in which he/she practices, to dispense a controlled substance in the course of professional practice. Examples of mid-level practitioners include, but are not limited to, health care providers such as nurse practitioners, nurse midwives, nurse anesthetists, clinical nurse specialists, and physician assistants who are authorized to dispense controlled substances by the State in which they practice, as specified in 21 CFR 1300.01.
MINIMUM PERFORMANCE STANDARD (MPS)	The minimal expected level of performance by the Contractor.
MONITORING ***Revised: 07/2023***	The process of auditing, observing, evaluating, analyzing, conducting follow-up activities, and documenting results.
MONTHLY AVERAGE ABANDONMENT RATE (MAAR)	The number of calls abandoned in a 24-hour period, divided by the total number of calls received in the same 24-hour period, summed for each day of the month, and then divided by the number of days in the monthly reporting period.

MONTHLY AVERAGE SERVICE LEVEL (MASL)	The total of the month's calls answered within 45 seconds divided by the sum of the following: all calls answered in the month, all calls abandoned calls in the month and all calls receiving a busy signal in the month (if available).
MONTHLY FIRST CONTACT CALL RESOLUTION RATE (MFCCR)	The sum of the Daily First Contact Call Resolution Rate (DFCCR)s divided by the number of days in the reporting period.
MULTI-SPECIALTY INTERDISCIPLINARY CLINIC (MSIC)	An established facility where specialists from multiple specialties meet with members and their families for the purpose of providing interdisciplinary services to treat members.
MULTI-SPECIALTY INTERDISCIPLINARY TEAM (MSIT)	A team of specialists from multiple specialties who meet with members and their families for the purpose of determining an interdisciplinary treatment plan.

N	
NATIONAL PROVIDER IDENTIFIER (NPI)	A unique Identification (ID) number for covered health care providers, assigned by the Center for Medicare and Medicaid Services (CMS) contracted national enumerator.
NATUROPATHIC PHYSICIAN (ND)	An individual that diagnoses, treats, and helps prevent diseases using a system of practice that is based on the natural healing capacity of individuals. May use physiological, psychological, or mechanical methods. May also use natural medicines, prescription or legend drugs, foods, herbs, or other natural remedies.
NEGLECT (OF A VULNERABLE ADULT)	A pattern of conduct without the individual's informed consent resulting in deprivation of food, water, medication, medical services, shelter, cooling, heating, or other services necessary to maintain minimum physical or mental health as specified in ARS 46-451(A)(7).
NEGLECT (OF A CHILD)	As specified in ARS 8-201, the inability or unwillingness of a parent, guardian, or custodian of a child to provide that child with supervision, food, clothing, shelter, or medical care.
NETWORK **(Defined per CMS)** ***Revised: 07/2023***	Physicians, health care providers, suppliers and hospitals that contract with a health plan to give care to members.
NEW PATIENT	A member who has not received any professional services from the physician/non-physician practitioner or another physician of the same specialty who belongs to the same group practice within the previous three years.
NOTICE OF APPEALS RESOLUTION (NOAR)	The written notice to the member/Health Care Decision Maker (HCDM) or, Designated Representative (DR) regarding the final determination of an appealed action. The contents of a Notice of Appeal Resolution are strictly defined in Contract, Rule, and Policy.
NOMINAL PRICE	A drug that is purchased for a price that is less than 10% of the Average Manufacturer Price (AMP) in the same quarter for which the AMP is computed.
NON-CONTRACTING PROVIDER	An individual or entity that provides services as specified in ARS 36-2901 who does not have a subcontract with an AHCCCS Contractor.
NON-INSTITUTIONAL SETTING	Long-term care arrangement in which skilled home health nursing services can be provided. Non-Institutional Settings include: 1. A member's "own" home, as specified in AAC R9-28-101(B). 2. Assisted Living Facility. 3. Division of Developmental Disabilities (DDD) Group Home. 4. DDD Adult & Child Developmental Home, and 5. Behavioral Health Residential Facility.

NON-PREFERRED DRUG	A medication that is not listed on the AHCCCS Drug List. Non-preferred drugs require Prior Authorization (PA).
NON-QUALIFIED MEDICARE BENEFICIARY (NON-QMB) DUAL	An individual who qualifies to receive both Medicare and Medicaid services but does not qualify for the Qualified Medicare Beneficiary (QMB) program as specified in AAC R9-29-101.
NON-TITLE XIX/XXI FUNDING	AHCCCS' funding sources outside of Title XIX/XXI Medicaid funds that could include but are not limited to; state appropriated general funds, state non-appropriated funds, county funds, block or formula grants, discretionary grants, or other grant-based funding.
NON-TITLE XIX/XXI MEMBER OR NON-TITLE XIX/XXI ELIGIBLE INDIVIDUAL	An individual who needs or may be at risk of needing covered health-related services but does not meet Federal and State requirements for Title XIX or Title XXI eligibility.
NON-TITLE XIX/XXI SERIOUS MENTAL ILLNESS (SMI) MEMBER	A Non-Title XIX/XXI member who has met the criteria to be designated as SMI.
NOTICE OF ADVERSE BENEFIT DETERMINATION (NOA)	The written notice provided to the affected member/Health Care Decision Maker (HCDM) which explains the Adverse Benefit Determination made by the Contractor or AHCCCS regarding the service authorization to deny, reduce, suspend, or terminate a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested as specified in 42 CFR 438.210(c), 42 CFR 438.404, and 42 CFR 438.400(b).
NOTICE OF CONCERN (NOC)	A written communication to the Contractor regarding a concern. Failure to correct the issue(s) identified in the notice may result in additional contract enforcement remedies.
NOTICE OF EXTENSION (NOE)	The written notice to a member/Health Care Decision Maker (HCDM), and Designated Representative (DR) to extend the timeframe for making either an expedited or standard authorization decision by up to 14 days if criteria for a service authorization extension are met.
NOTICE OF PRIVACY PRACTICES (NPPS)	A Notice available on the AHCCCS website that describes: 1. The uses and disclosures of Protected Health Information (PHI). 2. Patient rights concerning PHI, and 3. The AHCCCS legal duties pertaining to PHI. The Health Insurance Portability and Accountability Act (HIPAA), requires covered entities, such as AHCCCS and its Contractors to provide this Notice upon a member's enrollment in the plan, within 60 days of a material change to the Notice, and upon request by any individual. In addition, every three years a health plan also shall notify members who are covered by the plan that the Notice of Privacy Practices is available, including how to obtain the Notice.

NOTICE TO CURE (NTC)	A formal written communication to a Contractor regarding specific non-compliance. The NTC contains specific timelines for meeting performance standards and possible penalties for continued non-compliance. An NTC may contain specific activities or reporting requirements that must be adhered to as the Contractor works toward compliance. Failure to achieve compliance as the result of a Notice to Cure may result in the imposition of a Sanction.
NURSING FACILITY ***Revised: 10/2021***	As defined in 42 USC 1396r(a), an institution (or a distinct part of an institution) which: 1. Is primarily engaged in providing to residents: a. Skilled nursing care and related services for residents who require medical or nursing care, b. Rehabilitation services for the rehabilitation of injured, disabled, or sick individuals, or c. On a regular basis, health-related care, and services to individuals who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities, and d. Is not primarily for the care and treatment of mental diseases, 2. Has in effect a transfer agreement (meeting the requirements of 42 USC 1861(l)) with one or more hospitals having agreements in effect under section 1866, and 3. Meets the requirements for a Nursing Facility (NF) described in subsections (b), (c), and (d) of this section.
NURSING SUPPORTED GROUP HOME FOR INDIVIDUALS WITH INTELLECTUAL/DEVELOPMENTAL DISABILITIES ***Revised: 09/2022***	A community residential facility contracted with DES for up to six residents that provides room, board, personal care, daily habilitation, supervision, and continuous nursing support and intervention. Refer to AAC Title 9, Chapter 33, Article 1 and ARS 36-551.
NUTRITIONIST	An individual who has a bachelor's or master's degree in Food and Nutrition.

O

OBJECTIVE	A measurable step, generally one of a series of progressive steps, to achieve a goal.
OBSERVATION SERVICES	Include the use of a bed and periodic monitoring by hospital nursing staff and/or other staff to evaluate, stabilize, or treat medical conditions of a significant degree of instability and/or disability.
OCCUPATIONAL THERAPY (OT)	Medically ordered treatments to improve or restore functions which have been impaired by illness or injury, or which have been permanently lost, or reduced by illness or injury, or to attain or acquire a particular skill or function never learned or acquired and maintain that function once acquired. OT is intended to improve the member's ability to perform those tasks required for independent functioning as specified in ARS 32-3401.
OFFICE OF HUMAN RIGHTS (OHR)	Established within AHCCCS and is responsible for the hiring, training, supervision, and coordination of human rights advocates. Human rights advocates assist and advocate on behalf of members determined to have a Serious Mental Illness (SMI) with Service Planning, Inpatient Discharge Planning, and resolving appeals and grievances.
OFFICE OF INDIVIDUAL AND FAMILY AFFAIRS (OIFA)	An area that promotes recovery, resiliency, and wellness for individuals with mental health and substance use challenges.
OFFICE OF INDIVIDUAL AND FAMILY AFFAIRS (OIFA) ALLIANCE	The OIFA Alliance promotes the growth and expansion of peer support and family support services across the state; and engages with peers, family members, and other stakeholders to ensure their voices are included in system transformation.
OPIOID TREATMENT PROGRAMS (OTPS)	Licensed and accredited Programs also referred to as Medications for Opioid Use Disorder (MOUD) Programs, authorized to dispense medications for the treatment of opioid use disorder through highly structured protocols defined by Federal and State regulations.
ORGAN PROCUREMENT AND TRANSPLANTATION NETWORK (OPTN)	Established through the National Organ Transplant Act (NOTA), OPTN is a public-private partnership operated through U.S. Department of Health and Human Services. The OPTN policies govern operation of all member transplant hospitals, Organ Procurement Organizations (OPOs) and histocompatibility labs in the United States.
ORTHOTIC	Devices that are prescribed by a physician or other licensed practitioner of the healing arts to support a weak or deformed portion of the body, or prevent or correct physical deformity or malfunction, as specified in 42 CFR 440.120, and AAC R9-22-212).
OTHER FULL BENEFIT DUAL ELIGIBLE (FBDE)	An AHCCCS member who does not meet the income or resources criteria to be a Qualified Medicare Beneficiary (QMB) or a Specified Low-Income Medicare Beneficiary (SLMB). Is eligible for Medicaid either categorically or through optional coverage groups, such as Medically Needy, Ticket to Work waiver, or special income levels for institutionalized or home and community-based waivers.

OTHER PROVIDER-PREVENTABLE CONDITION (OPPC)	A condition occurring in the inpatient and outpatient health care setting which AHCCCS has limited to the following: 1. Surgery on the wrong member. 2. Wrong surgery on a member. 3. Wrong site surgery.
OUT-OF-NETWORK PROVIDER (Defined by CMS) ***Revised: 07/2023***	A health care provider that has a provider agreement with AHCCCS but does not have a contract with your health plan. You may be responsible for the cost of care for out-of-network providers.
OUT-OF-STATE SERVICES	Services provided to members outside of Arizona that are covered as provided for under Code of Federal Regulations (CFR) 42 CFR, Part 431, Subpart B. This includes services that, as determined on the basis of medical advice, are more readily available in other states and services needed due to a medical emergency. Services furnished to AHCCCS members outside the United States are not covered.
OUTCOMES	Changes in patient health, functional status, satisfaction, or goal achievement that result from health care or supportive services as specified in 42 CFR 438.320.
OUTREACH	Activities designed to inform individuals of behavioral health services availability and to engage or refer those individuals who may need services.
OWN HOME	Refer to the term Home.
OWN HOME – ALTCS	Refer to the term Home – ALTCS.
OWNERSHIP INTEREST	The possession of equity in the capital, the stock, or the profits of the provider as specified in 42 CFR 455.101.

OWNERSHIP OR CONTROL INTEREST	As specified in 42 CFR 455.101, an individual or entity that: 1. Has a direct ownership interest equal to 5% or more in a provider. 2. Has an indirect ownership interest equal to 5% of more in a provider. 3. Has a combination of direct and indirect ownership interests equal to five percent or more in a provider. 4. Owns an interest of five percent or more in any mortgage, deed of trust, note, or other obligation secured by the provider if that interest equals at least five percent of the value of the property or assets of the provider. 5. Is an officer or director of a provider that is organized as a corporation; or a partner in a provider that is organized as a partnership. For reference only, some examples of Ownership or Control Interest included below: 1. If Entity A has a 100% interest in the provider entity, then Entity A has an Ownership of Control Interest and shall be disclosed. 2. Any entity with a 5% or greater interest in Entity A also has an Ownership or Control Interest and shall be disclosed.

P	
PALLIATIVE CARE	Medical care for members with a chronic or terminal illness. It focuses on providing members with relief from symptoms and the stress of illness. The goal is to improve the quality of life for both the member and his or her families. It is appropriate at any age and any stage in the illness and can be provided in conjunction with curative treatment outside the context of hospice care.
PARENT	A biological, adoptive, or custodial mother or father of a child, or an individual who has been appointed as a legal guardian or custodian of a child by a court of competent jurisdiction.
PARENT/CARETAKER RELATIVES	Eligible individuals and families as specified in Section 1931 of the Social Security Act, with household income levels at or below 100% of the Federal Poverty Level (FPL).
PARENT/FAMILY SUPPORT SERVICES	Home care training (family support) with family member(s) directed toward restoration, enhancement, or maintenance of the family functions in order to increase the family's ability to effectively interact and care for the individual in the home and community.
PEER	An individual with lived experience of mental health conditions, substance use, and/or other traumas resulting in emotional distress and significant life disruption, for which they have sought help or care, and has an experience of recovery to share.
PEER SUPPORT EMPLOYMENT TRAINING PROGRAM (PSETP) ***Revised: 07/2023***	A Training Program encompassing the Peer-And-Recovery Support Specialist (PRSS) credentialing process and recognized by the Office of Individual and Family Affairs (OIFA) Alliance.
PEER AND RECOVERY SUPPORT (PRSS) ***Revised: 10/2021***	A distinct health care practice involving intentional partnerships to provide social and emotional support based on shared experiences of living with behavioral health and/or substance use disorders, and/or other traumas associated with significant life disruption. This support is coupled with specific, skill-based training, coaching, or assistance to bring about social or personal change at the individual, family, or community level. These services can include a variety of individualized and personal goals, including living preferences, employment or educational goals and development of social networks and interests.
PEER AND RECOVERY SUPPORT SPECIALIST (PRSS) – CREDENTIAL ***Revised: 07/2023, 09/2024***	A written and/or electronic document issued to a qualified individual by operators of an AHCCCS-recognized Peer Support Employment Training Program (PSETP). A PRSS credential is necessary for provision of Medicaid-reimbursed peer support services.
PEER AND RECOVERY SUPPORT (PRSS) - SPECIALIST	An individual trained, credentialed, and qualified to provide peer/recovery support services within the AHCCCS Programs.

PEER-REVIEWED STUDY	Prior to publication, a medical study that has been subjected to the review of medical experts who: 1. Have expertise in the subject matter of the study. 2. Evaluate the science and methodology of the study. 3. Are selected by the editorial staff of the publication. 4. Review the study without knowledge of the identity or qualifications of the author. 5. Are published in the United States (U.S.).
PEER-RUN ORGANIZATION (PRO)	Owned, administratively controlled, and operated by peers, and emphasize self-help as an operational approach. 1. Independent- Owned, administratively controlled, and operated by peers that share the lived experiences of the members and populations they serve. 2. Autonomous- Decisions about governance related to fiscal and financial, personnel, policy, contracting, training, program, advocacy, cultural competence and services and operational management are made by the peer-run program. 3. Accountable- Responsibility for decisions rests with the peer-run program. 4. Peer Controlled- The governance board composition is at least 51% peers. 5. Peer Workers- Staff, management, and board of directors (governance) are individuals who share the lived experiences of the members and populations they serve.
PERFORMANCE IMPROVEMENT PROJECT (PIP) ***Revised: 07/2023,09/2024***	A planned process of data gathering, evaluation, and analysis to determine interventions or activities that are projected to have a positive outcome. This process includes measuring the impact of the interventions or activities aimed toward improving quality of care and service delivery. Performance Improvement Projects (PIPs) are designed to achieve significant improvement, sustained over time, in health outcomes and member satisfaction, and include the elements outlined in 42 CFR 438.330(d)(2) . A PIP may also be referred to as a Quality Improvement Project (QIP).
PERFORMANCE IMPROVEMENT/QUALITY IMPROVEMENT ***Revised: 07/2023***	The approach utilized to better services and/or outcomes through the continuous improvement of processes intended to prevent or decrease the likelihood of issues. This is generally accomplished through identifying areas of opportunity and testing new solutions/interventions to correct underlying causes of persistent/systemic issues or overcome identified barriers.
PERFORMANCE MEASURE PERFORMANCE STANDARD (PMPS)	The minimal expected level of Contractor performance as it relates to performance measures. Official performance measure results shall be evaluated based upon the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®) Medicaid Mean or Centers for Medicare and Medicaid Services (CMS) Medicaid Median (for selected CMS Core Set-Only Measures), as identified by AHCCCS, as well as the line of business aggregate rates, as applicable.

PERFORMANCE MEASURE SCORE	This score measures the Contractor's performance relative to the minimum performance standards established by AHCCCS Quality Improvement for each Quality Measure Performance Measure (QMPM).
PERFORMANCE RANK SCORE	This score measures the ranking of the Contractor's performance for each Quality Measure Performance Measure (QMPM).
PERFORMANCE STANDARD	A set of standardized measures designed to assist AHCCCS in evaluating, comparing, and improving the performance of its Contractors.
PERIOD OF CRISIS	A period (up to 24 hours per day) in which the hospice eligible member requires continuous care to achieve palliation or management of acute medical symptoms.
PERIODIC	Intervals established by AHCCCS for screening to assure that a condition, illness, or injury is not developing or present.
PERMANENT SUPPORTIVE HOUSING (PSH) ***Revised: 08/2023***	Housing assistance (e.g., long-term leasing or rental assistance) and supportive services are provided to assist households with at least one member with a disability in achieving housing stability.
PERSON WITH AN INTELLECTUAL/DEVELOPMENTAL DISABILITY	REFER TO "INDIVIDUAL WITH AN INTELLECTUAL/DEVELOPEMENTAL DISABILITY".
PERSON-CENTERED	An approach to planning designed to assist the member to plan their life and supports. This model enables individuals to increase their personal self-determination and improve their own independence.
PERSON-CENTERED SERVICE PLAN (PCSP) ***Revised: 09/2022***	A written plan developed through an assessment of functional need that reflects the services and supports (paid and unpaid) that are important for and important to the member in meeting the identified needs and preferences for the delivery of such services and supports. The PCSP shall also reflect the member's strengths and preferences that meet the member's social, cultural, and linguistic needs, individually identified and prioritized goals and desired outcomes, and reflect risk factors (including risks to member rights) and measures in place to minimize them, including individualized back-up plans and other strategies as needed.
PERSONAL RESTRAINT	The application of physical force without the use of any device, for the purpose of restricting the free movement of a member's body. For Behavioral Health Inpatient Facility (BHIF) or outpatient treatment centers licensed to provide behavioral health observation/stabilization services (Crisis Facility), personal restraint does not include: 1. Holding a member for no longer than five minutes, without undue force, in order to calm or comfort the member. 2. Holding a member's hand to escort the member from one area to another.

PERSONALLY IDENTIFYING INFORMATION (PII)	An individual's name, address, date of birth, social security number, tribal enrollment number, telephone or fax number, e-mail address, social media identifier, driver license number, places of employment, school identification or military identification number or any other distinguishing characteristic that tends to identify a particular individual as specified in ARS 41-3804 (K).
PHARMACY AND THERAPEUTICS (P&T) COMMITTEE	The advisory committee to AHCCCS, which is responsible for developing, managing, updating, and administering the AHCCCS Drug List. The P&T Committee is primarily comprised of physicians, pharmacists, nurses, other health care professionals and community members.
PHYSICAL THERAPY (PT)	Medically ordered treatments to restore, maintain, or improve muscle tone, joint mobility, or physical function; and to attain or acquire a particular skill or function never learned or acquired and maintain that function once acquired as specified in ARS 32-2001.
PHYSICIAN SERVICES (Defined per CMS) ***Revised: 07/2023***	Health care services given by a licensed physician.
PLAN-DO-STUDY-ACT (PDSA) – CYCLE ***Revised: 07/2023***	A scientific method for testing a change or intervention, designed to result in improvement in a specific area. The cycle designed to result in improvement in a specific area. The cycle is completed by planning the change/intervention, trying it, observing the results, and acting on what is learned. When these steps are conducted over a relatively short time period (e.g., over days, weeks, months), the approach is also known as Rapid Cycle Improvement.
PLAN-DO-STUDY-ACT (PDSA) – METHOD ***Revised: 07/2023***	A four-step model to test a change that is implemented. Going through the prescribed four steps utilizing one or more PDSA cycles guides the thinking process into breaking down the task into steps and then evaluating the outcome, improving on it, and testing again.
PLANNING TEAM ***Revised: 01/2022***	A defined group of individuals that shall include the member/Health Care Decision Maker (HCDM) and with the member's/HCDMs consent, their individual representative, Designated Representative (DR), and any individuals important in the member's life, including but not limited to extended family members, friends, service providers, community resource providers, representatives from religious/spiritual organizations, and agents from other service systems like Department of Child Safety (DCS). The size, scope, and intensity of involvement of the team members are determined by the objectives of the Planning Team to best meet the needs and individual goals of the member.
POST STABILIZATION CARE SERVICES	Medically necessary services, related to an emergency medical condition provided after the member's condition is sufficiently stabilized in order to maintain, improve, or resolve the member's condition so that the member could alternatively be safely discharged or transferred to another location as specified in 42 CFR 438.114(a).

POST-PAYMENT RECOVERY	Subsequent to payment of a service by a Contractor, efforts by that Contractor, to retrieve payment from a liable third party. Pay and Chase is one type of post-payment recovery.
POSTPARTUM ***Revised: 10/2022***	For individuals determined eligible for 12-months postpartum coverage, postpartum is the period that begins on the last day of pregnancy and extends through the end of the month in which the 12-month period following termination of pregnancy ends. For individuals determined eligible for 60-days postpartum coverage, postpartum is the period that begins on the last day of pregnancy and extends through the end of the month in which the 60-day period following termination of pregnancy ends. Quality measures used in maternity care quality improvement may utilize different criteria for the postpartum period.
POSTPARTUM CARE ***Revised: 02/2024***	Health care provided in the postpartum period to assess and treat the member's physical, psychological, and social well-being after pregnancy, regardless of how a pregnancy ends. Services include but are not limited to, addressing chronic medical conditions (e.g., hypertension, diabetes, mood disorders), family planning, and a plan to transition to parenthood and well-woman or preventive care. Postpartum care visits are an ongoing process that should align with recommendations from the American College of Obstetricians and Gynecologists (ACOG).
POTENTIAL ENROLLEE	A Medicaid-eligible recipient who is not yet enrolled with a Contractor as specified in 42 CFR 438.10(a).
POTENTIAL MEMBER	A Medicaid-eligible recipient who is not yet enrolled with a Contractor or a member during Annual Enrollment Choice (AEC).
POTENTIAL PLAN LISTING (PPL)	A file which provides the Contractor with the basic demographic information of all members who may be joining or leaving.
PRACTICAL SUPPORT	REFER TO “INFORMAL SUPPORTS”.
PRACTICE SITE	A physical location in which ambulatory Targeted Investments (TI) projects will be conducted. One practice site can participate in multiple areas of concentration (e.g., an AHCCCS-registered Integrated Clinic can participate in a primary care and Behavioral Health area of concentration).
PRACTITIONER	Refers to certified nurse practitioners in midwifery, physician assistant(s), and other nurse practitioners. Physician assistant(s) and nurse practitioners as specified in ARS Title 32, Chapters 15 and 25, respectively.
PRE-ADMISSION SCREENING (PAS)	A process of determining an individual’s risk of institutionalization at a Nursing Facility (NF) or Intermediate Care Facility (ICF) level of care as specified in 9 AAC 28 Article 1.

PRECONCEPTION COUNSELING	The provision of assistance and guidance aimed at identifying/reducing behavioral and social risks, through preventive and management interventions, in women of reproductive age who are capable of becoming pregnant, regardless of whether she is planning to conceive. This counseling focuses on the early detection and management of risk factors before pregnancy and includes efforts to influence behaviors that can affect a fetus prior to conception. The purpose of preconception counseling is to ensure that a woman is healthy prior to pregnancy. Preconception counseling is considered included in the well-woman preventative care visit and does not include genetic testing.
PRE-PETITION SCREENING	The review of each application requesting court ordered evaluations, including an investigation of facts alleged in such application, an interview with each applicant and an interview, if possible, with the proposed patient as pursuant in ARS 36-501. The purpose of the interview with the proposed patient is to assess the problem, explain the application, and, when indicated attempt to persuade the proposed patient to receive, on a voluntary basis, evaluation, or other services.
PREFERRED DRUG	A medication that has been clinically reviewed and approved by the AHCCCS Pharmacy and Therapeutic (P&T) Committee for inclusion on the AHCCCS Drug List as a preferred drug due to its proven clinical efficacy and cost effectiveness.
PREMIUM **(Defined per CMS)** ***Revised: 07/2023***	The monthly amount that a member pays for health insurance. A member may have other costs for care including a deductible, copayments, and coinsurance.
PREMIUM TAX ***Revised: 09/2022***	The tax imposed pursuant to ARS 36-2905 and ARS 36-2944.01 for all payments made to the Contractor for the Contract Year.
PRENATAL CARE	The provision of health services during pregnancy which is composed of three major components: 1. Early and continuous risk assessment. 2. Health education and promotion. 3. Medical monitoring, intervention, and follow-up.
PREPAID MEDICAL MANAGEMENT INFORMATION SYSTEM (PMMIS)	An integrated information infrastructure that supports AHCCCS operations, administrative activities, and reporting requirements.
PREPONDERANCE OF EVIDENCE	A standard of proof that it is more likely than not that an alleged event occurred.
PRESCRIPTION DRUGS ***(Defined per CMS)*** ***Revised: 07/2023***	Medications ordered by a health care professional practitioner and given by a pharmacist.

PRESCRIPTION DRUG COVERAGE ***(Defined per CMS)*** ***Revised: 07/2023***	Prescription drugs and medications paid for by your health plan.
PREVALENT NON-ENGLISH LANGUAGE	A language determined to be spoken by a significant number or percentage of members who have a limited English proficiency.
PREVENTION	Delivered prior to the onset of a condition, these services or interventions are intended to prevent or reduce the risk of developing a behavioral health or substance use problem.
PRIMARY CARE	All health care services and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, pediatrician, or other licensed practitioner as authorized by the State Medicaid program, to the extent the furnishing of those services is legally authorized in the State in which the practitioner furnishes them [42 CFR 438.2].
PRIMARY CARE PHYSICIAN ***(Defined per CMS)*** ***Revised: 07/2023***	A doctor who is responsible for managing and treating the member's health.
PRIMARY CARE PROVIDER (PCP) ***(Defined per CMS)*** ***Revised: 07/2023***	A person who is responsible for the management of the member's health care. A PCP may be a: a. Person licensed as an allopathic or osteopathic physician, b. Practitioner defined as a licensed physician assistant, or c. Certified nurse practitioner.
PRIMARY HOSPITAL	Hospitals that are licensed institutions with at least six beds whose primary function is to provide diagnostic and therapeutic patient services for medical conditions by an organized physician staff and have continuous nursing services under the supervision of registered nurses.
PRIMARY PREVENTION	The focus on methods to reduce, control, eliminate, and prevent the incidence or onset of physical or mental health disease through the application of interventions before there is any evidence of disease or injury.
PRINCIPAL DIAGNOSIS	The condition established after study to be chiefly responsible for occasioning the admission or care for the member, (as indicated by the Principal Diagnosis on a Uniform Billing (UB) claim form from a facility or the first-listed diagnosis on a Centers for Medicare and Medicaid Services (CMS) 1500 claim line). The Principal Diagnosis should not be confused with the admitting diagnosis or any other diagnoses on the claim. Neither the admitting diagnosis nor any other diagnoses on the claim should be used in the assignment of payment responsibility.
PRINCIPLES OF CAREGIVING	A curriculum prepared under the guidance of the Direct Care Workforce Alliance and adopted by AHCCCS as the standard competencies and curriculum for Direct Care Worker (DCW)s. The curriculum is made available to the public at no cost, and on the AHCCCS website www.azahcccs.gov/dcw.

PRIOR AUTHORIZATION (PA) **(Defined per CMS)** ***Revised: 07/2023***	Approval from a health plan that may be required before you get a service. This is not a promise that the health plan will cover the cost of the service.
PRIOR AUTHORIZATION (PA) REQUEST SUBMISSION PROCESS	The process by which authorization requests are submitted with clinical documentation supporting the medical necessity for the services requested.
PRIOR PERIOD COVERAGE (PPC)	For Title XIX members, the period of time prior to the member's enrollment with a Contractor, during which a member is eligible for covered services. The timeframe is from the effective date of eligibility to the day a member is enrolled with a Contractor. Refer to 9 AAC 22 Article 1. If a member is made eligible via the Hospital Presumptive Eligibility (HPE) program and is subsequently determined eligible for AHCCCS via the full application process, PPC for the member will be covered by AHCCCS Fee-For-Service (FFS) and the member will be enrolled with the Contractor only on a prospective basis.
PRIOR QUARTER COVERAGE	The period of time prior to an individual's month of application for AHCCCS coverage, during which a member (limited to children under 19, individuals who are pregnant, and individuals who are in the 60-day postpartum period beginning the last day of pregnancy) may be eligible for covered services. Prior Quarter Coverage is limited to the three-month time period prior to the month of application. An applicant may be eligible during any of the three months prior to application if the applicant: 1. Received one or more covered services as specified in 9 AAC 22, Article 2 and Article 12, and 9 AAC 28, Article 2 during the month. 2. Would have qualified for Medicaid at the time services were received if the individual had applied regardless of whether the individual is alive when the application is made as specified in AAC R9-22-303. AHCCCS Contractors are not responsible for payment for covered services received during the prior quarter.
PRIORITY POPULATION	Populations that are acknowledged within specific grant or funding requirements, which are identified as the only allowable population subset to spend those specific funds. Priority populations are identified using demographic information. Different grants or funding sources may have varying priority populations.
PRIVATE DUTY NURSING	Nursing services for members who require more individual and continuous care than is available from a Home Health Agency providing intermittent care.
PRIVATE VOCATIONAL PROGRAM ***Revised: 10/2021***	An Approved Direct Care Worker Training and Testing Program that does not have an AHCCCS Provider Identification (ID) for providing services or is a training Program that is subsidiary of a Direct Care Worker (DCW) agency. Individuals not established as a business organization cannot be a private vocational Program.
PROFESSIONAL FEE	The amount paid for the professional services provided by the pharmacist for dispensing a prescription. The Professional Fee does not include any payment for the drug being dispensed.

PROGRAM CONTRACTOR	Refer to the term Contractor.
PROJECTS FOR ASSISTANCE IN TRANSITION FROM HOMELESSNESS (PATH)	A formula grant funded through the Substance Abuse and Mental Health Services Administration (SAMHSA) for people with a Serious Mental Illness (SMI) designation who are experiencing homelessness.
PROMOTION	Any activity in which marketing materials are given away or displayed with the intent to increase the Contractor's membership.
PROSTHETIC	Devices prescribed by a physician or other licensed practitioner to artificially replace missing, deformed, or malfunctioning portion of the body, such as artificial upper and lower limbs as specified in AAC R9-22-212.
PROTECTED HEALTH INFORMATION (PHI)	Individually identifiable health information as specified in 45 CFR 160.103(5) about an individual that is transmitted or maintained in any medium where the information is: 1. Created or received by a health care provider, health plan, employer, or health care clearinghouse. 2. Relates to the past, present or future physical or mental health condition of an individual, provision of health care to an individual, or payment for the provision of health care to an individual. Protected health information excludes information: 1. In education records covered by the Family Educational Rights and Privacy Act as specified in 20 USC 1232g. 2. In records as specified in 20 USC 1232g(a)(4)(B)(IV). 3. In employment records held by a covered entity in its role as employer, and 4. Regarding an individual who has been deceased more than 50 years.
PROVIDER (Defined per CMS) ***Revised: 07/2023***	A person, institution, or group engaged in the delivery of services, or ordering and referring those services, who has an agreement with AHCCCS to provide services to AHCCCS members.
PROVIDER – EPSDT	Any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is legally authorized to do so by the State in which it delivers the services, pursuant to ARS 36-2901, 42 CFR 457.10, and 42 CFR 438.2. Providers also include Naturopaths.
PROVIDER AFFILIATION TRANSMISSION (PAT)	A data file which provides details of the providers within the Contractor's network and is used to measure compliance with network adequacy requirements.
PROVIDER CASE MANAGER	An individual assigned as responsible for locating, accessing, and monitoring the provision of services to individuals in conjunction with a clinical team as specified in ARS Title 9, Chapter 21 and Chapter 28 and Title 6, Chapter 6.

PROVIDER GROUP	Two or more health care professionals who practice their profession at a common location (whether or not they share facilities, supporting staff, or equipment).
PRUDENT LAYPERSON	An individual without medical training who relies on the experience, knowledge, and judgment of a reasonable individual to make a decision regarding whether or not the absence of immediate medical attention will result in: 1. Placing the health of the individual in serious jeopardy. 2. Serious impairment to bodily functions, or 3. Serious dysfunction of a bodily part or organ.
PSYCHIATRIC SECURITY REVIEW BOARD (PSRB)	Consists of the following members who are appointed by the governor as specified in ARS 38-211 as specified in ARS 31-501 experienced in the criminal justice system: 1. One psychiatrist. 2. One psychologist. 3. One individual who is experienced in parole, community supervision or probation procedures. 4. One individual who is from the general public. 5. One individual who is either a psychologist or a psychiatrist.

Q	
QUALIFIED CHILDREN'S HOSPITAL	A healthcare facility that has a contract with the Contractor, is licensed in Arizona as a hospital, is registered with AHCCCS as a participating provider, and is also a freestanding children's hospital with more than 100 licensed pediatric beds.
QUALIFIED CLINICIAN	A behavioral health professional who is licensed or certified as specified in ARS Title 32, or a behavioral health technician who is supervised by a licensed or certified professional.
QUALIFIED DIRECT CARE WORKER	An individual who demonstrates Direct Care Worker (DCW) competencies by passing the required knowledge and skills tests. The DCW Agency is responsible to determine the DCWs competency to provide care utilizing the agency's policies and procedures, the DCW job description and the supports needs of the member's served by the DCW. In some instances qualified DCWs may not yet be employed or contracted by a DCW Agency.
QUALIFIED INTERPRETER ***Revised: 11/2024***	An interpreter who via a Video Remote Interpreting (VRI) service, over the phone, or an on-site appearance: Adheres to generally accepted interpreter ethical principles, including client confidentiality; has demonstrated proficiency in speaking and understanding both spoken English and at least one other spoken language; and is able to interpret effectively, accurately, and impartially, both receptively and expressly, to and from such language(s) and English, using any necessary specialized vocabulary, terminology and phraseology as specified in 45 CFR 92.4.
QUALIFIED MEDICARE BENEFICIARY DUAL ELIGIBLE MEMBER (QMB DUAL)	An individual determined eligible as specified in AAC R9-29 Article 2 for Qualified Medicare Beneficiary (QMB) and eligible for acute care services provided as specified in 9AAC Chapter 22 or ALTCS services provided as specified in 9 AAC Chapter 28. A QMB Dual receives both Medicare and Medicaid services and cost sharing assistance as specified in AAC R9-29-101.
QUALIFIED MEDICARE BENEFICIARY ONLY (QMB ONLY)	An individual who qualifies to receive Medicare services only and cost-sharing assistance, known as Qualified Medicare Beneficiary (QMB) Program as specified in AAC R9-29-101(B).
QUALIFIED TRANSLATOR	A translator who: adheres to generally accepted translator ethic principles, including client confidentiality; has demonstrated proficiency in writing and understanding both written English and at least one other written non-English language; and is able to translate effectively, accurately, and impartially to and from such language(s) and English, using any necessary specialized vocabulary, terminology and phraseology as specified in 45 CFR 92.4.
QUALIFYING CLINICAL TRIAL ***Revised: 09/2022***	Any clinical phase of development that is conducted in relation to the prevention, detection, or treatment of any serious or life-threatening disease or condition and is described in any of clauses (i)-(iii) of Section 1905(gg)(2)(A) of the Act. A study or investigation must be approved, conducted, peer-reviewed, or supported (including by funding through in-kind contributions) by national organizations.

QUALITY MANAGEMENT (QM)	The evaluation and assessment of member care and services to ensure adherence to standards of care and appropriateness of services; can be assessed at a member, provider, or population level.
QUALITY OF CARE (QOC)	An expectation that, and the degree to which the health care services provided to individuals and patient populations improve desired health outcomes and are consistent with current professionally recognized standards of care and service provision.
QUALITY OF CARE (QOC) CONCERN	An allegation that any aspect of care, or treatment, utilization of behavioral health services or utilization of physical health care services that caused or could have caused an acute medical or psychiatric condition or an exacerbation of a chronic medical or psychiatric condition and may ultimately cause the risk of harm to an AHCCCS member.

R	
RAPID CYCLE PERFORMANCE IMPROVEMENT PROJECT ***Revised 09/2022***	A performance improvement project for which interventions or activities are implemented and tested over a duration of eighteen months or less.
RATE CODE	Eligibility classification for capitation payment purposes.
RE-ENGAGEMENT ***Revised: 10/2021***	Activities designed to encourage individuals to continue participating in services.
READMISSION	A return to the facility following a temporary absence for hospitalization or for therapeutic leave.
RECEIVING CONTRACTOR	The Contractor with which the member will become enrolled as a result of Annual Enrollment Choice, open enrollment, a Contractor change or a change in eligibility.
RECERTIFICATION	A process through which the provider shall submit current credentials and confirm: 1. That it holds valid licensure/certification in accordance with the laws of any State in which its purports to be licensed/certified, and 2. Its licensure/certification has not expired and does not have any limitations.
RECOVERY ROOM EXTENSION	An outpatient extended recovery to allow the physician to monitor the condition for an extended period of time beyond the standard recovery room.
REDETERMINATION	A decision made by the AHCCCS/Division of Member and Provider Services (DMPS) regarding whether a member continues to meet the requirements as specified in AAC R9-22-1305.
REDUCTION OF SERVICE	A decision to reduce the frequency or duration of an ongoing behavioral health service. A Reduction of Service does not include a planned change in service frequency or duration that is initially identified in the individual's service plan and agreed to in writing by the individual receiving services or their Health Care Decision Maker (HCDM).
REENROLLMENT	A process through which a provider that has been terminated, deactivated, or otherwise removed as a state Medicaid provider, seeks to reactivate its enrollment. A reenrollment is subject to the same requirements as a new enrollment, including but not limited to disclosure, screening, and fingerprint-based background check requirements.
REFERRAL	A verbal, written, telephonic, electronic, or in-person request for health services.
REGIONAL BEHAVIORAL HEALTH AUTHORITY (RBHA)	Effective October 01, 2022, refer to AHCCCS COMPLETE CARE - REGIONAL BEHAVIORAL HEALTH AGREEMENT (ACC-RBHA) or (RBHA) CONTRACTOR.

REGISTERED DIETICIAN	An individual who meets all the requirements for membership in the American Dietetic Association, has successfully completed the examination for registration and maintains the continuing education requirements.
REHABILITATION (Defined per CMS) ***Revised: 07/2023***	Services that help a person restore and keep skills and functioning for daily living that have been lost or impaired.
REHABILITATION SERVICES ADMINISTRATION/VOCATIONAL REHABILITATION (RSA/VR)	An administration within the Department of Economic Security (DES) that oversees several programs which are designed to assist eligible individuals who have disabilities to achieve employment outcomes and enhanced independence by offering comprehensive services and supports. Vocational Rehabilitation (VR) is a program under RSA that provides a variety of services to individuals with disabilities, with the ultimate goal to prepare for, enter into, or retain employment.
REINSURANCE ***Revised: 09/2022***	A stop-loss program provided by AHCCCS to the Contractor for the partial reimbursement of covered medical services for the Contract year. Reinsurance case types include but are not limited to regular, catastrophic, and transplant. These case types may have different qualifying criteria and reimbursement.
RELINQUISHING Contractor	The Contractor in which the member will be leaving as a result of Annual Enrollment Choice, open enrollment, a Contractor change or a change in eligibility.
REMANDED JUVENILE	An individual under 18 years of age who has been transferred to the criminal division of the Superior Court pursuant to ARS 8-327 or who has been charged with an offense pursuant to ARS 13-501; and has not been sentenced, pursuant to ARS 13-701 on the charges pending against the juvenile in the criminal division of the Maricopa County Superior Court pursuant to ARS 8-327 or ARS 13-501.
REMOTE PATIENT MONITORING ***Revised: 04/2022***	Personal health and medical data collection from a member in one location via electronic communication technologies, which is transmitted to a provider in a different location for use in providing improved chronic disease management, care, and related support. Such monitoring shall be either synchronous (real-time) or asynchronous (store and forward).
REORGANIZATION	An arrangement where a company attempts to restructure to ensure it can continue operations. In Reorganization, a company may work with its creditors to restate liabilities in an effort to meet financial obligations and avoid a bankruptcy.
REPRODUCTIVE AGE	AHCCCS members, regardless of gender, from 12 to 55 years of age.
REQUEST FOR PROPOSAL (RFP)	A document prepared by AHCCCS which describes the services required and which instructs a prospective Offeror how to prepare a response (Proposal).

RESIDENT ASSESSMENT INSTRUMENT (RAI)	A three-part comprehensive assessment to include the Minimum Data Set (MDS) Version 3.0, the Care Area Assessment (CAA) process and the RAI Utilization Guidelines. The application of these three components of the RAI yields information about a resident's functional status, strengths, weaknesses, and preferences, as well as offering guidance on further assessment once problems have been identified.
RESIDENT REVIEW	A subsequent Level II evaluation and determination for existing Nursing Facility (NF) residents, triggered whenever an individual undergoes a significant change in status and that change has a substantial impact on their functioning as it relates to their Mental Illness/Intellectual Disability (MI/ID) status.
RESIDENTIAL CONTRACTOR	Any person, firm, partnership, corporation, association or other organization, or a combination of any of them, that for compensation undertakes to or offers to undertake to, purports to have the capacity to undertake to, submits a bid or responds to a request for qualification or a request for proposals for construction services to, or does themselves or by or through others, within residential property lines: 1. Construct, alter, repair, add to, subtract from, improve, move, wreck, or demolish any residential structure, such as houses, townhouses, condominiums or cooperative units and any appurtenances on or within residential property lines. 2. Connect such a residential structure to utility service lines, metering devices or sewer lines. 3. Provide mechanical or structural service for any such residential structure. Residential Contractor does not include an owner making improvements to the owner's property.
RESPONSIBLE CONTRACTOR - ID CARD PRODUCTION	The Contractor with which the member is enrolled for their physical health services.
RESTRAINT	Personal restraint, mechanical restraint or drug used as a restraint and is the following as specified in 42 CFR 482.13(e)(1): 1. Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a behavioral health recipient to move his or her arms, legs, body, or head freely. 2. A drug or medication when it is used as a restriction to manage the behavioral health recipient's behavior or restrict the behavioral health recipient's freedom of movement and is not a standard treatment or dosage for the behavioral health recipient's condition. 3. A restraint does not include devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a behavioral health recipient for the purpose of conducting routine physical examinations or tests, or to protect the behavioral health recipient from falling out of bed, or to permit the behavioral health recipient to participate in activities without the risk of physical harm (this does not include a physical escort).
RETROSPECTIVE REVIEW	The process of determining the medical necessity of a treatment/service post-delivery of care.

REVALIDATION	A process that occurs periodically after enrollment by which a provider is subject to the same screening, disclosures, and as applicable, Fingerprint-based Criminal Background Check (FCBC) requirements as a new enrollment, and through which a provider shall verify the accuracy of its enrollment information.
RISK ANALYSIS	The assessment of the risks and vulnerabilities that could negatively impact the confidentiality, integrity, and availability of the electronic protected health information held by a covered entity, and the likelihood of occurrence.
RISK CONTRACT ***Revised: 09/2022***	A Contract between the State and Managed Care Organization (MCO), under which the Contractor: 1. Assumes risk for the cost of the services covered under the Contract. 2. Incurs loss if the cost of furnishing the services exceeds the payments under the Contract as specified in 42 CFR 438.2.
RISK GROUP	Grouping of rate codes that are paid at the same capitation rate.
RISK MANAGEMENT	The actual implementation of security measures to sufficiently reduce an organization's risk of losing or compromising its electronic protected health information and to meet the general security standards.
ROOM AND BOARD (R&B) ***Revised: 08/2023***	The amount paid for food and/or shelter. Medicaid funds can be expended for room and board when an individual lives in an institutional setting (e.g., Nursing Facility (NF), Intermediate Care Facility [ICF]). Medicaid funds cannot be expended for room and board when a member resides in an Alternative Home and Community Based Service (HCBS) Setting (e.g., Assisted Living Facility (ALF), Behavioral Health Residential Facility [BHRF]) or an apartment like setting that may provide meals.
ROSTER BILLING	Any claim that does not meet the standardized claim requirements as specified in 9 AAC 22, Article 7.
RURAL HEALTH CLINIC (RHC) ***Revised: 08/2023***	A clinic that is located in a rural area designated as a shortage area, is not a rehabilitation agency or a facility primarily for the care and treatment of mental diseases, and meets all other requirements as specified in 42 CFR 491.

S	
SANCTION	A monetary and/or non-monetary penalty assessed or applied for failure to demonstrate compliance in one or more areas of contractual responsibility. Non-monetary penalties may include, but are not limited to: 1. Appointment of temporary management for the Contractor, granting the Contractor's enrollees the right to terminate enrollment with the Contractor. 2. Suspension of auto-assignment and/or new enrollment. 3. Suspension of payment to the Contractor until Centers for Medicare and Medicaid (CMS) or the State is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.
SCOPE OF WORK ***Revised: 08/2023***	Those provisions of the Solicitation/Contract that specify the work and/or results to be achieved by the Contractor. Also referred to as Program Requirements.
SCREENING AGENCY	A health care agency licensed by Arizona Department of Health Services (ADHS) and that provides those services required of such agency as pursuant in ARS 36-501.
SECLUSION	The restriction of a member to a room or area through the use of locked doors or any other device or method which precludes a member from freely exiting the room or area or which a member reasonably believes precludes their unrestricted exit as specified in AAC R9-21-101(B). In the case of an inpatient facility, confining a client to the facility, the grounds of the facility, or a ward of the facility does not constitute seclusion. In the case of a community residence, restricting a client to the residential site, according to specific provisions of a service plan or court order, does not constitute seclusion, as specified in AAC R9-21-101(B).
SECONDARY HOSPITAL	Hospitals capable of providing the majority of hospital-based services, both general medical and surgical, often Obstetrician (OB) and other services, but limited with regards to specialist access.
SECTION 1115 DEMONSTRATION WAIVER	Refers to section 1115 of the Social Security Act (SSA). States must comply with Title XIX (Medicaid) and Title XXI (Children's Health Insurance Program) of the SSA. AHCCCS has been providing Medicaid since October 1, 1982, making AHCCCS exempt from specific provisions of the SSA, pursuant to an 1115 Research and Demonstration Waiver.
SECURED BEHAVIORAL HEALTH RESIDENTIAL FACILITY (BHRF)	Refer to the term Behavioral Health Residential Facility (BHRF) – Secured.

SECTION 8	A more common name for the Housing Choice Voucher Program which is sponsored by Housing and Urban Development (HUD). Qualified applicants receive vouchers which are used to subsidize the cost of housing. These vouchers are awarded to individuals who meet certain income requirements. The goal of these programs is to provide affordable low-cost housing to low-income occupants.
SELF-DIRECTED ATTENDANT CARE (SDAC)	A service option offered to members who are elderly and/or have physical disabilities and who reside in their own home. Within this option, members utilize a Direct Care Worker (DCW) to perform tasks such as homemaking, personal care, and general supervision. The DCW may also provide limited skilled services in specific circumstances. This service differs from traditional attendant care in that the DCW who provides these services is an employee, not of an agency, but of the member who hires, trains, and supervises the caregiver. The member is supported by a Fiscal Employer Agent.
SELF-HELP/PEER SERVICES (PEER SUPPORT)	Supports intended for members and/or their families who require greater structure and intensity of services than those available through community-based recovery fellowship groups and who are not yet ready for independent access to community-based recovery groups.
SELF-MANAGEMENT TOOL	Tasks that help members determine risk factors, provide guidance on health issues, recommend ways to improve health or support reducing risk factors or maintaining low risk.
SELF-NEGLECT	An adult's inability, due to a physical or mental impairment or diminished capacity to perform essential self-care tasks, including: 1. Obtaining essential food, clothing, shelter, and medical care. 2. Obtaining goods and services necessary to maintain minimum physical health, mental health, or general safety, or 3. Managing one's own financial affairs.
SERIOUS EMOTIONAL DISTURBANCE (SED) ***Revised: 09/2022, 09/2024***	A designation for individuals from birth until the age of 18 with a qualifying mental, behavioral, or emotional diagnosis as specified in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders that resulted in functional impairment(s), that substantially interferes with or limits the child's role or functioning in family, school, or community activities.
SERIOUS EMOTIONAL DISTURBANCE (SED) ELIGIBILITY DETERMINATION	A determination as to whether or not an individual meets the diagnostic and functional criteria established for the purpose of determining an individual's eligibility for receiving all medically necessary behavioral health services.
SERIOUS INJURY	Any type of injury requiring medical care or treatment beyond first aid, including, but not limited to: assessment/treatment in an emergency room, treatment center, physician's office, urgent care, or admission to a hospital.

SERIOUS MENTAL ILLNESS (SMI)	A designation as specified in ARS 36-550 and determined in an individual 18 years of age or older.
SERIOUS MENTAL ILLNESS (SMI) – DECERTIFICATION	The process that results in a modification to an individual's medical record by changing the behavioral health category designation from Serious Mental Illness (SMI) to general mental health.
SERIOUS MENTAL ILLNESS (SMI) – ELIGIBILITY DETERMINATION	A determination as to whether or not an individual meets the diagnostic and functional criteria established for the purpose of determining an individual's eligibility for Serious Mental Illness (SMI) services.
SERIOUS MENTAL ILLNESS (SMI) - EVALUATION	The process of analyzing current and past treatment information including assessment, treatment other medical records and documentation for purposes of making a determination as to an individual's serious mental illness eligibility.
SMI HOUSING TRUST FUND (HTF)	As specified in ARS 41-3955.01, a trust fund dedicated to provide capital funding for housing individuals determined SMI.
SUBSTANCE USE DISORDER (SUD)	A range of conditions that vary in severity over time, from problematic, short-term use/abuse of substances to severe and chronic disorders requiring long-term and sustained treatment and recovery management.
SERVICE AUTHORIZATION REQUEST	A request by the member/Health Care Decision Maker (HCDM), and Designated Representative (DR) or a provider for a physical or behavioral health service for the member which requires Prior Authorization (PA) by the Contractor.
SERVICE LEVEL AGREEMENT	A type of subcontract with a corporate owner or any of its Divisions or Subsidiaries that requires specific levels of service for administrative functions or services for the Contractor specifically related to fulfilling the Contractor's obligations to AHCCCS under the terms of this Contract.
SERVICE PLAN **(Defined per CMS)** ***Revised: 07/2023***	A written description of covered health services, and other supports which may include: a. Individual goals, b. Family support services, c. Care coordination, and d. Plans to help the member better their quality of life.
SETTING IN WHICH NORMAL LIFE ACTIVITIES TAKE PLACE	A setting other than a hospital, nursing facility, Intermediate Care Facility (ICF) for individuals with intellectual/developmental disabilities or any setting in which payment is or could be made under Medicaid for inpatient services that include room and board.
SHALL ***Revised: 03/2025, 08/2023***	Mandatory requirements, actions, duties, etc., as specified in AAC R2-7-101 (44).

SHARE OF COST ***Revised: 07/2023***	The amount an ALTCS member is required to pay toward the cost of long-term care services.
SHOULD	A suggestion that is recommended but not required.
SIGNIFICANT CHANGE	A major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status and requires interdisciplinary review or revision of the care plan, or both as specified in 42 CFR 483.20.
SIMPLE-MAJORITY	Minimum number that is greater than 50 percent. With respect to approving a motion, a simple majority of the quorum present at the Committee meeting must vote in favor of the motion in order for the motion to be approved. Committee members who are AHCCCS staff do not have voting rights.
SKILLED NURSING CARE **(Defined per CMS)**	Skilled services provided in your home or in a nursing home by licensed nurses or therapists.
SKILLED SERVICE	A Competent Member, who is Medically Stable, or the member's legal guardian may employ an attendant care worker to also provide the following Skilled Services as specified in AAC R9-28-508(G) including: 1. Bowel care, including: a. Suppositories, b. Enemas, c. Manual evacuation, and d. Digital stimulation. 2. Bladder catheterizations (non-indwelling) that do not require a sterile procedure. 3. Wound care (non-sterile). 4. Glucose monitoring. 5. Glucagon as directed by the health care provider. 6. Insulin by subcutaneous injection only if the member is not able to self-inject. 7. Permanent gastrostomy tube feeding, and 8. Additional services requested in writing with the approval of the Director and the Arizona State Board of Nursing.
SOCIAL DETERMINANTS OF HEALTH (SDOH)	The World Health Organization defines SDOH as the conditions of the community in which an individual is born, grows, works, lives, and ages, and the wider set of forces and systems shaping their conditions of daily life, including economic policies and systems, development agendas, social norms, social policies, and political systems. These are also known as Social Risk Factors of Health (SRFOH).

SOCIAL NETWORKING ACTIVITY	The use of Social Networking Applications, to support learning and engagement through the development of Contractor-specific Social Networking Application sites/pages, and Broadcast activities.
SOCIAL NETWORKING APPLICATION	Web based services/platforms (excluding the Contractor's State mandated website content, member portal, and provider portal) for online collaboration that provide a variety of ways for users to interact, such as email, comment posting, image sharing, invitation, and instant messaging services – collectively also referred to as social media (e.g., Facebook).
SOCIAL NETWORKING - FRIENDS/FOLLOWERS	Individuals who choose to interact through online social networks by creating accounts or pages and proactively connecting with others.
SOCIAL NETWORKING -TAGS/TAGGING	Placing personal identification information within a picture or video. Tags generally are presented as hovering links to additional information about the individual identified.
SOCIAL NETWORKING-USERNAME	An identifying pseudonym associating the author to messages or content generated.
SOCIAL WORKER	An individual who possesses a baccalaureate or master's degree in social work from a school or program accredited by the Council on Social Work Education. Social workers shall comply with the licensing and certification requirements of the state(s) or jurisdiction(s) in which she or he practices and shall possess the skills and professional experience necessary to practice social work.
SPECIAL ASSISTANCE	The support provided to a member designated as Seriously Mentally Ill who is unable to articulate treatment preferences and/or participate effectively in the development of the Service Plan, Inpatient Treatment, and Discharge Plan (ITDP), grievance and/or appeal processes due to cognitive or intellectual impairment and/or medical condition.
SPECIAL HEALTH CARE NEEDS (SHCN)	Serious and chronic physical, developmental, or behavioral conditions requiring medically necessary health and related services of a type or amount beyond that required by members generally; that lasts or is expected to last one year or longer and may require ongoing care not generally provided by a Primary Care Provider (PCP).
SPECIALIST **(Defined per CMS)**	A doctor who practices a specific area of medicine or focuses on a group of patients.
SPECIALIST SUPPORT AND REHABILITATION SERVICES PROVIDERS	Provide either a limited scope of Support and Rehabilitation Services (such as primarily specializing in respite services or skills training services) and/or services that may be designed for a specific population, age, gender, frequency, duration, or some other factor (such as a service specializing in working with teenagers or those with a history of displaying harmful sexual behaviors).

SPECIALIZED SERVICE	Services provided to individuals with Mental Illness/Intellectual Disability (MI/ID) or with a related condition residing in a nursing facility. These services exceed those typically provided by a nursing facility under its daily or per diem rate and address the individualized needs related to an individual's MI/ID, or related condition, as identified through the Pre-Admission Screening and Resident Review (PASRR) Level II Evaluation.
SPECIALTY PHYSICIAN	A physician who is specially trained in a certain branch of medicine related to specific services or procedures, certain age categories of patients, certain body systems, or certain types of diseases.
SPECIALTY PROVIDER ***Revised: 07/2023***	Refer to "SPECIALIST"
SPECIFIED LOW-INCOME MEDICARE BENEFICIARY (SLMB)	An individual who qualifies as a Medicare beneficiary and for cost sharing assistance with the individual's Part B premium is known as a Specified Low Income Medicare Beneficiary (SLMB). This individual does not qualify for Qualified Medicare Beneficiary (QMB) due to the individual's income exceeding the QMB Federal Poverty Level (FPL).
SPEECH THERAPY (ST)	Diagnostic and treatment services that include evaluation, program recommendations for treatment and/or training in receptive and expressive language, voice, articulation, fluency, rehabilitation, and medical issues dealing with swallowing.
STABILIZED	With respect to an emergency medical condition, means that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility.
STANDING ORDER	An AHCCCS Registered Prescriber's order that can be exercised by other health care workers for a member that meets the designated criteria by the prescribing provider.
STATE	The State of Arizona and Department or Agency of the State that executes the Contract.
STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP) ***Revised: 08/2023***	State Children's Health Insurance Program under Title XXI of the Social Security Act (Also known as Children's Health Insurance Program [CHIP]). The Arizona version of CHIP is referred to as "KidsCare." REFER TO "KIDSCARE."
STATE FISCAL YEAR	The budget year-State fiscal year: July 1 through June 30.
STATE ONLY TRANSPLANT MEMBERS	Individuals who are eligible under one of the Title XIX eligibility categories and found eligible for a transplant, but subsequently lose Title XIX eligibility under a category other than Adult Group due to excess income become eligible for one of two extended eligibility options as specified in ARS 36-2907.10 and ARS 36-2907.11.

STATE OPIOID TREATMENT AUTHORITY (SOTA)	The individual responsible for administrative and clinical oversight of certified Opioid Treatment Programs (OTPs), including, but not limited to planning, developing, educating, and implementing policies and procedures to ensure that opioid dependency treatment is provided at an optimal level.
STATE PLACING AGENCY	The Department of Juvenile Corrections, Department of Economic Security, Arizona Department of Child Safety (DCS), the Arizona Health Care Cost Containment System (AHCCCS) or the Administrative Office of the Court as specified in ARS 15-1181(12).
STATE-ONLY COVERED SERVICES/NON-TITLE XIX/XXI COVERED SERVICES	A subset of services identified by the Arizona legislature that can be covered under non-Title XIX/XXI funds but are not covered under Title XIX/XXI funds.
STATEWIDE	Of sufficient scope and breadth to address the health care service needs of members throughout the State of Arizona.
STATEWIDE HOUSING ADMINISTRATOR	The entity contracted with AHCCCS to provide administration of the AHCCCS Housing Program (AHP).
STATISTICALLY SIGNIFICANT ***Revised: 10/2021***	A judgment of whether a result occurs because of chance. When a result is statistically significant, it means that it is unlikely that the result occurs because of chance or random fluctuation. There is a cutoff for determining statistical significance. This cutoff is the significance level. If the probability of a result (the significance value) is less than the cutoff (the significance level), the result is judged to be statistically significant. Refer to Watson's Analytics Guide at www.ibm.com.
STEP THERAPY	The practice of initiating drug therapy for a medical condition with the most cost-effective and safe drug and stepping up through a sequence of alternative drug therapies if the preceding treatment option fails.
STRETCHER VAN	Refer to the term Transportation - Stretcher Van.
SUBCONTRACT ***Revised: 08/2023***	Any Contract, express or implied, between the Contractor and another party or between a subcontractor and another party delegating or assigning, in whole or in part, the making or furnishing of any material or any service required for the performance of the Contract.
SUBCONTRACTOR	1. A provider of health care who agrees to furnish covered services to members. 2. An individual, agency, or organization with which the Contractor, or its Subcontractor, has contracted or delegated some of its management/administrative functions or responsibilities. 3. An individual, agency, or organization with which a fiscal agent has entered into a Contract, agreement, purchase order or lease (or leases of real property) to obtain space, supplies equipment or services provided under the AHCCCS agreement.
SUBSIDIARY	An entity owned or controlled by the Contractor.

SUBSTANCE ABUSE ***Revised: 09/2024***	As specified in AAC R9-10-101, an individual's misuse of alcohol or other drug or chemical that: 1. Alters the individual's behavior or mental functioning. 2. Has the potential to cause the individual to be psychologically or physiologically dependent on alcohol or another drug or chemical. 3. Impairs, reduces, or destroys the individual's social or economic functioning.
SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION (SAMHSA)	A public agency within the U.S. Department of Health and Human Services (HHS) established by Congress in 1992 to make substance use and mental disorder information, services, and research more accessible.
SUBSTANCE USE DISORDER (SUD)	A range of conditions that vary in severity over time, from problematic, short-term use/abuse of substances to severe and chronic disorders requiring long-term and sustained treatment and recovery management.
SUBSTANCE USE DISORDER (SUD) BENEFIT	Items or services for SUD, as specified in the State and in accordance with applicable Federal and State law. Any disorder defined by the State as being or not being a substance use disorder shall be defined to be consistent with generally recognized independent standards of current medical practice. SUD Benefits include long-term care services.
SUPPLEMENTAL SECURITY INCOME (SSI) AND SSI RELATED GROUPS	Eligible individuals receiving income through Federal cash assistance programs under Title XVI of the Social Security Act (SSA) who are aged, blind or have a disability and have household income levels at or below 100% of the Federal Poverty Level (FPL).
SUPPORTIVE HOUSING	Housing, as specified in 24 CFR Part 583, in conjunction with supportive services are provided for tenants if the housing is safe and sanitary and meets any applicable State and local housing codes and licensing requirements in the jurisdiction in which the housing is located and the requirements of this part; and the housing is transitional housing; safe haven; permanent housing for homeless individuals with disabilities; or is a part of, a particularly innovative project for, or alternative method of, meeting the immediate and long-term needs of homeless individuals and families.
SUPPORTIVE HOUSING SERVICES	Services to assist individuals or families to obtain and maintain housing in an independent community setting including the individual's own home or apartments and homes that are owned or leased by a subcontracted provider. These services may include: 1. Utility subsidies. 2. Relocation services to an individual or family for the purpose of securing and maintaining housing. 3. Employment services. 4. Budget and finance counseling, and 5. Eviction prevention.

SYSTEM UPGRADE	Any upgrade or changes to a data collection or information system that may result in disruption to Contractor services.

T	
TARGETED CASE MANAGEMENT (TCM)	A covered service provided by the Arizona Department of Economic Security Division of Developmental Disabilities (DES DDD) to members with Developmental Disabilities (DD) who are financially eligible for the Title XIX and Title XXI acute care programs, but do not meet the functional requirements of the ALTCS program.
TARGETED INVESTMENT (TI) – PROGRAM ***Revised: 12/2024***	A strategy managed by AHCCCS to provide financial incentives to participating AHCCCS providers to develop systems for integrated care that address members' medical, behavioral, and health-related social needs.
TARGETED INVESTMENT PROGRAM – BEHAVIORAL HEALTH PROVIDER ***Revised: 01/2022***	An outpatient Behavioral Health provider classified by AHCCCS as Provider Type 77 or Integrated Clinic.
TARGETED INVESTMENT (TI) – PRACTICE SITE ***Revised: 01/2022***	A physical location in which ambulatory TI projects will be conducted. One practice site can participate in multiple areas of concentration (for example, an AHCCCS-registered Integrated Clinic can participate in a primary care and Behavioral Health area of concentration).
TARGETED INVESTMENT (TI) – PRIMARY CARE PROVIDER (PCP) ***Revised: 01/2022***	A Provider Type 8 (M.D.), 19 (Registered Nurse Practitioner), or 31(D.O.) clinician who delivers primary care as part of a practice team that has AHCCCS attributed members and assumes full responsibility for meeting all of the primary care needs of a group of patients seen at the practice.
TEAM DECISION MAKING (TDM)	A meeting process utilized to discuss a child's safety and where the child will live when an emergency removal of a child has occurred, or the removal of a child is being considered.
TELEDENTISTRY	The acquisition and transmission of all necessary subjective and objective diagnostic data through interactive audio, video, or data communications by an AHCCCS registered dental provider to a dentist at a distant site for triage, dental treatment planning, and referral.
TELEHEALTH ***Revised: 04/2022***	Healthcare services delivered via asynchronous, audio-only, remote patient monitoring, teledentistry, or telemedicine.
TELEMEDICINE ***Revised: 04/2022***	The practice of synchronous (real-time) health care delivery, diagnosis, consultation, and treatment and the transfer of medical data through interactive audio and video communications that occur in the physical presence of the member.

TELEHEALTH - ASYNCHRONOUS (STORE AND FORWARD)	Transmission of recorded health history (e.g., pre-recorded videos, digital data, or digital images, such as x-rays and photos) through a secure electronic communications system between a practitioner, usually a specialist, and a member or other practitioner, in order to evaluate the case or to render consultative and/or therapeutic services outside of a synchronous (real-time) interaction. As compared to a real-time member care, asynchronous care allows practitioners to assess, evaluate, consult, or treat conditions using secure digital transmission services, data storage services, and software solutions.
TELEHEALTH - DISTANT SITE	Site at which the provider is located at the time the service is provided via telehealth.
TELEHEALTH - ORIGINATING SITE	Location of the AHCCCS member at the time the service is being furnished via telehealth or where the asynchronous service originates.
TELEHEALTH – AUDIO ONLY	The practice of synchronous (real-time) health care delivery, through interactive audio-only communications.
TELEHEALTH – E- CONSULTS	Asynchronous, non-face-to-face consultations between a primary care provider and a specialist, to discuss a member's health condition(s) and treatment, using a secure electronic communication platform. They include the transmission of a member's health information without being in the presence of the member.
TERMINALLY ILL	A medical prognosis of life expectancy for six months or less if the illness runs its normal course.
TERTIARY HOSPITAL	Hospitals with access to a broad range of specialists and equipment necessary and usually receiving their patients from a large catchment area and referral base.
TERTIARY PREVENTION	Aims to soften the impact of an ongoing behavioral health or Substance Use Disorder (SUD) that has lasting effects. This is done by helping people manage long-term, often-complex health problems and injuries (e.g., chronic diseases, permanent impairments) in order to improve as much as possible their ability to function, their quality of life, and their life expectancy.
THERAPEUTIC FOSTER CARE (TFC)	A family-based placement option for children with serious behavioral or emotional needs who can be served in the community with intensive support.
THERAPEUTIC FOSTER CARE (TFC) - AGENCY PROVIDER	A TFC Agency Provider credentialed by MCOs to oversee professional TFC Family Providers and holds contracts with pertinent health plans and/or Division of Child Safety (DCS) to provide TFC services to children.
THERAPEUTIC FOSTER CARE (TFC) - FAMILY PROVIDER	Specially trained adult(s) in a family unit licensed by Division of Child Safety (DCS) and endorsed to provide TFC services to children. Also known as TFC Parent(s).

THERAPEUTIC FOSTER CARE (TFC) - TREATMENT PLAN	The plan details the specific behavioral goals that the TFC Family and TFC Agency Providers will help the member achieve during member's time in TFC. These TFC treatment goals will be explicit, observable, attainable, tailored to the member's strengths and needs; and will align with the comprehensive Individualized Service Plan (ISP) of the Child and Family Team (CFT). The TFC Treatment Plan will outline the steps the TFC Family and TFC Agency Providers will implement to help member attain the FTC treatment goals and thus successfully discharged from TFC.
THIRD-PARTY LIABILITY (TPL)	The legal obligation of third parties (e.g., certain individuals, entities, insurers, or programs) to pay part or all of the expenditures for medical assistance furnished under a Medicaid state plan.
TIERED RECONCILIATION POPULATION	All Children's Rehabilitative Services (CRS) members, with the exception of State Only Transplant members, are subject to this tiered reconciliation.
TITLE XIX	Known as Medicaid, Title XIX of the Social Security Act provides for Federal grants to the states for medical assistance programs. Title XIX enables states to furnish medical assistance to those who have insufficient income and resources to meet the costs of necessary medical services, rehabilitation, and other services, to help those families and individuals become or remain independent and able to care for themselves. Title XIX members include but are not limited to those eligible under Section 1931 of the Social Security Act (SSA), Supplemental Security Income (SSI), SSI-related groups, Medicare cost sharing groups, Breast and Cervical Cancer Treatment Program (BCCTP) and Freedom to Work Program. Which includes those populations specified in 42 USC 1396 a(a)(10)(A).
TITLE XIX MEMBER ***Revised: 09/2024***	Title XIX members include those eligible under Section 1931 provisions of the Social Security Act (previously Aid to Families with Dependent Children [AFDC]), Supplemental Security Income (SSI) or SSI-related groups, Medicare Cost Sharing groups, Adult Group at or below 106% Federal Poverty Level (Adults </= 106%), Adult Group above 106% Federal Poverty Level (Adults > 106%), Breast and Cervical Cancer Treatment Program (BCCTP), Title IV-E Foster Care and Adoption Subsidy, Young Adult Transitional Insurance, and Freedom to Work.
TITLE XXI	Title XXI of the Social Security Act provides funds to states to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner that is coordinated with other sources of child health benefits coverage.
TITLE XXI MEMBER	Member eligible for acute care services under Title XXI of the Social Security Act (SSA), referred to in Federal legislation as the "Children's Health Insurance Program" (CHIP). The Arizona version of CHIP is referred to as "KidsCare."

TOTAL PARENTERAL NUTRITIONAL (TPN) THERAPY	Nourishment provided through the venous system to members with severe pathology of the alimentary tract that does not allow absorption of sufficient nutrients to maintain weight and strength appropriate for the individual's general condition. Nutrients are provided through an indwelling catheter.
TRANSITION TO EMPLOYMENT (TTE)	Provides a member with individualized instruction, training, and support in the meaning, values, and demands of work to promote skill development for integrated and competitive employment.
TRANSITIONAL HOUSING	Housing services that facilitate the movement of homeless individuals and families to permanent housing. A homeless individual may stay in transitional housing for a period not to exceed 24 months.
TRANSLATION	The conversion of written communication from English into the member's preferred language while maintaining the original intent.
TRANSPORTATION - ADVANCED LIFE SUPPORT (ALS)	Either transportation by ground ambulance vehicle, that has medically necessary supplies and services, and the treatment includes administration of at least three medications by intravenous push/bolus or by continuous infusion, excluding crystalloid, hypotonic, isotonic, and hypertonic solutions (Dextrose, Normal Saline, Ringer's Lactate); or transportation, medically necessary supplies and services, and the provision of at least one ALS procedure as specified in 42 CFR 414.605, including: 1. Manual defibrillation/cardioversion. 2. Endotracheal intubation. 3. Central venous line. 4. Cardiac pacing. 5. Chest decompression. 6. Surgical airway, or 7. Intraosseous line.
TRANSPORTATION - AIR AMBULANCE	A helicopter or fixed wing aircraft licensed under Arizona Department of Health Services (ADHS) as mandated in ARS 36-2201 to be used in the event of an emergency to transport members or to obtain services.
TRANSPORTATION - AMBULANCE	A motor vehicle licensed by Arizona Department of Health Services (ADHS) pursuant to ARS 36-2201 specially designed or constructed, equipped, and intended to be used, maintained, and operated for the transportation of individuals requiring ambulance services.
TRANSPORTATION - AMBULATORY	A vehicle other than a taxi but includes vans, cars, minibus, or mountain area transport. The AHCCCS member shall be able to transfer with or without assistance into the vehicle and not require specialized transportation modes.

TRANSPORTATION - BASIC LIFE SUPPORT (BLS)	Transportation by ground ambulance vehicle that has medically necessary supplies and services, plus the provision of BLS ambulance services. The ambulance must be staffed by an individual who is qualified in accordance with State and local laws as specified in 42 CFR 414.605.
TRANSPORTATION - EMERGENCY	Emergency ground and air ambulance services required to manage an emergency medical condition of an AHCCCS member at an emergency scene and transport to the nearest appropriate facility. Emergency transportation is needed when due to a sudden onset of a physical or behavioral health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could be expected to result in: 1. Placing the member's health in serious jeopardy. 2. Serious impairment of bodily functions. 3. Serious dysfunction of any bodily organ or part, or 4. Serious physical harm to self or another individual.
TRANSPORTATION - NON-EMERGENCY MEDICAL TRANSPORTATION (NEMT) BROKER	An entity which may provide administrative functions such as scheduling, verifying enrollment, validating service appointments when appropriate, as well as billing.
TRANSPORTATION - PUBLIC	Transportation via buses, trains, or other forms of transportation that run on a set route and schedule and are available to the public.
TRANSPORTATION - STRETCHER VAN	A vehicle that is specifically designed for the purpose of transportation of a member on a medically approved stretcher device. The stretcher shall be secured to avoid injury to the member or other passengers. Safety features of stretcher vans shall be maintained, as necessary. Any additional items being transported shall also be secured for safety. The AHCCCS member shall need to be transported by stretcher and shall be physically unable to sit or stand and any other means of transportation is medically contraindicated.
TRANSPORTATION - TAXI	A vehicle that has been issued and displays a special taxi license plate as specified in ARS 28-9506.
TRANSPORTATION - WHEELCHAIR VAN	A vehicle that is specifically equipped for the transportation of a member seated in a wheelchair. Wheelchair vans shall include doors wide enough to accommodate loading and unloading of a wheelchair, electronic lifts for loading and unloading wheelchairs, and restraints for securing wheelchairs during transit. Safety features of wheelchair vans shall be maintained, as necessary. Any additional items being transported shall also be secured for safety. The member shall require transportation by wheelchair and shall be physically unable to use other modes of ambulatory transportation.
TREATMENT	A procedure or method to cure, improve, or palliate an individual's medical condition or behavioral health issue as specified in AAC R9-10-101.

TREATMENT LIMITATIONS	Limits on benefits based on the frequency of treatment, number of visits, days of coverage, days in waiting period, or other similar limits on the scope or duration of treatment. Treatment Limitations include both quantitative Treatment Limitations, which are expressed numerically (such as 50 outpatient visits per year), and non-quantitative Treatment Limitations, which otherwise limit the scope or duration of benefits for treatment under a plan or coverage. A permanent exclusion of all benefits for a particular condition or disorder, however, is not a treatment limitation for purposes of this definition.
TREATMENT PLAN	A written plan of services and therapeutic interventions based on a complete assessment of a member's developmental and health status, strengths and needs that are designed and periodically updated by the multi-specialty, interdisciplinary team.
TRIAGE/EMERGENCY MEDICAL SCREENING SERVICES FOR NON-FES MEMBERS	Services provided by acute care hospitals, U.S. Indian Health Service/638 (IHS/638) facilities and urgent care centers to determine whether or not an emergency exists; assessment of the severity of the member‘s medical condition and determination of what services are necessary to alleviate or stabilize the emergent condition.
TRIBAL ARIZONA LONG TERM CARE SYSTEM (TRIBAL ALTCS) ***Revised: 09/2024***	A program managed by AHCCCS to provide covered, medically necessary ALTCS services to ALTCS American Indian members who reside on a tribal land in Arizona or resided on tribal land immediately before being placed in a nursing facility or alternative Home and Community Based Services (HCBS) setting off tribal land.
TRIBAL REGIONAL BEHAVIORAL HEALTH AUTHORITY (TRBHA)	A tribal entity that has an intergovernmental agreement with the administration, the primary purpose of which is to coordinate the delivery of comprehensive mental health services to all eligible members assigned by the administration to the tribal entity. Tribal governments, through an agreement with the State, may operate a TRBHA for the provision of behavioral health services to American Indian members as specified in ARS 36-3401, 36-3407, and AAC R9-22-1201.
TRIBAL SOVEREIGNTY IN THE UNITED STATES	The inherent authority of indigenous tribes to govern themselves within the borders of the United States of America. The U.S. federal government recognizes tribal nations as "domestic dependent nations" and has established a number of laws attempting to clarify the relationship between the United States federal and state governments and the tribal nations. The Constitution and later federal laws grant to tribal nations more sovereignty than is granted to states or other local jurisdictions, yet do not grant full sovereignty equivalent to foreign nations, hence the term "domestic dependent nations".
TUBERCULOSIS (TB)	A bacterium called Mycobacterium Tuberculosis (TB). The Mycobacterium bacteria usually attacks the lungs, but TB bacteria can attack any part of the body such as the kidney, spine, and brain. Not everyone infected with TB bacteria becomes sick. As a result, two TB-related conditions exist: Latent TB Infection (LTBI) and TB disease. If not treated properly, TB disease can be fatal.

U	
UNDERINSURED ***Revised: 09/22***	Term used to describe when an individual who is underinsured meets at least one of the following criteria: has health benefits that do not adequately cover their medical needs, including those who qualify for Medicaid under a limited benefit eligibility category; or qualifies for health benefits through a public, private, or employer-based option, but the costs of premiums, deductibles, or cost-sharing are prohibitive to continuing coverage.
UNEXPECTED MATERIAL CHANGE TO THE PROVIDER NETWORK OR BUSINESS OPERATIONS	A material change that was not anticipated by the Contractor. Examples of unexpected changes to the provider network include a provider giving less than 30 days to the Contractor that they would no longer serve Medicaid members, or the Contractor's failure to reach an agreement with a provider on a contract renewal less than 30 days before the previous contract expires. An example of an unexpected material change to business operations includes the unexpected closure of an administrative services subcontractor.
UNIFORM ASSESSMENT TOOL (UAT)	A standardized tool that is used by Contractors to assess the acuity of nursing facility residents and commonly used for residents residing in Assisted Living Centers (ALC), Assisted Living Holmes (ALH) and Adult Foster Care (AFC) settings. The use of the Uniform Assessment Tool (UAT) is not intended to impact how Contractors determine authorizations for specialty levels of care (e.g., wandering dementia, medical sub-acute and behavioral management).
UNINSURED ***Revised: 09/2022***	Term used to describe when an individual who has no health insurance, including other sources of third-party coverage from medical/health services.
UNITED NETWORK FOR ORGAN SHARING (UNOS)	Private, non-profit organization that manages the nation's organ transplant system under contract with Organ Procurement and Transplantation Network (OPTN), including managing the national transplant waiting list and maintaining database that contains all organ transplant data for every transplant event that occurs in U.S.
UNITED STATES CORE DATA FOR INTEROPERABILITY (USCDI)	A standardized set of health data classes and constituent data elements for nationwide, interoperable (electronic) health information exchange issued by the Centers for Medicare and Medicaid Services (CMS) Office of the National Coordinator. A USCDI "Data Class" is an aggregation of various Data Elements by a common theme or use case. A USCDI "Data Element" is the most granular level at which a piece of data is exchanged.
URGENT CARE **(Defined per CMS)**	Care for an illness, injury, or condition serious enough to seek immediate care, but not serious enough to require emergency room care.
URGENT CARE APPOINTMENT	An appointment for medically necessary services to prevent deterioration of health following the acute onset of an illness, injury, condition, or exacerbation of symptoms.

USUAL & CUSTOMARY PRICE (U&C)	The dollar amount of a pharmacy's charge for a prescription to the general public, a special population, or an inclusive category of customers that reflects all advertised savings, discounts, special promotions, or other programs including membership-based discounts.
UTILIZATION MANAGEMENT (UM)	Often referred to as utilization review, is a methodology used by healthcare professionals for assessing the medical necessity, appropriateness and cost effectiveness of professional care, services, procedures, and facilities.

V	
VACCINE	A preparation administered to stimulate the production of antibodies and provide immunity against one or several diseases.
VALIDATION ***Revised: 07/2023***	The review of information, data, and procedures to determine the extent to which they are accurate, reliable, free from bias and in accordance with standards for data collection and analysis.
VALUE-BASED PURCHASING (VBP) PAYMENT PER VALUE- BASED PURCHASING CONTRACT	A payment from a Contractor to a provider upon successful completion or expectation of successful completion of contracted goals/measures in accordance with the VBP strategy selected for the contract. This is a non-encounterable payment and does not reflect payment for a direct medical service to a member. This payment will typically occur after the completion of the contract period but could include quarterly or semi- annual payments if contract terms specify such payments in recognition of successful performance measurement.
VIRTUAL CLINIC	Integrated services provided in community settings through the use of innovative strategies for care coordination such as Telemedicine, integrated medical records and virtual interdisciplinary treatment team meetings.
VISIT	All services received in one day from a single provider, or components of the same service received in one day from multiple providers, e.g., a surgery in an Ambulatory Surgical Center (ASC) where both the ASC and the surgeon provide the same service.
VULNERABLE ADULT ***Revised: 09/2022***	As specified in ARS 46-451(A)(10), an individual who is 18 years of age or older and who is unable to protect themself from abuse, neglect, or exploitation by others because of a physical or mental impairment (ARS 46-451). Vulnerable adults include an incapacitated person as defined in ARS 14-1501.
VOLUNTARY EVALUATION	An inpatient or outpatient professional multidisciplinary service based on analysis of data describing the individual's identity, biography and medical, psychological, and social conditions that is provided after a determination that an individual willingly agrees to consent to receive the service and is unlikely to present a danger to self or others until the service is completed. A voluntary evaluation is invoked after the filing of a pre-petition screening but before the filing of a court ordered evaluation and requires the informed consent of the individual. Additionally, the individual must be able to manifest the capacity to give informed consent.

W	
WAITING LIST	As defined by Organ Procurement and Transplantation Network (OPTN), a computerized list of candidates who are waiting to be matched with specific deceased donor organs for transplant.
WASTE	Over-utilization or inappropriate utilization of services, misuse of resources, or practices that result in unnecessary costs to the Medicaid Program.
WELL EXAM	An annual physical examination in the absence of any known disease, symptom, or specific medical complaint by the member precipitating the examination.
WELL WOMAN HEALTH CHECK PROGRAM (WWHP)	Administered by the Arizona Department of Health Services (ADHS), the Well Woman Health check Program (WWHP) is one of the programs within Arizona National Breast and Cervical Cancer Early Detection Program (AZ-NBCCEDP) that provides breast and cervical cancer screening and diagnosis to uninsured and underinsured women in Arizona.
WHEELCHAIR VAN	Refer to the term Transportation - Wheelchair Van.
WHOLE PERSON CARE	A health care delivery system that addresses the full spectrum of an individual's needs – medical, behavioral, socioeconomic, and beyond to encourage better health outcomes.
WOMEN, INFANTS, AND CHILDREN (WIC)	The Special Supplemental Nutrition Program for WIC that provides federal grants to states for supplemental foods, health care referrals, and nutrition education for low-income pregnant, breastfeeding, and non-breastfeeding postpartum women, and to infants and children up to age five who are found to be at nutritional risk.
WORK ADJUSTMENT TRAINING (WAT)	A time-limited, transitional, and systematic program designed to assist members with enhancing soft skills (e.g., attendance, hygiene, focus, interaction with coworkers/supervisors) to reach optimal levels of vocational development by utilizing real work activity. Review of progress meetings occur on a regular basis with the member and the support team to make recommendations for continued services. 1. The WAT programs support members in: a. Understanding the meaning, value and demands of work. b. Developing positive work attitudes and habits by increasing interpersonal skills and self-confidence. c. Learning or re-establishing skills, attitudes, personal characteristics, and work behavior, and d. Identifying necessary work characteristics important to obtaining competitive integrated employment.
WORKFORCE CAPACITY	The number of qualified, capable, and culturally representative personnel required to sufficiently deliver services to members.

WORKFORCE COMPETENCY AND CAPABILITY *Revised: 07/2023*	A worker's demonstrated ability to intentionally, successfully, and efficiently perform the basic requirements of a job, multiple times, at or near the required standard of performance. The core areas of healthcare competence and capability are interpersonal, cultural, clinical/medical, and technical.
WORKFORCE DEVELOPMENT ALLIANCES AND COALITION *Revised: 07/2023*	Partnerships with health plan Workforce Development Operations (WFDOs). Their purpose is to be a single point of contact and referral to provider organizations regarding Workforce Development (WFD) matters, and to ensure that WFD initiatives are aligned with all Line of Business (LOB), provider needs, AHCCCS and health plan policies, and statewide regulations. The WFD Coalition is a partnership consisting of all WFDOs.
WORKFORCE DEVELOPMENT OPERATION (WFDO) *Revised: 07/2023*	The personnel or organizational unit designated by the Contractor to be responsible for performing the duties required by Workforce Development (WFD) Program.
WORKFORCE DEVELOPMENT PLAN (WFDP) *Revised: 07/2023*	The WFDP is the Contractor's blueprint for ensuring the ongoing growth and development of the network's workforce.
WORKING DAY	Refer to the term Day – Business/Working.
WORKPLACE CONNECTIVITY	The workplace's linkage to sources of potential workers, information required by workers to perform their jobs, and technologies for connecting to workers and or connecting workers to information.

X

Y

Z

MISCELLANEOUS	
1115 WAIVER	Refer to the term Section 1115 Demonstration Waiver.
1800 REPORT	An AHCCCS generated document, provided quarterly, that identifies Primary Care Physicians (PCPs) with a panel of more than 1800 AHCCCS members.
638 TRIBAL FACILITY	A facility that is owned and/or operated by a Federally recognized American Indian/Alaskan Native (AI/AN) Tribe and that is authorized to provide services pursuant to Public Law 93-638, as amended. Also referred to as: tribally owned and/or operated 638 facility, tribally owned and/or operated facility, 638 tribal facility, and tribally-operated 638 health program.
834 ENROLLMENT TRANSACTION FILE	A nightly transaction file provided by AHCCCS to its Contractors. The file identifies newly enrolled members and enrollment changes for existing members.