SECTION VII: Behavioral Health Services

OVERVIEW

Care1st will cover behavioral health services consistent with the information below. AHCCCS Covered Behavioral Health Services Guide has a complete list of covered services.

AVAILABLE BEHAVIORAL HEALTH SERVICES*

- Behavioral Health Counseling & Therapy (Individual, Group, Intensive Outpatient Programming, and Family*)
- Behavioral Health Screening, Mental Health Assessment and Specialized Testing
- Rehabilitation Services
  - Skills Training and Development
  - Cognitive Rehabilitation
  - Behavioral Health Prevention/Promotion Education
  - Psycho Educational Services and Ongoing Support to Maintain Employment
- Other Professional (Traditional Healing, Auricular Acupuncture**)
- Medical Services***
  - Medication Services
  - Lab, Radiology and Medical Imaging
  - Medication Management
  - Electro-Convulsive Therapy
- Support Services
  - Case Management
  - Behavior Coaching
  - Personal Care
  - Home Care Training (Family)
  - Self Help/Peer Services
  - Home Care Training to Home Care Client (HCTC)
  - Respite Care****
  - Supportive Housing *****
  - Sign Language or Oral Interpretive Services
  - Transportation
- Crisis Intervention Services
- Inpatient Services (Hospital & Behavioral Health Inpatient Facility)
- Residential Services
- Behavioral Health Day Programs (Supervised, Therapeutic, Medical)

*Intensive Outpatient Programming (IOP) consists of programming that occurs for 3 days a week with each session being a minimum of 3 hours in length. Service codes utilized include H0015 (Substance Use) and S9480 (Mental Health). IOP requires prior authorization.

** Services not available with TXIX/XXI funding, but may be provided based upon available grant funding and approved use of general funds.

***See the Care1st Drug List for further information on covered medications.

****No more than 600 hours of respite care per contract year. The 12 months will run from Oct 1 through September 30 of the next year.

*****Services may be available through federal block grants

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SYSTEM VALUES AND GUIDING PRINCIPLES

All healthcare services must be delivered in accordance with AHCCCS system values and adhere to the following vision and principles:

Children's System of Care

1. Arizona's Vision:
    - In collaboration with the child and family and others, Arizona will provide accessible behavioral health services designed to aid children to achieve success in school, live with their families, avoid delinquency, and become stable and productive adults. Services will be tailored to the child and family and provided in the most appropriate setting, in a timely fashion and in accordance with best practices, while respecting the child's family's cultural heritage.

2. Arizona's Twelve Principles:
    - Collaboration with the Child and Family- Respect for and active collaboration with the child and parents is the cornerstone to achieving positive behavioral health outcomes. Parents and children are treated as partners in the assessment process, and the planning, delivery, and evaluation of behavioral health services, and their preferences are taken seriously.
    - Functional outcomes – Behavioral health services are designed and implemented to aid children to achieve success in school, live with their families, avoid delinquency, and become stable and productive adults. Implementation of the behavioral health services plan stabilizes the child's condition and minimizes safety risks.
    - Collaboration with others – When children have multi-agency, multi-system involvement, a joint assessment is developed and a jointly established behavioral health services plan is collaboratively implemented. Client centered teams plan and deliver services. Each child's team includes the child and parents and any foster parents, any individual important in the child's life who is invited to participate by the child or parents. The team also includes all other persons needed to develop an effective plan, including, as appropriate, the child's teacher, the child's Department of Child Safety representative and/or Division of Developmental Disabilities caseworker, and the child's probation officer. The team (a) develops a common assessment of the child's and family's strengths and needs, (b) develops an individualized service plan, (c) monitors implementation of the plan and (d) makes adjustments in the plan if it is not succeeding.
        - Accessible services – Children have access to a comprehensive array of behavioral health services, sufficient to ensure that they receive the treatment they need. Plans identify transportation the parents and child need to access behavioral health services, and how transportation assistance will be provided. Behavioral health services are adapted or created when they are needed but not available.
        - Best practices – Competent individuals who are adequately trained and supervised provide behavioral health services. They are delivered in accordance with guidelines adopted by ADHS that incorporate evidence-based "best practice." Behavioral health service plans identify and appropriately address behavioral symptoms that are reactions to death of a family member, abuse or neglect, learning disorders, and other similar traumatic or frightening circumstances, substance abuse problems, the specialized behavioral health needs of children who

are developmentally disabled, maladaptive sexual behavior, including abusive conduct and risky behavior, and the need for stability and the need to promote permanency in class member's lives, especially class members in foster care. Behavioral Health Services are continuously evaluated and modified if ineffective in achieving desired outcomes.

- Most appropriate setting – Children are provided behavioral health services in their home and community to the extent possible. Behavioral health services are provided in the most integrated setting appropriate to the child's needs. When provided in a residential setting, the setting is the most integrated and most home-like setting that is appropriate to the child's need.
- Timeliness – Children identified as needing behavioral health services are assessed and served promptly.
- Services tailored to the child and family – The unique strengths and needs of children and their families dictate the type, mix, and intensity of behavioral health services provided. Parents and children are encouraged and assisted to articulate their own strengths and needs, the goals they are seeking, and what services they think are required to meet these goals.
- Stability – Behavioral health service plans strive to minimize multiple placements. Service plans identify whether a member is at risk of experiencing a placement disruption and, if so, identify the steps to be taken to minimize or eliminate the risk. Behavioral health service plans anticipate crises that might develop and include specific strategies and services that will be employed if a crisis develops. In responding to crises, the behavioral health system uses all appropriate behavioral health services to help the child remain at home, minimize placement disruptions, and avoid the inappropriate use of the police and criminal justice system. Behavioral health service plans anticipate and appropriately plan for transitions in children's lives, including transitions to new schools and new placements, and transitions to adult services.
- Respect for the child and family's unique cultural heritage – Behavioral health services are provided in a manner that respects the cultural tradition and heritage of the child and family. Services are provided in Spanish to children and parents whose primary language is Spanish.
- Independence – Behavioral health services include support and training for parents in meeting their child's behavioral health needs, and support and training for children in self-management. Behavioral health service plans identify parents' and children's need for training and support to participate as partners in the assessment process, and in the planning, delivery, and evaluation of services, and provide that such training and support, including transportation assistance, advance discussions, and help with understanding written materials, will be made available.
- Connection to natural supports – The behavioral health system identifies and appropriately utilizes natural supports available from the child and parents' own network of associates, including friends and neighbors, and from community organizations, including service and religious organizations.

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Adult System of Care

1. Provision of Person Centered Care – Services are provided that meets the member where they are without judgment, with great patience, and compassion.
2. Individualized Treatment and Choice - Persons in Mental health and/or Substance recovery choose services and are included in program decisions that are based on their individual and unique treatment needs.
3. Program Development Efforts - A person in recovery has choice and a voice. Their self-determination in driving services, program decisions and program development is made possible, in part, by the ongoing dynamics of education, discussion, and evaluation, thus creating the "informed consumer" and the broadest possible palette from which choice is made. Persons in recovery should be involved at every level of the system, from administration to service delivery.
4. Focus on Individual as a Whole Person - Every member is held as nothing less than a whole being: capable, competent, and respected for their opinions and choices. As such, focus is given to empowering the greatest possible autonomy and the most natural and well-rounded lifestyle. This includes access to and involvement in the natural supports and social systems customary to an individual's social community.
5. Empower Individuals Taking Steps Towards Independence and Increased Autonomy - Members find independence through exploration, experimentation, evaluation, contemplation and action. An atmosphere is maintained whereby steps toward independence are encouraged and reinforced in a setting where both security and risk are valued as ingredients promoting growth.
6. Integration, Collaboration, and Participation with the Community of One's Choice - Every member is a valued, contributing member of society and, as such, is deserving of and beneficial to the community. Such integration and participation underscores one's role as a vital part of the community, the community dynamic being inextricable from the human experience. Community service and volunteerism is valued.
7. Partnership Between Individuals, Staff, and Family Members/Natural Supports for Shared Decision Making with a Foundation of Trust - Treatment decisions are made through a collaborative partnership with the member who is the driving force in their treatment. Compassion-based alliances with a focus on recovery optimization bolster self-confidence, expands understanding and empathy, and leads to the creation of optimum protocols and outcomes.
8. Strengths–Based, Flexible, Responsive Services Reflective of an Individual's Cultural Preferences - All members can expect and deserves flexible, timely, and responsive services that are accessible, available, reliable, accountable, and sensitive to cultural values and mores. A person in recovery is the source of his/her own strength and resiliency. Those who serve as supports and facilitators identify, explore, and serve to optimize demonstrated strengths in the individual as tools for generating greater autonomy and effectiveness in life and in daily functioning.
9. Hope Is the Foundation for The Journey Towards Recovery - A person in recovery has the capacity for hope and thrives best in associations that foster hope. Through hope, a future of possibility enriches the life experience and creates the environment for uncommon and unexpected positive outcomes to be made real. A person in recovery is held as boundless in potential and possibility.

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PHARMACY MANAGEMENT

Psychotropic Medication: Prescribing And Monitoring
Policies and procedures on the appropriate use of psychotropic medications have been developed based on AHCCCS guidance and minimum requirements. As stated in the Arizona Administrative Code R9-21-207 (C), our policies and procedures provide guidance on the appropriate use of psychotropic medications by:

- Promoting the safety of persons taking psychotropic medications;
- Reducing or preventing the occurrence of adverse side effects;
- Promoting positive clinical outcomes for behavioral health recipients who are taking psychotropic medications.
- Monitoring the use of psychotropic medications to foster safe and effective use; and
- By clarifying that medications will not be used for the convenience of the staff, in a punitive manner or as a substitute for other services and shall be given in the least amount medically necessary with particular emphasis placed on minimizing side effects which would otherwise interfere with aspects of treatment.

Visit our website at www.care1staz.com for additional information on the Minimum Laboratory Monitoring Requirements for Psychotropic Medications. Providers can also call Providers Services at 866-560-4042 to obtain a hard copy document.

Psychotropic medication will be prescribed by a licensed psychiatrist, psychiatric nurse practitioner, licensed physician assistant, or other physician trained or experienced in the use of psychotropic medication. The prescribing clinician must have seen the member and is familiar with the member's medical history or, in an emergency, is at least familiar with the member's medical history.

When a member on psychotropic medication receives a yearly physical examination, the results of the examination will be reviewed by the physician prescribing the medication. The physician will note any adverse effects of the continued use of the prescribed psychotropic medication in the member's record.

Whenever a prescription for medication is written or changed, a notation of the medication, dosage, frequency or administration, and the reason why the medication was ordered or changed will be entered in the member's record.

Assessments
Reasonable clinical judgment, supported by available assessment information, must guide the prescription of psychotropic medications. To the extent possible, candidates for psychotropic medications must be assessed prior to prescribing and providing psychotropic medications. Psychotropic medication assessments must be documented in the person's comprehensive clinical record and must be scheduled in a timely manner.

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Behavioral health medical professionals (BHMPs) can use assessment information that has already been collected by other sources and are not required to document existing assessment information that is part of the person's comprehensive clinical record.
At a minimum, assessments for psychotropic medications must include:

- An adequately detailed medical and behavioral health history
- A mental status examination
- A diagnosis
- Target Symptoms
- A review of possible medication allergies
- A review of previously and currently prescribed psychotropic medications including any noted side effects and/or potential drug-drug interactions
- All current medications prescribed by the PCP and medical specialists and current over the counter (OTC) medications, including supplements currently being taken for the appropriateness of the combination of the medications;
- For sexually active females of childbearing age, a review of reproductive status (pregnancy)
- For post-partum females, a review of breastfeeding status
- Psychotropic medication monitoring parameters (heart rate, blood pressure, weight, BMI, labs, including serum levels, as indicated)
- A review of the recipient's profile in the Arizona State Board of Pharmacy Controlled Substance Prescription Monitoring Program (CSPMP) database when initiating a controlled substance (i.e. amphetamines, opiates, benzodiazepines, etc.) that will be used on a regular basis or for short term. Evaluate addition of such agents when the member is known to be receiving opioid pain medications or another controlled substance from a secondary prescriber.

Annual Assessments
Reassessments must ensure that the provider prescribing psychotropic medication notes in the member's record:

- The reason for the use of each medication and the effectiveness of that medication
- The appropriateness of the current dosages
- An updated medication list that includes all prescribed medications, dose and frequency prescribed by the PCP and medical specialists, OTC medications, and supplements being taken
- Any side effects such as weight gain and/or abnormal involuntary movements if treated with an anti-psychotic medication;
- Rationale for the use of two medications from the same pharmacological class
- Rationale for the use of more than three different psychotropic medications in adults, and
- Rationale for the use of more than one psychotropic medication in the child and adolescent population.

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Informed Consent
Informed consent must be obtained from the member and/or legal guardian for each psychotropic medication prescribed. When obtaining informed consent, the BHMP must communicate in a manner that the member and/or legal guardian can understand and comprehend. It is preferred that the prescribing clinician provide information forming the basis of an informed consent decision. In specific situations in which this is not possible or practicable, information may be provided by another credentialed behavioral health medical practitioner or registered nurse with at least one year of behavioral health experience. Documentation must be completed on AMPM Policy 310-V, Attachment A, Informed Consent/Assent for Psychotropic Medication Treatment.

The comprehensive clinical record must include documentation of the essential elements for obtaining informed consent. If Informed Consent for Psychotropic Medication Treatment is not used to document informed consent, the essential elements for obtaining informed consent must be documented in the member's individual comprehensive clinical record in an alternative fashion.

For more information regarding informed consent, please see section on General and Informed Consent to Treatment and AHCCCS AMPM Policy 320-Q General and Informed Consent.

Prior Authorization Criteria for Behavioral Health Drugs
The Care1st Preferred Drug List and Behavioral Health Drug List available on our public website lists preferred drugs that have been reviewed and selected by the AHCCCS Pharmacy and Therapeutics (P&T) committee. Care1st Prior Authorization (PA) requirements are also based on AHCCCS recommendations. Care1st uses a combination of AHCCCS PA criteria and Health Plan PA criteria to review requests for medications that are not on the Care1st drug lists or are listed on the preferred drug lists but require PA. The AHCCCS Pharmacy and Therapeutics (P&T) committee and Health Plan P&T committee are responsible for developing, managing and updating the Pharmacy Prior authorization criteria. Care1st PA criteria is based on clinical appropriateness, scientific evidence, and standards of practice that include, but are not limited, to all of the following:

- Food and Drug Administration (FDA) approved indications and limits,
- Published practice guidelines and treatment protocols,
- Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes,
- Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmaco-economic studies, and
- Drug reference resources (e.g. Micromedex, Drug Facts and Comparisons, Up-to-date)

All Antipsychotics and lithium prescriptions have to be prescribed by a licensed psychiatrist, psychiatric nurse practitioner, licensed physician assistant, or other physician trained in the use of psychotropic medications. Care1st maintains a list for Behavioral Health (BH) providers and claims will not adjudicate unless the provider is listed on the Care1st BH roster file. Providers prescribing antipsychotic drugs and Lithium still have to comply with PA requirements. Please

review the Care1st Preferred Drug List and Behavioral Health Drug List for additional information on medications and PA requirements. If you are a BH provider and needs to be added to the Care1st BH roster file contact your Provider Network Representative for assistance.

Quantity Limits

- Opioid prescriptions: For adults, limited to not more than a 5-day supply for initial fill. For minors, except in case of cancer, other chronic disease (see 310-V) or traumatic injury, all fills are limited to a 5-day supply or less days. See AHCCCS Policy 310-V for a list of diagnoses that are exempt from these opioid quantity limits for adults and minors. All opioids prescriptions are subject to a MME of < 90 MME (morphine milligram equivalents).

Arizona Opioid Epidemic Act

Care1st providers will adhere to the provisions and directives of the Arizona Opioid Epidemic Act. Provisions in the Arizona Opioid Epidemic Act include the following (which are effective as of April 26, 2018, unless otherwise specified):

- A five-day limit on the first fill of an opioid prescription (with some exceptions, including for infants being weaned off opioids at the time of hospital discharge).
- A dosage limit of less than 90 MME (morphine milligram equivalent) for new opioid prescriptions, with some exceptions.
- Regulatory oversight by the Arizona Department of Health Services on pain management clinics to ensure that opioid prescriptions are provided only when necessary and to prevent patients from receiving multiple prescriptions. This provision also includes enforcement mechanisms.
- A "Good Samaritan" law to encourage people to call 9-1-1 in an overdose situation.
- Three hours of education on the risks associated with opioids for all professions that prescribe them.
- A requirement that opioid prescriptions must be issued electronically.
- Medication Assisted Treatment
- Care1st will attempt to expand MAT access to 24 hours/seven days per week. Care1st's contracting efforts will include the 24/7 Opioid Treatment Providers in all its GSAs.
- Care1st will provisionally credential Mid-Level Practitioners, as outlined in AMPM 950, providing Medication Assisted Treatment at Opioid Treatment Programs approved by exemption as laid out in AMPM Policy 660 after its effective date of 10/1/18
- Care1st will comply with the decisions made by the AHCCCS Pharmacy and Therapeutics Committee regarding preferred agents for MAT available without prior authorization. Non-preferred agents are available with prior authorization.
- Care1st will educate providers on the use of Naloxone, promote its accessibility, and encourage co-prescribing in individuals taking 90MED or more daily.

- Expand Peer support services for individuals with Opioid Use Disorders (OUDs) for navigating individuals to Medication Assisted Treatment (MAT), and increasing participation and retention in MAT treatment and recovery supports.
- Care1st's contracting strategy includes Peer and Family Support Organizations in all its GSAs
- Care1st actively promotes collaboration between Emergency Department and Inpatient providers and Peer Support service providers to increase access to peer supports for our individuals with OUD.
- PCPs who treat individuals with OUD may provide Medication Assisted Treatment where appropriate within their scope of practice. PCPs prescribing medications to treat Opioid Use Disorder (OUD) must refer the individual to a behavioral health provider for the psychological and/or behavioral therapy component of the Medication Assisted Treatment (MAT) model and coordinate care with the behavioral health provider.
- The Individual Handbook will contain educational information on how to access behavioral health services.
- Care1st shall ensure through its' education and monitoring efforts with PCPs that regular screening takes place for substance use disorders and that individuals screening positive are appropriately referred for behavioral health services.

Guest Dosing

Care 1st ensures that guest dosing is consistent with Substance Abuse and Mental Health Services Administration's (SAMHSA's) guidance regarding medication safety and recovery support. An individual may be administered sufficient daily dosing from an Opioid Treatment Program (OTP) center other than their Home OTP Center when they are unable to travel to the Home OTP Center or when traveling outside of the home OTP center's area, for business, pleasure, or emergency. The member may receive guest dosing from another OTP center (Guest OTP Center) within their GSA, or outside their GSA. Guest dosing may also be approved outside the State of Arizona when the member's health would be endangered if travel were required back to the state of residence

A member may qualify for guest dosing when:

- The member is receiving administration of Medication Assisted Treatment (MAT) services from a SAMHSA-Certified Opioid Treatment Program (OTP)
- The member needs to travel outside their Home OTP Center area
- The member is not eligible for take home medication
- The Home OTP center (Sending OTP Center) and Guest OTP Center have agreed to transition the member to the Guest OTP center for a scheduled period of time.

When referring a member for services, the sending OTP center shall:
1) Forward information to the Receiving OTP Center prior to the member's arrival, Information shall include at a minimum:

a) A valid release of information signed by the patient,
b) Current medications,
c) Date and amount of last dose administered or dispensed,
d) Physician order for guest dosing, including first and last dates of guest dosing,
e) Description of clinical stability including recent alcohol or illicit drug abuse,
f) Any other pertinent information,
2) Provide a copy of the information to the member in a sealed, signed envelope for the member to present to the Receiving OTP Center,
3) Submit notification to the Contractor of enrollment of the guest dosing arrangement, and
4) Accept the member upon return from the Receiving OTP Center unless other arrangements have been made.

Upon receipt of the referral, the Guest OTP Center shall:
1) Respond to the Sending OTP Center in a timely fashion, verifying receipt of information and acceptance of the member for guest medication as quickly as possible,
2) Provide the same dosage that the patient is receiving at the member's Sending OTP Center, and change only after consultation with Sending OTP Center,
3) Bill the member's Contractor of enrollment for reimbursement utilizing the appropriate coding and modifier,
4) Provide address of Guest OTP Center and dispensing hours,
5) Determine appropriateness for dosing prior to administering a dose to the member. The Guest OTP Center has the right to deny medication to a patient if they present inebriated or under the influence, acting in a bizarre manner, threatening violence, loitering, or inappropriately interacting with patients,
6) Communicate any concerns about a guest-dosing the member to the Sending OTP Center including termination of guest-dosing if indicated, and
7) Communicate last dose date and amount back to the Sending OTP Center.

Psychotropic Medication Monitoring
Psychotropic medications are known to affect health parameters. Depending on the specific psychotropic medication(s) prescribed, these parameters must be monitored according to current national guidelines, taking into account-individualized factors. At a minimum, these must include:
On initiation of any medication and at each BHMP evaluation and monitoring visit:

- Heart Rate
- Blood Pressure
- Weight

On initiation of any medication and at least every six months thereafter, or more frequently as clinically indicated:

- Body Mass Index (BMI)

On initiation of any medication affecting this parameter and at least annually thereafter or more frequently as clinically indicated:

- Fasting glucose
- Lipids
- Complete Blood Count (CBC)
- Liver function
- Lithium level, including with any significant change in dose
- Thyroid function, including within one month of initiation of lithium or a thyroid medication
- Renal function, including within one month of initiation of lithium
- Valproic acid or divalproex level, including with any significant change in dose
- Carbamazepine level, including with any significant change in dose

Abnormal Involuntary Movements (AIMS), including for members on any antipsychotic medication

Children are more vulnerable than adults with regard to developing a number of antipsychotic induced side effects. These included higher rates of sedation, extrapyramidal side effects (except for akathisia), withdrawal dyskinesia, prolactin elevation, weight gain and at least some metabolic abnormalities. (Journal of Clinical Psychiatry 72:5 May 2011)

Type of Medication	Monitoring Action
Controlled Substances	Prescribers should check the Arizona Pharmacy Board's Controlled Substance Prescription Monitoring Program (CSPMP) when prescribing a controlled substance (i.e. amphetamines, opiates, benzodiazepines, etc.). Medical decision-making regarding the results should be documented in the medical record. Health Plans may consider members for single pharmacy and/ or provider locks. Send requests for consideration to Care1st Pharmacy Department at 602-778-8387. The Health Plan also does monthly monitoring for poly-pharmacy and poly-prescribers. Please see AMPM 310-FF for the specifics of this program. • Opioid prescriptions: For adults, limited to a 5 day supply or less for initial fill. For minors, except in case of cancer, other chronic disease (See AMPM 310-V for a list of exempt diagnoses) or traumatic injury, all fills are limited to 5 days or less. See AHCCCS Policy 310-V for a list of diagnoses that are exempt from these opioid quantity limits for adults and minors.
Opiate dependence medications	It is not necessary that a behavioral health medical practitioner must always perform a psychiatric assessment on a member who is being referred to an Opiate Maintenance program prior

	to that referral, as the Opiate Maintenance Program medical practitioner is the treating physician who will make the determination as to the appropriateness of opiate maintenance medications. Methadone and other opiate dependence medications, such as buprenorphine, are provided as per federal and licensure standards. When opiate dependence medications are discontinued, they are tapered in a safe manner in order to minimize the risks of relapse and physiologic jeopardy.
Transition of medications when person loses medication benefit	Providers ensure that members who need to be dis-enrolled or who lose their Care1st medication benefit while receiving psychotropic medications, including methadone, are monitored by an appropriate medical professional who gradually and safely decreases the medication, or continues to prescribe the medication until an alternate provider has assumed responsibility for the member.
Medications during transitions between ACC, RBHAs, agencies or prescribers	It is the responsibility of the member's current prescriber, including the PCP, to ensure that persons transitioning have adequate supplies of medications to last until the appointment with the next prescriber. It is the responsibility of the provider assuming the person's care to ensure that the person is scheduled with an appointment within clinically appropriate time frames such that the person does not run out of medications, does not experience a decline in functioning and in no case longer than 30 days from identification of need.

CRISIS INTERVENTION SERVICES

Crisis intervention services are provided to a member for the purpose of stabilizing or preventing any sudden, unanticipated, or potentially dangerous behavioral health condition, episode or behavior. Crisis intervention services are delivered in a variety of settings, such as hospital emergency departments, face-to-face at a member's home, over the telephone or in the community. These intensive and time limited services may include screening (i.e. triage and arranging for the provision of additional crisis services) assessing, evaluating or counseling to stabilize the situation, medication stabilization and monitoring, observation, and/or follow-up to ensure stabilizations, and/or therapeutic and supportive services to prevent, reduce, or eliminate a crisis situation.

In the event crisis intervention services are needed this is provided through the local county crisis line:

- Maricopa
  1-800-631-1314 or 1-800-327-9254 (TTY)

- Pima and Pinal
  1-866-495-6735 or 1-877-613-2076 (TTY)
- Apache, Coconino, Gila, Mohave, Navajo and Yavapai
  1-877-756-4090 or 1-800-327-9254 (TTY)
- Gila River and Ak-chin Indian Community
  1-800-259-3449
- Salt River Pima Maricopa Indian Community
  1-855-331-6432

REFERRAL PROCESS

A referral may be made directly by the member, Health Care Decision Maker, a Contractor, Primary Care Provider (PCP) or other provider within their scope of practice, hospital, treat and refer provider, jail, court, probation or parole officer, tribal government, Indian Health Services, school or other governmental or community agency; and for members in the legal custody of the Department of Child Safety (DCS) and/or in out-of-home placement as specified in A.R.S. §8-512.01 and ACOM Policy 449.

Accepting Referrals
Providers are required to accept referrals for behavioral health services 24 hours a day, 7 days a week. The processing of referrals will not be delayed to missing or incomplete information. An acknowledgement of receipt of a referral will be provided to the referring entity within 72 hour from the date it was received.

Sufficient information is collected through the referral to:

- Assess the urgency of the member's needs,
- Track and document the disposition of referral to ensure subsequent initiation of services. BH provider will comply with timeliness standards as specified in ACOM Policy 417,
- Ensure members who have difficulty communicating due to a disability, or who require language services, are afforded appropriate accommodations to assist them in fully expressing their needs.

Information or documents collected in the referral process are kept confidential and protected in accordance with applicable federal and state statutes, regulations, and policies.

Providers offer a range of appointment availability and flexible scheduling options based upon the needs of the member.

Member's and referrals sources may contact Care1st Customer Service line at 602.778.1800 or 1.866.560.4042 for additional assistance.

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Referrals for Members Admitted to a Hospital
Referrals involving members admitted to a hospital for psychiatric reasons are to be responded to as outlined below:

1. For referrals involving an individual not currently receiving behavioral health services, the Behavioral Health Provider will attempt to conduct a face-to-face intake evaluation with the member within 24 hours of referral, but will ensure the evaluation occurs prior to discharge from the hospital.
2. For members already receiving behavioral health services, the Behavioral Health Provider will ensure coordination, transition, and discharge planning activities are completed in a timely manner as outlined in AMPM Policy 1020.

PCP Referral to Behavioral Health Services
A PCP is able to refer a member to behavioral health services in a variety of ways. These include:

1. Referring to an Outpatient Clinic Provider (PT 77) for specific services (i.e. peer support, counseling, etc.) as an intake/assessment and treatment plan must be completed indicating the service(s) to be provided are medically necessary.
2. Contacting the provider service line at 602.778.1800 or 1.866.560.4042.
3. Referring to the provider directory: www.care1staz.com>Providers>Our Network
4. Contacting the Member Services Monday-Friday 8 a.m.-5 p.m. at 602.778.1800
5. Submitting a referral to Care Management by using the Care1st Care Management Referral Form, which can be found at https://care1staz.com/az/providers/frequentlyusedforms.asp
6. Establishing a collaborative relationship with neighboring contracted behavioral health providers

PCP/Member Self-Referral to Behavioral Health Specialty Providers
A PCP/member may refer directly to a specialty provider for behavioral health services. Examples of specialty providers include, but are not limited to, the following: Community Service Agencies (CSAs), Peer Run and Family Run Organizations, Meet Me Where I Am (MMWIA) Providers, or Employment Network Providers (i.e. Wedco. Beacon Group, Focus Employment Services).

An intake/assessment and treatment plan must be completed indicating the service(s) to be provided are medically necessary. Specialty providers may engage in assessment and service/treatment planning activities to support timely access to medically necessary behavioral health services. Specialty providers will provide documentation to the Behavioral Health provider for inclusion in the member's comprehensive Behavioral Health clinical record.

Referral to A Provider For A Second Opinion
Title XIX/XXI health care members are entitled to a second opinion. Upon a Title XIX/XI eligible healthcare member's request or at the request of the treating physician, Care1st must provide for

a second opinion from a healthcare professional within the network, or arrange for the healthcare member to obtain one outside the network when an in-network provider is not available, at no cost to the member.

Eligibility Verification and Screening

Behavioral health providers are required to assist members with applying of Arizona Public Programs (Title XIX/XXI, Medicare Savings Programs, Nutrition Assistance, and Cash Assistance), and Medicare Prescription Drug Program (Medicare Part D), including the Medicare Part D "Extra Help with Medicare Prescription Drug Plan Costs" low income subsidy program, as well as verification of U.S. citizenship/lawful presence prior to receive Non-Title XIX/XXI covered behavioral health services, at the time of intake for behavioral health services.

Eligibility status is essential for identification of the types of behavioral health services an individual may be able to access.

For individuals who are not currently Title XIX/XXI eligible, a financial and eligibility screening and application will be completed to determine eligibility. Verification of an individual's identification and citizenship/lawful presence in the United States is completed through the AHCCCS Health-e-Arizona Plus (HEAPlus) application process. Behavioral health Providers are required to assist individuals in completing this screening and verification process.

An individual who is not eligible for Title XIX/XXI covered services may still be eligible for Non-Title XIX/XXI services including services through the Substance Abuse Block Grant (SABG), the Mental Health Block Grant (MHBG), or the Projects for Assistance in Transition from Homelessness (PATH) Program. See AMPM Policy 320-T regarding non-discretionary federal grants and the delivery of behavioral health services. An individual may also be covered under another health insurance plan, including Medicare.

If the individual is in need of emergency services, the individual may begin to receive services immediately provided that within five days from the date of service a financial screening is initiated.

Individuals presenting for and receiving crisis services are not required to provide documentation of Title XIX/XXI eligibility nor are they required to verify U.S. citizenship/lawful presence prior to or in order to receive crisis services.

Title XIX/XXI Eligibility Verification and Screening/Application Process

Verification of an individual's current Title XIX/XXI eligibility status. The following verification processes are available 24 hours a day, 7 days a week:

a) AHCCCS web-based verification (Customer Support 602-417-4451)
b) Interactive Voice Response (IVR) system
c) Medifax

d) If an individual's Title XIX/XXI eligibility status cannot be determined using one of the above methods, the provider will:
    a. Call Care1st for assistance during normal business hours or
    b. Call the AHCCCS Verification Unit, which is open Monday through Friday, from 8:00-5:00 p.m.

Interpret eligibility information.

a) A provider can access the AHCCCS Codes and Values (CV) 13 Reference System when using the eligibility verification methods described above. This includes a key code index that may be used to interpret AHCCCS' eligibility key codes and/or AHCCCS rate codes,
b) For information on the eligibility key codes and AHCCCS rate codes refer to the AHCCCS Reference Subsystem Codes and Values on the AHCCCS website, and
c) If Title XIX/XXI eligibility status and provider responsibility is confirmed, the provider shall provide any needed covered behavioral health services in accordance with AMPM.

For individuals that are not identified as Title XIX/XXI eligible, providers are to assist individuals with the AHCCCS screening/application process for Title XIX/XXI or other Public Program eligibility through HEAPlus at the following times:

a) Upon initial request for behavioral health services
b) At least annually, if still receiving behavioral health services, and
c) When significant changes occur in the individual's financial status.

To conduct the AHCCCS screening/application for Title XIX/XXI or other Public Program eligibility through HEAPlus, behavioral health providers will meet with the individual and complete the AHCCCS HEAPlus online application. Once completed, HEAPlus will indicate if the individual is potentially Title XXI/XXI eligible.

a) To the extent that it is practicable, the provider is expected to assist applicants in obtaining the required documentation of identification and U.S. citizenship/lawful presence within the timeframes indicated by HEAPlus,
b) For information regarding what documents are required in order to verify proof of U.S. citizenship/lawful presence refer to Arizona's Eligibility Policy Manual for medical, Nutrition, and Case Assistance Manual Chapter 500, Policy 507 and Policy 524
c) Documentation of Title XIX/XXI and other Public Program eligibility screening/application will be included in the individual's medical record including the Application Summary and final Determination of eligibility status notification printed from HEAPlus,
d) Pending the outcome of the Title XIX/XXI or other Public Program screening/application, if the individual is determined ineligible for Title XIX/XXI or other Public Program benefits,
e) Upon the final processing of a Title XIX/XXI and other Public Program screening/application, if the individual is determined ineligible for Title XIX/XXI or other Public Program benefits, regardless of verification of US Citizenship/Lawful

Presence, the individual is eligible for covered Non-Title XIX/XXI services in accordance with AMPM 320-T.

f) An individual found not to be eligible for Title XIX/XXI or other Public Program benefits may submit the application for review by AHCCCS and/or DES. Additional information requested and verified by AHCCCS and/or DES may result in the individual subsequently receiving Title XIX/SSI or other Public Program.

PCP SCREENING

1. PCPs are to use validated screening instruments to screen adults and children related behavioral health needs, social determinants of health and trauma.
2. Providers have access to the screening tools above and other tools via links on the Care1st website: https://www.care1staz.com/az/providers/preventivehealth.asp.
3. The medical record will reflect screening results and timely referral to a behavioral health provider if needed. A PCP must provide three culturally and linguistically appropriate behavioral health provider referrals.
4. If the PCP practice uses an integrated services healthcare delivery model, with onsite behavioral health professionals, an in-house referral and intake and assessment session is expected to occur within 7 days for routine situations, and immediately for urgent situations. Based upon the behavioral health assessment, the behavioral health professional will determine if an individual's behavioral health needs can be addressed within the integrated care provider, or if the individual requires more extensive or specialized services beyond the scope of the integrated care provider practice (e.g. longer term psychotherapy, neuropsychological testing).
5. If the PCP does not have onsite behavioral health professionals, or if the integrated behavioral health provider's assessment determines that the member requires specialized service beyond the scope of the services provided at the integrated care practice, then the PCP is expected to provide at least three culturally and linguistically appropriate behavioral health provider referrals, connect the member with the member's chosen behavioral health provider, and track the member's subsequent appointment with that provider.
6. For PCPs prescribing medications to treat Substance Use Disorders (SUDs), the PCP must refer the member to a behavioral health provider for the psychological and/or behavioral therapy component of the Medication Assisted Treatment (MAT) model and coordinate care with the behavioral health provider.

OUTREACH, ENGAGEMENT, REENGAGEMENT AND CLOSURE

The behavioral health system provides outreach activities to inform the public of the benefits and availability of behavioral health services and how to access them. Care1st disseminates information to the general public, other human service providers, school administrators and teachers and other interested parties regarding the behavioral health services that are available to eligible members. Outreach activities include, but are not limited to:

- Participation in local health fairs or health promotion activities;
- Involvement with local schools;
- Involvement with Outreach Activities for military veterans, such as Arizona Veterans Stand Down Coalition events,
- Development of Outreach program and activities for first responders (i.e. policy, fire, EMT),
- Development of Outreach programs to members experiencing homelessness;
- Development of outreach programs to members who are at risk, are identified as a group with high incidence or prevalence of behavioral health issues or are underserved;
- Publication and distribution of informational materials;
- Liaison activities with local and county jails, county detention facilities, and local/county Arizona Department of Child Safety (DCS) offices and programs;
- Regular interaction with agencies that have contact with pregnant women/teenagers who have a substance use disorder;
- Development and implementation of outreach programs that identify members with co-morbid medical and behavioral health disorders and those who have been determined to have a Serious Mental Illness (SMI) within Care1st geographic service areas, including members who reside in jails, homeless shelters, county detention facilities or other settings;
- Provision of information to behavioral health advocacy organizations, and
- Development and coordination of outreach programs to Native American tribes in Arizona to provide services for tribal members.

Engagement

Behavioral Health Providers actively engage the following in the treatment planning process by including the following:

- The member/Health Care Decision Maker (HCDM), Designated Representative (DR),
- The member's family / significant others, if applicable and amenable to the member;
- Other agencies/providers as applicable; and,
- The member/HCDM, and DR as applicable, advocate, or other individual designated to provide Special Assistance for members with a Serious Mental Illness who are receiving Special Assistance as specified in AMPM Policy 320-R.

SECTION VII: Behavioral Health Services

Providers engage incarcerated members with high incidence or prevalence of behavioral health issues, or who are underserved as specified in AMPM Policy 1022.

Re-Engagement
Re-engagement efforts will be made for members who have withdrawn from participation in the treatment process prior to the successful completion of treatment, refused services or failed to appear for a scheduled service based on a clinical assessment of need. All attempts to re-engage members who have withdrawn from treatment, refused services or failed to appear for a scheduled service must be documented in the comprehensive clinical record. The behavioral health provider must attempt to re-engage the member by:

- Communicating in the member's preferred language;
- Contacting the member/HCDM, DR as applicable by telephone, at times when the member may reasonably be expected to be available (e.g., after work or school);
- Whenever possible, contacting the member/HCDM, DR as applicable face-to-face, if telephone contact is insufficient to locate the member or determine acuity and risk; and
- Sending a letter to the current or most recent address requesting contact, if all attempts at personal contact are unsuccessful, except when a letter is contraindicated due to safety concerns (e.g., domestic violence) or confidentiality issues. The provider will note safety or confidentiality concerns in the progress notes section of the clinical record and include a copy of the letter sent in the comprehensive clinical record.

If the above activities are unsuccessful the providers will make further attempts to re-engage the following populations:

a. Members determined to have an SMI
b. Members on court ordered treatment,
c. Members known to have been recently released from incarceration,
d. Children, pregnant women, and/or teenagers with a substance abuse disorder, and
e. Any member determined to be at risk of relapse, increased symptomology, or deterioration,
f. Individuals with a potential for harm to self or others

Further attempts include at a minimum: contacting the member/HCDM, DR face-to-face, and contacting natural supports for whom the member has given permission to the provider to contact. All attempts to re-engage these members must be clearly documented in the comprehensive clinical record.

If face-to-face contact with the member is successful and the member appears to meet clinical standards as a danger to self, danger to others, persistently and acutely disabled or gravely disabled the provider must determine whether it is appropriate, and make attempts as appropriate, to engage the member to seek inpatient care voluntarily. If this is not a viable option for the member and the clinical standard is met, initiate the pre-petition screening or petition for treatment process.

Follow-Up After Significant and/or Critical Events
Providers are to document in the clinical record any follow-up activities that are conducted to maintain engagement within the following timeframes:

- Discharged from inpatient services in accordance with the discharge plan and within 7 days of the members' release to ensure member stabilization, medication adherence, and to avoid re-hospitalization;
- Involved in a behavioral health crisis within timeframes based upon the person's clinical needs, but no later than 7 days;
- Refusing to adhere to prescribed psychotropic medication schedule, based upon the member's clinical needs and history, and
- When the member changes location or when a change in the member's level of care occurs

Ending an Episode of Care for Member's in Behavioral Health System

Under certain circumstances, it may be appropriate or necessary to disenroll a member or end an episode of care from services after re-engagement efforts have been expended. Ending the episode of care can occur due to clinical or administrative factors involving the enrolled person. The episode of care can be ended for both Non-Title XIX and Title XIX individuals, but Title XIX eligible members no longer in an episode of care for behavioral health services remain enrolled with AHCCCS. When a member is disenrolled or has an episode of care ended, notice and appeal requirements may apply.

Clinical Factors
Treatment Completed:
A member's episode of care must end upon completion of treatment. A Non-Title XIX person would also be dis-enrolled at treatment completion. Prior to ending the episode of care or dis-enrolling a person following the completion of treatment, the behavioral health provider and the member or the member's legal guardian must mutually agree that behavioral health services are no longer needed.
Further Treatment Declined:
A member's episode of care must be ended if the member or the member's legal guardian decides to refuse ongoing behavioral health services. A Non-Title XIX person would also be dis-enrolled from services.

Prior to ending the episode of care or dis-enrolling a member for declining further treatment, the behavioral health provider must ensure the following:

- All applicable and required re-engagement activities have been conducted and clearly documented in the member's comprehensive clinical record; and
- The member does not meet clinical standards for initiating the pre-petition screening or petition for treatment process

Lack of Contact:

- A member's episode of care may be ended if Care1st or behavioral health provider is unable to locate or make contact with the person after ensuring that all applicable and required re-engagement activities have been conducted. A Non-Title XIX individual would also be dis-enrolled from services.

Administrative Factors:

Eligibility/Entitlement Information Changes Including:

- Loss of Title XIX/XXI eligibility, if other funding is not available to continue services; and
- member s who become or are enrolled as elderly or physically disabled (EPD) under the Arizona Long Term Care System (ALTCS) must be dis-enrolled after ensuring appropriate coordination and continuity of care with the ALTCS program contractor. (Not applicable for developmentally delayed ALTCS members ALTCS/DD whose behavioral health treatment is provided through the T/RBHA system.)

Behavioral health providers may dis-enroll Non-Title XIX/XXI eligible persons for non-payment of assessed co-payments, under the following conditions:

- The person is not eligible as a person determined to have a Serious Mental Illness (SMI)
- Attempts at reasonable options to resolve the situation, (e.g., informal discussions) do not result in resolution. All efforts to resolve the issue must be documented in the person's comprehensive clinical record

Out-of-State Relocations:

- A member's episode of care must be ended for a person who relocates out-of-state after appropriate transition of care. A Non-Title XIX individual would also be disenrolled. This does not apply to member s placed out-of-state for purposes of providing behavioral health treatment.

Inter-T/RBHA Transfers:

- A member who relocates to another ACC or T/RBHA and requires ongoing behavioral health services must be closed from one ACC or T/RBHA and transferred to the new ACC or T/RBHA. Services must be transitioned.

Arizona Department of Corrections Confinements:

- A member age 18 or older must be disenrolled upon acknowledgement that the member has been placed in the long-term control and custody of a correctional facility.

Children Held at County Detention Facilities

- Children who become incarcerated should not automatically have their Episode of Care closed.

Inmates of public institutions:

- Members who become incarcerated should not automatically have their Episode of Care closed.

Deceased Persons:

- A member's episode of care must be ended following acknowledgement that the person is deceased, effective on the date of the death. The Non-Title XIX member would be disenrolled from the system.

Crisis Episodes:

- The behavioral health provider conducts all applicable and required re-engagement activities and such attempts are unsuccessful; or the behavioral health provider and the member or the member's legal guardian mutually agrees that ongoing behavioral health services are not needed; a Non-Title XIX member would be dis-enrolled from the system.
- For members who are enrolled as a result of a crisis episode, the member 's episode of care would end if the following conditions have been met:
    - The behavioral health provider conducts all applicable and required re-engagement activities and such attempts are unsuccessful; or
    - The behavioral health provider and the member or the member's legal guardian mutually agrees that ongoing behavioral health services are not needed; a Non-Title XIX member would be dis- enrolled from the system.

One-Time Consultations: For members who are in the system for the purpose of a one-time consultation, the member's episode of care may be ended if the behavioral health provider and the member or the member's legal guardian mutually agrees that ongoing behavioral health services are not needed. The Non-Title XIX individual would also be dis-enrolled.

DUGless Data Reporting

For demographic elements with no identified alternative data source or Social Determinate identifier, AHCCCS has created an online portal (DUGless) to be accessed directly by providers for the collection of the remaining data elements for members.

Providers are required to submit demographic data directly to AHCCCS. Information on specific data elements is available at https://www.azahcccs.gov/PlansProviders/Demographics/. Data and information assist in monitoring and tracking of the following:

1. Access and utilization of services,
2. Community and stakeholder information
3. Compliance of Federal, State, and grant requirements,
4. Health disparities and inequities,
5. Member summaries and outcomes,
6. Quality and Medical Management activities, and
7. Social Determinants of Health

At times, technical problems or other issues may occur in the electronic transmission of the clinical and demographic data from the behavioral health provider to AHCCCS. Any questions

about the portal or the data fields in the portal should be submitted to DHCM/DAR Information Management/Data Analytics Unit Manager and Data Analysis and Research Manager. In addition, support can be obtained at ISDCustomerSupport@azahcccs.gov or 602-417-4451.

Serving Member's Previously Enrolled in the Behavioral Health System
Some members who have ended their episode of care or were dis-enrolled may need to re-enter the behavioral health system. The process used is based on the length of time that a person has been out of the behavioral health system.

For members not receiving services for less than 6 months:

- If the member has not received a behavioral health assessment in the past 6 months, conduct a new behavioral health assessment and revise the member's service plan as needed. If the member has received a behavioral health assessment in the last six months and there has not been a significant change in the member's behavioral health condition, behavioral health providers may utilize the most current assessment. Review the most recent service plan (developed within the last six months) with the member, and if needed, coordinate the development of a revised service plan with the person's clinical team.
- If the member presents at a different ACC, T/RBHA or provider, obtain new general and informed consent to treatment.
- If the member presents at a different ACC, T/RBHA or provider, obtain new authorizations to disclose confidential information.
- Submit new demographic and enrollment data

For members not receiving services for 6 months or longer:

- Conduct a new intake, behavioral health assessment and service plan
- Obtain new general and informed consent to treatment
- Obtain new authorizations to disclose confidential information
- Submit new demographic and enrollment data

ASSESSMENT, SERVICE AND/OR TREATMENT PLANNING

Overview
Behavioral Health Assessments, Service, and/or Treatment Planning are conducted in compliance with Adult Behavioral Health Service Delivery System-Nine Guiding Principles, and the Arizona Vision and Twelve Principles for Children's Behavioral Health Service Delivery as specified in AMPM Policy 100, AMPM Chapter 200, AMPM 320-O, and A.A.C. Title 9, Chapters 10 and 21, as applicable.

1. General Requirements
   A. Assessments, Service, and Treatment Plans are conducted by an individual within their scope of practice (e.g. Behavioral Health Professionals (BHPs), Behavioral Health Technicians (BHTs) and under the appropriate oversight or supervision, as applicable

B. Incorporate the concept of a "team" established for each member receiving behavioral health service,
    a. The team is based on member/Health Care Decision Maker (HCDM) choice,
    b. The team does not require a minimum number of participants and can consist of whoever is identified by the member/HCDM,
C. Utilize Service Plan Rights Acknowledgement Template to indicate agreement or disagreement with the service plan and awareness of the right to appeal if not in agreement with the service plan.

2. The health home provider serves as the primary responsible entity for coordination of all primary, physical and/or behavioral health services and supports to deliver and/or arrange whole person care.
3. Behavioral health providers outside of the Health Home may complete assessment, service, and treatment planning to support timely access to medically necessary behavioral health services, as allowed under licensure (A.A.C. R9 et. Seq.) and specified in ACOM Policy 417.
    a) Should a behavioral health provider outside the Health Home complete any type of Behavioral Health Assessment, the behavioral health provider will communicate with the Health Home regarding assessment findings within 30 days of the first date of service. In situations when a specific assessment is duplicated, the results of such assessments will be discussed collaboratively to address clinical implications for treatment needs. Differences will be addressed within the CFT participation from both the Health Home and Behavioral Health Provider outside of the Health Home.
    b) Behavioral health providers will supply completed Assessment, Service, and Treatment Plan documentation to the health home for inclusion in the member's medical record.
4. The Assessment, Service, and Treatment Plan are included in the medical record in accordance with AMPM Policy 940,
5. Behavioral Health Assessments, service, and Treatment Plans are updated at minimum once annually or more often as needed based on clinical necessity and/or upon significant life events including but not limited to:

    i. Moving,
    ii. Death of a friend or family member,
    iii. Change in family structure (e.g. divorce, incarceration),
    iv. Hospitalization,
    v. Major illness of individual or family member,
    vi. Incarceration, and
    vii. Any event which may cause a disruption of normal life activities.
6. The Health home is responsible for maintaining the Treatment and Service Plan updates to meet the changing behavioral health needs for members.

SECTION VII: Behavioral Health Services

Behavioral Health Assessments

1. Comprehensive Assessments
    a. Individuals receiving behavioral health services receive a comprehensive behavioral health assessment. The assessment conducted is in compliant with the Rules set forth in A.A.C. Title 9, Chapters 10 and 21, and/or ACOM Policy 417, as applicable
    b. The health home is responsible for maintaining the comprehensive behavioral health assessment within the medical record, and for ensuring periodic assessment updates are completed to meet the changing behavioral health needs for individuals who continue to receive behavioral health services.
        i. An assessment will include an evaluation of the member's:
            1. Presenting concerns,
            2. Information on the strengths and needs of the member and his/her/their family,
            3. Behavioral health treatment
            4. Medical conditions and treatment
            5. Sexual behavior and, if applicable, sexual abuse
            6. Substance abuse, if applicable,
            7. Living environment
            8. Educational and vocational training
            9. Employment
            10. Interpersonal, social, and cultural skills
            11. Development history
            12. Criminal justice history,
            13. Public (e.g. unemployment, food stamps, etc.) and private resources (e.g. faith-based, natural supports, etc.)
            14. Legal status (e.g. presence or absence of a legal guardian) and apparent capacity (e.g. ability to make decisions or complete daily living activities)
            15. Need for special assistance, and
            16. Language and communication capabilities
        ii. Additional components of the assessment include:
            1. Risk assessment of the member
            2. Mental status examination of the member
            3. A summary of impressions, and observations,
            4. Recommendations for next steps
            5. Diagnostic impressions of the qualified clinician
            6. Identification of the need for further or specialty evaluations, and
            7. Other information determined to be relevant.
    c. In situations when a specific assessment is duplicated (e.g. developmental assessment, CALOCUS), the results of such assessments are discussed collaboratively with any other provider that may have completed an assessment, to address clinical indications for treatment needs. Differences are addressed

within the "team" with participation from both the health home and behavioral health provider outside of the health home.

2. Additional Assessments
    a. Children ages 0 through five: Developmental screening shall be conducted for children age 0-5 with a referral for further evaluation when developmental concerns are identified. Information on standardized assessments is available within AMPM Behavioral Health Practice Tool (BHPT) 210
    b. Children Age 6 through 17 – an age appropriate assessment will be completed by the Health Home during the initial assessment and updated at every six months,
    c. Children Age 6 through 17 – Strengths, Needs and Culture Discovery Document will be completed as deemed appropriate by the Health Home
    d. Children Age 11 through 17 - Standardized tool is used to evaluate for potential substance use
        i. In the event of positive results, the information is shared with the providers involved in the child's care and may be shared only if the member has authorized sharing of protected health information.
    e. Individuals ages 18 and up: A standardized tool, ASAM will be used to evaluate for potential substance use.
        i. In the event of positive results, the information is shared with the providers involved with the member's care and may be shared only if the member has authorized sharing of protected health information.

Service and/or Treatment Planning

Service planning encompasses a description of all covered health services that are deemed as medically necessary and based on member voice and choice. The service plan has a uniform, single plan that is developed and administered by the health home, FFS provider or the ALTCS Case Manager, and includes all treatment plans and additional relevant documents from other service providers or entities involved in the members' care (i.e., education, probation, etc.).

Treatment planning may occur within or outside of the health home based on the member's identified need. A member may have multiple treatment plans based on various clinical needs.

1. The service and/or treatment plan is based on a current assessment and/or specific treatment need (e.g., out of home services, specialized behavioral health treatment for substance use).

2. The service or treatment plan identifies the services and supports to be provided, according to the covered, medically necessary services specified in AMPM Policy 310-B.

3. Providers make available and offer the option of having a Family Support Specialist and/or Peer Recovery specialist to provide covered services when appropriate, as well as for the purpose of navigating members to treatment or increasing participation and retention in treatment and recovery support services.

4. The behavioral health provider documents whether or not the member, or when applicable, their HCDM, and/or Designated Representative (DR) agrees or disagrees with the service or

treatment plan and has indicated such agreement or disagreement by either a written or electronic signature on the service or treatment plan.

5. The health home coordinates with any entity involved in the member's care including, but not limited to Care1st, PCP(s), TRBHAs, case managers, DCS, probation as applicable, regarding Behavioral Health Assessments, Service, and Treatment Planning as specified in AMPM Policy 541.

Crisis and Safety Planning

General Purpose of a Crisis and Safety Plan

A Crisis and Safety Plan provides a written method for potential crisis support or intervention which identifies needs and preferences that are most helpful in the event of a crisis. The Crisis and Safety Plan will be developed in accordance with the Vision and Guiding Principles of the Children's System of Care and the Nine Guiding Principles of the Adult System of Care as specified in AMPM Policy 100. Crisis and Safety plans will be trauma informed, with a focus on safety and harm reduction.

The development of a Crisis and Safety Plan will be completed in alignment with the member's Service and Treatment Plan, and any existing Behavior plan if applicable. It will be considered, when clinically indicated. Clinical indicators may include, but are not limited to needs identified in members Treatment, Service, or Behavior plan in addition to any one or a combination of the following:

a) Justice Invovlement
b) Previous psychiatric hospitalizations
c) Out of home placements
    a. Home and Community Based Service (HCBS) settings (e.g. assisted living facility)
    b. Nursing facilities
    c. Group Home settings,
d) Special Health Care Needs,
e) Court Ordered Treatment,
f) History of DTS/DTO
g) Individuals with an SMI designation,
h) Individuals identified as High Risk/High Needs, and
i) Children ages 6-17 with a CALOCUS Level of 4, 5, or 6.

Crisis and Safety Plans are updated annually, or more frequently if a member meets one or a combination of the above criteria, or if there is a significant change in the member's needs. A copy of the Crisis and Safety Plan will be distributed to the team members that assisted with development of the Crisis and Safety Plan.

A Crisis and Safety Plan does not replace or supplant a Mental Health Power of Attorney or behavior plan, but rather serves as a compliment to these existing documents.

Essential Elements
A Crisis and Safety Plan establishes goals to prevent or ameliorate the effects of a crisis and will specifically address:

a) Techniques for establishing safety, as identified by the member and/or healthcare decision maker, as well as members of the CFT or ART,
b) Identification of realistic interventions that are most helpful to the individual and his/her family members or support system,
c) Reduction of symptoms
d) Guiding the support system toward ways to be most helpful
e) Any physical limitations, comorbid conditions, or unique needs of the member (e.g. involvement with DCS or Special Assistance)
f) Necessary resources to reduce the change for a crisis or minimize the effects of an active crisis for the member. This may include, but is not limited to:
    i. Clinical (support staff/professionals), medication, family, friends, parent, guardian, environment
    ii. Notification to and/or coordinate with others, and
    iii. Assistance with and/or management of concerns outside of crisis (e.g. animal care, children, family members, room-mates, housing, financials, medical needs, school, work).

Psychotropic Medications
For members for or identified as needing ongoing psychotropic medications for a behavioral health condition, the assessor must establish an appointment with a licensed medical practitioner with prescribing privileges. If the assessor is unsure regarding a member's need for psychotropic medications, then the assessor must review the initial assessment and treatment recommendations with her/her clinical supervisor or a licensed medical practitioner with prescribing privileges.

Members with substance use disorders, primarily opioid addiction, may be appropriately referred to Medication Assisted Treatment (MAT). MAT services are a combination of medications and counseling/behavioral therapies to provide a "whole patient" approach to the treatment of substance use disorders. Care1st contracts with network providers to specifically prescribe and/or dose medications to normalize brain chemistry, block the euphoric effects of alcohol and opioids, relieve physiological cravings and normalize body functions without the negative effects of the used drug. Care1st members may solely receive behavioral health services from contracted MAT providers; members may also receive behavioral health services from one agency and receive MAT services from another provider. Providers involved are required to provide care coordination to optimize treatment outcomes for these members.

Serving Member's Previously Enrolled in the Behavioral Health System
Some members who have ended their episode of care or were dis-enrolled may need to re-enter the behavioral health system. The process used is based on the length of time that a person has been out of the behavioral health system.

For members not receiving services for less than 6 months:

- If the member has not received a behavioral health assessment in the past 6 months, conduct a new behavioral health assessment and revise the member's service plan as needed. If the member has received a behavioral health assessment in the last six months and there has not been a significant change in the member's behavioral health condition, behavioral health providers may utilize the most current assessment. Review the most recent service plan (developed within the last six months) with the member, and if needed, coordinate the development of a revised service plan with the person's clinical team.
- If the member presents at a different ACC, T/RBHA or provider, obtain new general and informed consent to treatment.

Required for Children Ages 6 through 17

Care1st requires its contracted providers to have policies and procedures in place to ensure that staff (i.e. case managers, clinicians, etc.) implement and administer the Child and Adolescent Level of Care Utilization System (CALOCUS) for all children receiving services between the ages of 6 through 17. All individuals administering the CALOCUS will complete initial training, which will be recorded in Relias, and will pass initial and ongoing fidelity monitoring.

The CALOCUS will be administered within the first 45 days of intake, at least every six months, and as significant changes occur in the life of the child. This may include but not limited to discharge from inpatient, behavioral health short-term residential treatment, or therapeutic foster care.

In addition to the CALOCUS (or other assessment) level of acuity and high-need determination for children ages six through 17 may be assessed through clinical evaluation as well as CALOCUS score. This evaluation and high need identification will also trigger an updated CALOCUS, as well as review of the current treatment/service plan.

CALOCUS assessments can be completed by any individual who has been trained to implement this assessment, and is practicing within their scope. Due to the potential for duplication of the CALOCUS assessment, treating behavioral health providers shall collaborate to ensure that differences in CALOCUS levels are addressed at the clinical level and through the CFT.

The following AHCCCS Behavioral Health Practice Tools shall be utilized:

1. Youth Involvement in the Children's Behavioral Health System,
2. Child and Family Team,
3. Children's Out of Home Services,
4. Family and Youth Involvement in the Children's Behavioral Health System,
5. Psychiatric Best Practice for Children Birth to Five Years of Age,
6. Support and Rehabilitation Services for Children, Adolescents, and Young Adults,
7. Transition to Adulthood, and
8. Working with the Birth to Five Population.

Required for Children Age 6 to 17 with CALOCUS Score of 4 or Higher

- Strength, Needs and Culture Discovery Document
- Referral to a High Needs Case Manager (HNCM)

High Needs Case Management (HNCM)

Children that are considered high needs are to be referred to a high needs case manager. The following options are offered when assigning an agency to provide high needs case management:

a. Option 1: The member's originally assigned provider offers high needs case management. In these situations, the family may be offered to receive high needs case management and other needed services through a single provider agency. In these circumstances, the provider serves as the designated health home for that child.
b. Option 2: The originally assigned provider does not offer high needs case management necessitating an external referral to another provider agency to access high needs case management services. In this situation the family has two additional options:
    i. Responsibility for all services can be transferred to the high needs case management provider agency and this provider will become the member's designated health home. This option is ideal as it streamlines the coordination of care and medical record documentation under one entity; OR
    ii. The child and family can choose to remain with the originally assigned provider (i.e. maintain established relationship, better alignment with family preferences or needs) and only receive high needs case management from the high needs case management provider agency. In these circumstances, the originally assigned provider shall function as the member's designated health home. Providers are responsible for ensuring timely and efficient care coordination between all involved provider agencies. This may include referral expectations and allowable exceptions based on family preference.

Behavioral Health Providers are to ensure that caseload ratios are within the indicated parameters and will notify the RBHA and/or Care1st when barriers exist to meeting the establishment requirements. Caseloads are submitted to the RBHA and/or Care1st (for those agencies not contracted with the RBHAs) on a monthly basis. The RBHAs then share this information with Care1st and the other AHCCCS Complete Care Contractors. Collectively these are monitored for compliance. When an issue of noncompliance has occurred the RBHA and Care1st partner together to develop and address the need for a corrective action plan.

HNCM caseload requirements are as follows:

- For a full FTE (1.0), have a caseload ratio of high needs children not less than 1:8 and not more than 1:25, with 1:15 being the desired target. The caseload cap is 25 to allow for continuity of care for children who have been receiving high needs case management, but are not ready to begin transition from that level of care and for high needs case management siblings, and

- Provide case management and other support and rehabilitation services to their assigned members.

Transition Age Youth

Providers are expected to follow the AHCCCS Behavioral Health Guidance Tool: Transition to Adulthood Practice Tool. The transition from child to adult services will include at minimum the following:

1. A coordination plan between child providers and the anticipated adult providers.
2. A process that begins no later than when the child reaches the age of 16.
3. A transition plan for the member that focuses on assisting the member with gaining the necessary skills and knowledge to become a self-sufficient adult and facilitates a seamless transition from child services to adult services.
4. Based on clinical presentation, an SMI eligibility determination is completed when the adolescent reaches the age of seventeen, but no later than age 17 and 6 months.
5. Any additional stakeholder, behavioral and physical healthcare entity involved with the child will be included in the transition process, as applicable (e.g. DDD, juvenile justice, CMDP, education system).
6. A coordination plan to meet the unique needs for Members with Special Health Care Needs, including members with CRS designation.

In addition, providers delivering care to Transition Age Youth will provide and/or refer members to child providers who utilize the Transition to Independence (TIP) model of care into their service delivery.

Providers are encouraged to utilize identified First Episode Psychosis (FEP) centers, which have implemented evidence-based practices and track outcomes for children with specialized healthcare needs such as Transition Aged Youth: FEP Programs. Providers will coordinate with FEP Centers through Child & Family Team or Adult Recovery Team process.

When appropriate for members, who are uninsured or underinsured and have been determined to have an FEP, behavioral health providers will refer and assist in coordinating care to MHBG providers. The MHBG is allocated from the Substance Abuse and Mental Health Services Administration (SAMHSA) to provide mental health treatment services to adults with Serious Mental Illness (SMI) and children with Serious Emotional Disturbance (SED). Each Regional Behavioral Health Authority receives funding as a pass through grant to ensure access to covered behavioral health services.

Funding targets the following populations:

- Adults (18 and older) with a serious mental illness (SMI)
- Children (17 and under) with a serious emotional disturbance (SED)
- Individuals experiencing a Frist Episode of Psychosis (FEP)

SECTION VII: Behavioral Health Services

Providers will have an established process for ensuring that staff that provide service delivery to adolescents, young adults and their families have been trained and understand how to implement the practice elements outlined in Care1st Policy 550: Transition Age Youth as well as AHCCCS: Transition to Adulthood Practice Tool. Verification of training completion must be documented in Relias.

Case Management Services for Members determined to be SMI
Behavioral Health Providers are to ensure that caseload ratios and contact requirements are within the indicated parameters as outlined in AMPM Policy 570 and Attachment A Case Management Caseload Ratios and Review Cycle and will notify the RBHA and/or Care1st when barriers exist to meeting the established requirements. Caseloads are submitted to the RBHA and/or Care1st through a quarterly case management inventory deliverable. These deliverables are monitored for compliance and when an issue of noncompliance has occurred the RBHA and contracted provider will work together to develop and address the need for a corrective action plan.

Caseload requirements are as follows:

- SMI Assertive Caseload is 12:1
- SMI Supportive Caseload is 30:1
- SMI Connective Caseload is 70:1

ASSERTIVE COMMUNITY TREATMENT SERVICES

Service Requirements

Providers delivering ACT Team services may be required to establish ACT teams that comply with the requirements outlined in the SAMHSA Assertive Community Treatment (ACT) Evidence-Based Practices Kit, https://store.samhsa.gov/product/Assertive-Community-Treatment-ACT-Evidence-Based-Practices-EBP-KIT/SMA08-4345, in communities approved by the Health Plan. Compliance expectations will be based on geographic service needs and available resources.

Fidelity Standards

Providers delivering ACT Team services shall participate in SAMSHA EBP fidelity audits coordinated with the Health Plan on an annual basis at minimum.

Reporting Requirements

Providers shall submit all documents, reports and data in the format prescribed by the Health Plan and within the time frames specified. Provider is required to submit any additional documents and/or ad hoc reports as requested by the Health Plan.

Other Requirements

ACT Team providers must participate in all trainings and meetings required or requested by AHCCCS and/or The Health Plan. ACT Team providers must coordinate for continuity of care between provider, member's Behavioral Health Home, community stakeholders, and other Specialty Providers (both physical and behavioral health) involved with the member.

COORDINATION OF CARE WITH OTHER GOVERNMENTAL AGENCIES

Arizona Department of Child Safety (DCS)

When a child receiving behavioral health services is also receiving services from DCS, the provider must work towards effective coordination of services with the DCS Specialist. Providers are expected to:

- Coordinate the development of the Service Plan with the DCS case plan to avoid redundancies and/or inconsistencies.
- Provide the DCS with preliminary findings and recommendations on behavioral health risk factors, symptoms and service needs for court hearings.
- Perform an assessment and identify behavioral health needs of the child, the child's parents and family and provide necessary behavioral health services, including support services to temporary caretakers.
- As appropriate, engage the child's parents, family, caregivers, and DCS Specialist in the behavioral health assessment and service planning process as members of the Child and Family Team (CFT).
- Attend team meetings such as Team Decision Meetings (TDM) for the purpose of providing input about the child and family's behavioral health needs. When it is possible, TDM and CFT meetings should be combined.
- Coordinate necessary services to stabilize in-home and out-of-home placements provided by DCS.
- Coordinate provision of behavioral health services in support of family reunification and/or other permanency plans identified in DCS.
- Coordinate activities and service delivery that supports the child and family Plans and facilitates adherence to established timeframes.
- Coordinate actives that include coordination with the adult service providers rendering services to adult family members.

DCS Arizona Families F.I.R.S.T (Families in Recovery Succeeding Together-AFF) Program

Providers are to coordinate with parents/families referred through the Arizona Families F.I.R.S.T (AFF) program and participate in the family's CFT to coordinate services for the family and temporary caretakers.

SECTION VII: Behavioral Health Services

The AFF Program provides expedited access to substance use treatment for parents/families/caregivers referred by DCS and the ADES/Family Assistance Administration (FAA) Jobs Program. AHCCCS participates in statewide implementation of the program with DCS. Providers are too coordinate the following:

Accept referrals for Title XIX and Title XXI eligible and enrolled members and families referred through AFF:

a. Accept referrals for Title XIX/XXI eligible and enrolled members and families referred through the AFF program, Non-Title XIX/XXI members and families referred through the AFF Program, if eligible
b. Ensure that services made available to members who are Non-Title XIX/XXI eligible are provided by maximizing available federal funds before expending state funding as required in the Governor's Execution Order 2008-01
c. Collaborate with DCS, the ADES/FAA Jobs Program and substance use disorder treatment providers to minimize duplication of assessments
d. Develop procedures for collaboration in the referral process to ensure effective service delivery through the behavioral health system. Appropriate authorizations to release information will be obtained prior to releasing information

Arizona Department of Education (ADE), Schools, Or Other Local Educational Authorities
AHCCCS has delegated the functions and responsibilities as a State Placing Agency to Care1st for members in the Northern and Central GSA under A.R.S. §15-1181 for children receiving special education services pursuant to A.R.S. §15-761 et seq. This includes the authority to place a student at a Behavioral Health Inpatient Facility, which provides care, safety, and treatment.

Providers are to collaborate with schools and help a child achieve success in schools as follows:

a. Work with the school and share information to the extent permitted by law and authorized by the member or Health Care Decision Maker (HCDM) as specified in AMPM Policy 940.
b. For children receiving special education services, actively consider information and recommendations contained in the Individualized Education Program (IEP) during the ongoing assessment and service planning;
c. For children receiving special education services, include information and recommendations contained in the Individualized Education Program (IEP) during the assessment and service planning process (refer to AMPM Policy 320-O). Behavioral health providers participate with the school in developing the child's IEP and share the behavior treatment plan interventions, if applicable;
d. Invite teachers and other school staff to participate in the CFT if agreed to by the child and Health Care Decision Maker;
e. Support accommodation for students with disabilities who qualify under Section 504 of the Rehabilitation Act of 1973, and
f. Ensure that transitional planning occurs prior to and after discharge of an enrolled child from any out-of-state placement.

SECTION VII: Behavioral Health Services

Behavioral health providers collaborate with schools to provide appropriate behavioral health services in school settings, identified as Place of Service (POS) 03 and submit reports as specified by Care1st.

Care1st is not responsible for services provided by Local Educational Authorities (LEAs), as specified in AMPM Policy 710, for members receiving special education services.

Department of Economic Security
Arizona Early Intervention Program (AzEIP)
Providers will coordinate member care with AzEIP as follows:

a. Ensure that children birth to three years of age are referred to AzEIP in a timely manner when information obtained in the child's behavioral health assessment reflects developmental concerns,
b. Ensure that children found to require behavioral health services as part of the AzEIP evaluation process receive appropriate and timely service delivery, and
c. Ensure that, if an AzEIP team has been formed for the child, the behavioral health provider coordinates team functions to avoid duplicative processes between systems.

Courts and Corrections
Behavioral health providers collaborate and coordinate care for members with behavioral health needs and for members involved with:

1. Arizona Department of Corrections (ADOC)
2. Arizona Department of Juvenile Corrections (ADJC)
3. Administrative Offices of the Court (AOC), or
4. County Jails System

Behavioral health providers will coordinate member care as follows:

1. Work in collaboration with the appropriate staff involved with the member. Invite probation or parole representatives to participate in the development of the Service Plan and all subsequent planning meetings for the CFT and ART with the member's/Health Care Decision Maker's approval
2. Actively consider information and recommendations contained in probation or parole case plans when developing the Service Plan
3. Ensure that the behavioral health provider evaluates and participates in transition planning prior to the release of eligible members and arranges and coordinates enrolled member care upon the member's release.

Arizona Department of Economic Security/Rehabilitation Services Administration (ADES/RSA)

SECTION VII: Behavioral Health Services

The purpose of RSA is to work with individuals with disabilities to achieve increased independence or gainful employment through the provision of comprehensive rehabilitative and employment support services.

Providers must coordinate member care by:

1. Working in collaboration with the vocational rehabilitation (VR) counselors or employment specialists in the development and monitoring of the member's employment goals;
2. Ensuring that all related vocational activities are documented in the comprehensive clinical record;
3. Inviting RSA staff to be involved in planning for employment programming to ensure that there is coordination and consistency with the delivery of vocational services; and
4. Participating and cooperating with RSA in the development and implementation of a Regional Vocational Service Plan inclusive of RSA services available to adolescents.

PROVIDER AND STATEWIDE HOUSING ADMINISTRATOR RESPONSIBILITIES

Health Plan Provider Agencies shall designate a primary clinical or housing point of contact for the AHP Administrator to reach when applications for housing have been approved and a member receives an available unit/voucher. Please provide that POC via email to Kristi.Denk@care1staz.com and OIFA@care1staz.com

AHCCCS Housing Program (AHP) is administered by Arizona Behavioral Health Corporation (ABC) and HOM Inc. All applications and waitlist questions are to be directed to ABC. The Housing Application and ABC process can be found at the ABC Housing web site https://azabc.org/ahp/. 602-712-9200 Only Provider Agencies and Clinics shall contact ABC Housing.

HOM Inc. 602 265-4640 Phoenix 520 534-2941 Pima & BOS
Contact for Members/Clients and Health Home or Housing Staff about a housing concern for people already housed or approved for a housing voucher. https://www.hominc.com/ https://www.hominc.com/ahp-faqs/

When a member identifies a need for housing services and supports Provider Agencies are required to add to the Individual Service Plan (ISP) and fill out the AHP housing application forms. The AHP forms are fillable and will require signatures from all parties. These forms are emailed via secure email to the AHP Administrator for processing. The member will be added to the statewide housing list. When the AHP Administrator has a housing option available the member will be notified via email along with the Provider clinical teams, case managers and the health plan. This

is in effort to coordinate care as much as possible with AHCCCS Providers and the AHP Administrator.

AHCCCS is responsible for the overall oversight, fund distribution, operation, and ensuring that AHP funds are utilized for their intended purposes and in compliance with all federal, state, and local laws and regulations. To achieve these goals, AHCCCS utilizes a statewide Housing Administrator to manage and operate the AHCCCS Housing Program.

Provider Responsibilities

The Provider Agency is responsible for assisting and supporting members to secure and maintain housing as part of overall physical and behavioral health service provision. This includes coordination with the AHP Administrator for AHP programs if eligible, as well as other community-based housing and programs (e.g., Housing Choice Vouchers, Department of Housing and Urban Development (HUD) COC programs).

The designated provider agency will provide housing support services to members. The service provider can be the member's assigned health home/designated provider, or the services can be offered by referral to a qualified third party as noted in the member's individual service plan. If offered by a third party provider, the health home/assigned provider will ensure coordination of services as part of the member's integrated care plan

To adequately support members housing needs, the Provider Agencies shall: Ensure identification, assessment, screening, and documentation of individuals that have housing needs including homelessness, housing instability, or adequate and appropriate setting at discharge from residential, crisis or inpatient facility. It may also include administration of any AHCCCS approved standardized assessment tools that include housing evaluation, coordinate with the AHP Administrator and contracted providers to identify and refer members identified with a high need for housing services.

The Provider Agency shall assist members to identify, apply and qualify for housing options they may be eligible for including AHP subsidies and supports as well as other mainstream affordable and PSH programs (e.g., HUD Housing Choice Vouchers, HUD McKinney Vento COC grants), to ensure a range of housing settings and programs are available to individuals consistent with the individual's recovery goals, individual's service plan, choice and offer the least restrictive environment necessary to support the member. Shelters, hotels, and similar temporary living arrangements do not meet this expectation.

The Provider Agency is required to coordinate with an individual's treatment team or care coordinator, to participate and support AHP Administrator and other mainstream housing processes including assistance in securing eligibility documentation, attending housing briefings

to ensure tenant understand housing rights, duties and processes, assist in housing search and lease up process help with move in and ongoing requirements (e.g., lease renewal).

Whenever possible, not actively refer or place individuals in a homeless shelter, licensed Supervisory Care Homes, unlicensed board and care homes, or other similar facilities upon discharge from an institutional setting. For individuals enrolled in AHP housing, Provider Agencies shall provide coordination between the housing provider, AHP Administrator, and clinical teams to ensure members receive appropriate wraparound supportive services to ensure housing stability and progress towards case plan goals. This may include delivery of services within the individual's housing placement as appropriate. Ensure coordination of services and housing for all eligible members including those from other systems of care (e.g., Fee for Services) as appropriate to ensure members have access to housing programs and services,

The Provider Agency Shall demonstrate that the provider agency staff and provider housing program staff have received training, demonstrated competency, and utilized evidence-based practices to coordinate housing based supportive services to assist individuals in attaining and maintaining permanent housing placement and retention.

The Provider Agencies shall demonstrate they can capably conduct and utilize any AHCCCS-required current or emerging standardized assessment tool for assessing and documenting housing needs such as the Vulnerability Index-Service Prioritization Decision Assistance Tool (VI-SPDAT) or other AHCCCS approved acuity tool.

The Provider Agency shall participate in the local HUD COC Homeless Management Information System (HMIS), a software application designed to record and store client-level information on the characteristics and service needs of homeless persons. The HMIS is used to coordinate care, manage program operations, and better serve clients. Examples and suggested HMIS coordination requirements are included in the plan contracts, Collaborate with State, County and local government agencies to support homeless and housing initiatives to resolve issues, develop new housing capacity, and address barriers to housing that affect members.

RBHA will monitor housing providers for compliance with the SAMHSA Fidelity Monitoring tool as required. Provision of required housing specific data will require coordination with AHCCCS Housing Administrator.

Develop and make available to the Providers, policies, and procedures regarding specific housing coordination and related requirements and ensure all services including housing supports are provided in a culturally competent manner and do not intentionally or unintentionally discriminate, and work with providers and community to identify new projects for possible SMI HTF application to AHCCCS to expand housing capacity for individuals determined SMI.

It is the responsibility of the Provider Agency to be aware of AHP eligibility requirements and ensure that all members referred for AHP housing are eligible. Provider shall verify eligibility

upon issuance of housing support or renewal of the housing support. Have an established and publish processes verifying eligibility upon issuance of housing support or renewal of the housing support.

SMI ELIGIBILITY DETERMINATION

General Requirements

As per AMPM 320-P Serious Mental Illness Eligibility Determination, this section applies to:

- Members who are referred for, request or have been determined to need an eligibility determination for SMI;
- Members determined to be SMI for whom a review of the determination is indicated; and
- Care1st, subcontracted providers and the AHCCCS Determining Entity (Solari Crisis and Human Services).

All members must be evaluated for SMI eligibility by a qualified assessor (as defined in A.A.C. R9-21-101(B)), and have an SMI determination made by the Solari Crisis and Human Services, if:

- The member requests an SMI determination; or
- A guardian/legal representative who is authorized to consent to inpatient treatment pursuant to A.R.S. 14-5312.01 for the member makes a request on their behalf; or
- An Arizona Superior Court issues an order instructing the person to undergo an SMI evaluation.

The SMI eligibility determination record must include all of the documentation that was considered during the review of the determination as well as any current and/or historical treatment records used in consideration of the determination. All documentation used in consideration of the determination must be maintained in hardcopy or electronic format.

Computation of time is as follows:

- Day Zero: Initial assessment date with a qualified clinician regardless of time of the assessment
- Day One: The next business day after the initial assessment is completed. The initial assessment and all other required documents must be provided to Solari Crisis and Human Services as soon as practicable, but no later than 11:59PM on Day One. The qualified clinician will notify Care1st Care Management that an SMI eligibility application has been submitted.
- Day Three: The third business day after the initial assessment is completed. Solari Crisis and Human Services will complete the final determination no later than Day Three.
- **Determination Due Date:** Three business days after Day Zero, excluding weekends and holidays, and is the date that the determination decision will be rendered. This date is amended if an extension is approved in accordance with Care1st policy.

Process for Completion of the Initial SMI Evaluation

Upon receipt of a referral, request, or identification of the need for an SMI determination, Care1st, Care1st providers, designated Department of Corrections (DOC) or Arizona Department of Juvenile Corrections (ADJC) staff person will schedule an appointment for an initial meeting with the person and a qualified clinician (as per AMPM Policy 950 Credentialing and Re-Credentialing Process). This is to occur no later than 7 days after receiving the request or referral.

During the initial meeting with the person by a qualified assessor, they must:

- Make a clinical assessment whether the member is competent enough to participate in an evaluation;
- Obtain written consent from the person or, if applicable, the member's guardian to conduct an evaluation;
- Provide to the member and, if applicable, the member's guardian, the information required in A.A.C. R9-21-301(D)(2), a client rights brochure, and the appeal notice required by A.A.C. R9-21-401(B); and
- Obtain a release of information for any documentation that would assist in the determination
- Conduct an assessment if one has not been completed within the last six months
- Complete the SMI Determination Form as per AMPM Exhibit 320-P-1 Serious Mental Illness Determination which must be signed and dated by a licensed clinician

Upon completion of the initial evaluation, submit all information to the Determining Entity within one business day.

- Notify Care1st care management of the submission.

If, during the initial meeting with the member, the assessor is unable to obtain sufficient information to determine whether the applicant is SMI, the assessor must:

- Request the additional information in order to make a determination of whether the member is SMI and obtain an authorization for the release of information, if applicable
- Refer the member for a psychiatric evaluation for further diagnostic and functional clarification.

Criteria for SMI Eligibility Determination

The determination of SMI requires both a qualifying SMI diagnosis and functional impairment, or risk of deterioration, as a result of the qualifying diagnosis (see Exhibit 320-P-2, Serious Mental Illness Qualifying Diagnosis).

To meet the functional criteria for SMI status, a member must have, as a result of a qualifying SMI diagnosis, dysfunction in at least one of the following four domains, for most of the past twelve months or for most of the past six months with an expected continued duration of at least six months:

- Inability to live in an independent or family setting without supervision – neglect or disruption of ability to attend to basic needs. Needs assistance in caring for self.
- A risk of serious harm to self or others – seriously disruptive to family and/or community. Pervasively or imminently dangerous to self or others' bodily safety. Regularly engages in assaultive behavior. Has been arrested, incarcerated, hospitalized or at risk of confinement because of dangerous behavior. Persistently neglectful or abusive towards others in the person's care. Severe disruption of daily life due to frequent thoughts of death, suicide, or self-harm, often with behavioral intent and/or plan. Affective disruption causes significant damage to the person's education, livelihood, career, or personal relationships.
- Dysfunction in role performance – frequently disruptive or in trouble at work or at school. Frequently terminated from work or suspended/expelled from school. Major disruption of role functioning. Requires structured or supervised work or school setting. Performance significantly below expectation for cognitive/developmental level. Unable to work, attend school, or meet other developmentally appropriate responsibilities; or
- Risk of Deterioration for SMI Eligibility
    - A qualifying diagnosis with probable chronic, relapsing and remitting course.
    - Co-morbidities (like mental retardation, substance dependence, personality disorders, etc.).
    - Persistent or chronic factors such as social isolation, poverty, extreme chronic stressors (life-threatening or debilitating medical illnesses, victimization, etc.).
    - Other (past psychiatric history; gains in functioning have not solidified or are a result of current compliance only; court-committed; care is complicated and requires multiple providers; etc.).

The following reasons are not sufficient in and of themselves for denial of SMI eligibility:

- An inability to obtain existing records or information; or
- Lack of a face-to-face psychiatric or psychological evaluation.

Member with Co-occurring Substance Use

For members who have a qualifying SMI diagnosis and co-occurring substance abuse, for purposes of SMI determination, presumption of functional impairment is as follows:

- For psychotic diagnoses (bipolar I disorder with psychotic features, delusional disorder, major depression, recurrent, severe, with psychotic features, schizophrenia, schizoaffective disorder and psychotic disorder NOS) functional impairment is presumed to be due to the qualifying psychiatric diagnosis;
- For other major mental disorders (bipolar disorders, major depression and obsessive compulsive disorder), functional impairment is presumed to be due to the psychiatric diagnosis, unless:
    - The severity, frequency, duration or characteristics of symptoms contributing to the functional impairment cannot be attributed to the qualifying mental health diagnosis; or

  - The assessor can demonstrate, based on a historical or prospective period of treatment, that the functional impairment is present only when the person is abusing substances or experiencing symptoms of withdrawal from substances.
- For all other mental disorders not covered above, functional impairment is presumed to be due to the co-occurring substance use unless:
  - The symptoms contributing to the functional impairment cannot be attributed to the substance abuse disorder; or
  - The assessor can demonstrate, based on a historical or prospective period of treatment, that the functional impairment is present only when the individual is actively using substances or experiencing symptoms of withdrawal from substances.

- A diagnosis of substance-induced psychosis can only be made if both of the following conditions are present:
  - There is no psychosis present before a period of substance use that is of sufficient type, duration, and intensity to cause psychotic symptoms, and
  - The psychosis remits complete (not partially) after a period of abstinence of 30 Days or less

Continuation of new onset psychotic symptoms after a 30-Day period of abstinence requires a presumptive diagnosis of a persistent psychotic disorder.

For persistent psychosis of undetermined onset, the absence of clear remission of psychosis during a period of abstinence of 30 Days or less should be considered presumptive evidence of a persistent psychotic disorder for SMI eligibility purposes.

For individuals who are not able to attain or maintain a period of abstinence from substance use, who continue to use substances and/or do not experience consecutive Days of abstinence, this is not a disqualifier to initiate the SMI Eligibility and Determination process. Some individuals will not meet the 30 Day period of abstinence. This does not preclude them from the SMI Eligibility assessment and Determination process.

A Complete SMI Determination Packet Includes:

- Solari Crisis and Human Services Consent for Assessment Form
- SMI Determination Form
- Comprehensive assessment that must be dated within 6 months of the submission- Solari Crisis and Human Services has an example form that may be used
- Psychiatric evaluation or psychiatric evaluation and management visit that addresses the current and recurrent functional impairments, risk of deterioration and qualifying diagnoses of the individual
- Recent hospital records or treatment records demonstrating individual's level of functioning and evidence of deterioration

- Waiver of the Three Day Determination Form- applicants are encouraged to waive their right to a 3 day determination so that Solari Crisis and Human Services can pursue historical treatment records and have additional time to review the requests
- Demographic Form (optional) to assist Solari Crisis and Human Services with contacting the individual and other involved parties during the determination process
- Releases of Information Form for Solari Crisis and Human Services to communicate with emergency contact, family members or prior inpatient and outpatient providers

Submission of the SMI Determination Request

- All requests are submitted through the Solari Crisis and Human Services SMI Provider Submission Portal or by fax (844-611-4752)
- Clinical contact should be the clinician most familiar with the individual's clinical history and who can address the effect of substance use on clinical presentation, if applicable. In most cases this would be the behavioral health medical provider. This contact is used to obtain additional information and if there is a potential denial, to discuss appeal or reconsideration.
- Packets must be complete, dated and signed
- Additional documents can be submitted as updates to the original submission

SMI Eligibility Determination for Inmates in the Department of Correction (DOC)

An SMI eligibility designation/determination is done for purposes of determining eligibility for community-based behavioral health services. The Arizona Department of Health Services (ADHS) recognizes the importance of evaluating and determining the SMI eligibility for inmates in the Department of Corrections (DOC) with impending release dates in order to appropriately coordinate care between the DOC and the community based behavioral health system. Inmates of DOC pending release within 6 months, who have been screened or appear to meet the diagnostic and functional criteria, will now be permitted to be referred for an SMI eligibility evaluation and determination. Inmates of DOC whose release date exceeds 6 months are not eligible to be referred for an SMI eligibility evaluation and determination.

Completion Process of Final SMI Eligibility Determination

The licensed psychiatrist, psychologist, or nurse practitioner designated by Solari Crisis and Human Services must make a final determination as to whether the member meets the eligibility requirements for SMI status based on:

- A face-to-face assessment or reviewing a face-to-face assessment by a Solair Crisis and Human Services qualified assessor (see AMPM Policy 950 Credentialing and Re-Credentialing Processes); and
- A review of current and historical information, if any, obtained orally or in writing by the assessor from collateral sources, and/or present or previous treating clinicians.

The following must occur if the designated reviewing psychiatrist, psychologist, or nurse practitioner has not conducted a face-to-face assessment and has a disagreement with the current

evaluating or treating qualified behavioral health professional or behavioral health technician (that cannot be resolved by oral or written communication):

- Disagreement regarding diagnosis: Determination that the member does not meet eligibility requirements for SMI status must be based on a face-to-face diagnostic evaluation conducted by a designated psychiatrist, psychologist, or nurse practitioner. The resolution of (specific reasons for) the disagreement shall be documented in the person's comprehensive clinical record.
- Disagreement regarding functional impairment: Determination that the member does not meet eligibility requirements must be documented by the psychiatrist, psychologist, or nurse practitioner in the member's comprehensive clinical record to include the specific reasons for the disagreement and will include a clinical review with the qualified clinician.

If there is sufficient information to determine SMI eligibility, the person shall be provided written notice of the SMI eligibility determination within three (3) business days of the initial meeting with the qualified assessor.

Issues Preventing Timely Completion of SMI Eligibility Determination

The time to initiate or complete the SMI eligibility determination may be extended no more than 20 days if the member agrees to the extension and:

- There is substantial difficulty in scheduling a meeting at which all necessary participants can attend;
- The member fails to keep an appointment for assessment, evaluation or any other necessary meeting;
- The member is capable of, but temporarily refuses to cooperate in the preparation of the completion of an assessment or evaluation;
- The member or the member's guardian and/or designated representative requests an extension of time;
- Additional documentation has been requested, but has not yet been received; or
- There is insufficient functional or diagnostic information to determine SMI eligibility within the required time periods.

NOTE: Insufficient diagnostic information is understood to mean that the information available to the reviewer is suggestive of two or more equally likely working diagnoses, only one of which qualifies as SMI, and an additional piece of existing historical information or a face-to-face psychiatric evaluation is likely to support one diagnosis more than the other.

Solari Crisis and Human Services must:

- Document the reasons for the delay in the member's eligibility determination record when there is an administrative or other emergency that will delay the determination of SMI status; and

- Not use the delay as a waiting period before determining SMI status or as a reason for determining that, the member does not meet the criteria for SMI eligibility (because the determination was not made within the time standards).

Notification of SMI Eligibility Determination

1. If the member is determined SMI, the SMI status must be reported to the member or their legal guardian by CRN in writing, including notice of the member's right to appeal the decision (as outlined in ACOM Policy 444).

2. If the eligibility determination results in a denial of a SMI status, Solari Crisis and Human Services will provide written notice of the decision and include:

a. The reason for denial of SMI eligibility (as outlined in AMPM Exhibit 320-P-1),
b. The right to appeal (as outlined in ACOM Policy 414 and ACOM Policy 444), and
c. The statement that Title XIX/XXI eligible members will continue to receive needed Title XIX/XXI covered services. In such cases, the member's behavioral health category assignment must be assigned based on criteria in the AHCCCS Technical Interface Guidelines.

Re-Enrollment or Transfer

If the member's status is SMI at disenrollment or transition to another ACC, TRBHA or Tribal ALTCS, the member's status will continue as SMI. A member will retain their SMI status unless a determination is made by Solari Crisis and Human Services that the member no longer meets criteria.

Review of SMI Eligibility

Care1st care manager, or contracted behavioral health providers may seek a review of a member's SMI eligibility from Solari Crisis and Human Services :

a. As part of an instituted, periodic review of all members determined to have a SMI,
b. When there has been a clinical assessment that supports that the member no longer meets the functional and/or diagnostic criteria, or
c. As requested by a member who has been determined to meet SMI eligibility criteria, or their legally authorized representative.

A review of the determination may not be requested by Care1st or their contracted behavioral health providers within six months from the date a member has been determined SMI eligible.

SMI Decertification

There are two established methods for removing a SMI designation, one clinical and the other an administrative option, as follows:

1. A member who has a SMI designation or an individual from the member's clinical team may request a SMI Clinical Decertification from the AHCCCS designee, which conducts SMI determinations. A SMI Clinical Decertification is a determination that a member who has a SMI designation no longer meets SMI criteria. If, as a result of a

review, the member is determined to no longer meet the diagnostic and/or functional requirements for SMI status:

a. Solari Crisis and Human Services will ensure that written notice of the determination and the right to appeal is provided to the affected member with an effective date of 30 days after the date the written notice is issued,
b. Care1st requires that services are continued in the event an appeal is timely filed, and that services are appropriately transitioned as part of the discharge planning process.

CRISIS INTERVENTION SERVICES

Crisis intervention services are provided to a person for the purpose of stabilizing or preventing a sudden, unanticipated, or potentially dangerous behavioral health condition, episode, or behavior. Crisis intervention services are provided in a variety of settings, such as hospital emergency departments, face-to-face at a person's home, over the telephone, or in the community. These intensive and time limited services may include screening, (e.g., triage and arranging for the provision of additional crisis services) assessing, evaluating, or counseling to stabilize the situation, medication stabilization and monitoring, observation and/or follow-up to verify stabilization, and/or other therapeutic and supportive services to prevent, reduce or eliminate a crisis situation.

At the time behavioral health crisis intervention services are provided, a person's enrollment or eligibility status may not be known. However, crisis intervention services must be provided, regardless of enrollment or eligibility status.

Any person presenting with a behavioral health crisis in the community, regardless of Medicaid eligibility or enrollment status, is eligible for crisis services. Collaboration agreements between Health Plans and local law enforcement/first responders address continuity of services during a crisis, jail diversion and safety, and strengthening relationships between first responders and providers.

Overview of Crisis Intervention Services

To meet the needs of individuals in communities throughout Arizona, The Health Plan provides the following crisis services:

- Telephone crisis intervention services provided by The Health Plan contracted Crisis Call Center available 24 hours per day, seven days a week:
  - Arizona residents can access crisis services by calling the statewide crisis line at 844-534-4673 (HOPE).

- Mobile crisis intervention services, commonly known as Crisis Mobile Teams (CMTs), are available 24 hours a day, seven days a week.
  - If one person CMT responds, this person shall be a Behavioral Health Professional or a Behavioral Health Technician.

  - If a two-person CMT responds, one person may be a Behavioral Health Paraprofessional, including a peer or family member, provided they have supervision and training as currently required for all mobile team members.
  - Peers should comprise 25% of each CMT provider's CMT staff.
- Crisis stabilization/observation services, including detoxification services;
  - The Health Plan provides crisis stabilization and detoxification services through Behavioral Health Inpatient Facilities, Behavioral Health Hospital Facilities, and Substance Abuse Transitional Facilities.
  - Arizona residents can access crisis services by calling the statewide crisis line at 844-534-4673 (HOPE).
- Up to 24 hours of additional crisis stabilization as funding is available for mental health and substance abuse disorder related services.

Management of Crisis Services
The Health Plan maintains availability of crisis services in each county served. The Health Plan utilizes the following in managing crisis services:

- The Health Plan allocates and manages funding to maintain the availability of required crisis services for the entire fiscal year;
- The Health Plan works collaboratively with local hospital-based emergency departments to determine whether a The Health Plan-funded crisis provider should be deployed to such locations for crisis intervention services;
- The Health Plan works collaboratively with local Behavioral Health Inpatient Facilities to determine whether, and for how many hours, such locations are used for crisis observation/stabilization services; and
- When Non-Title XIX/XXI eligible individuals are receiving crisis services and require medication, The Health Plan uses the generic medication formulary identified in the Non-Title XIX/XXI Crisis benefit (see Pharmaceutical Requirements).

The Health Plan seeks to ensure Members receive crisis services on a timely basis and, when appropriate, in their homes and communities. CMTs are available to help Members obtain appropriate crisis services. The Health Plan discourages providers from sending Members to emergency rooms for non-medical reasons.

24-HR URGENT ENGAGEMENT (UE) PROGRAM REQUIREMENTS
Urgent Engagement is the process of engaging people into care who have experienced a crisis and have been admitted to an inpatient facility. It is intended to engage persons into care, rather than fulfilling an administrative function. The process includes ensuring effective coordination of care, engagement, discharge planning, a Serious Mental Illness (SMI) screening when appropriate (reference SMI Eligibility Determination), screening for eligibility, referral as appropriate, and prevention of future crises. Once the Behavioral Health Home completes the UE process, the Behavioral Health Home is the entity that is responsible for coordination of necessary service and discharge planning. Health Homes are required to begin each UE within

24 hours of activation by The Health Plan's Urgent Engagement Team and respond in person or by phone to the requesting Behavioral Health Inpatient Facility.

Behavioral Health Home Urgent Engagement Responsibility
Behavioral Health Homes must accept referrals and requests for Urgent Engagements 24 hours a day and seven days a week. Providers are required to record, report and track completion of Urgent Engagements.

For persons who are not yet enrolled in Medicaid, Block Grant programs or the Marketplace, Behavioral Health Homes are required to continue to pursue coverage for the person.

24-hour Urgent Engagements at a Behavioral Health Inpatient Facility (BHIF)
Every Care1st enrolled or State Only individual who resides in The Health Plan covered service area and meets the requirements (listed below) are eligible for an Urgent Engagement.

- Member is hospitalized at a Behavioral Health Inpatient Facility
- Member is not in active care with a Behavioral Health Home
  The selected Behavioral Health Home has 24-hours to arrive at the facility and complete the Urgent Engagement assessment. In the event the individual is sleeping or otherwise unable to participate in the Urgent Engagement process, the Behavioral Health Home shall reschedule the Urgent Engagement assessment within 24-hours and inform The Health Plan of the status.

Behavioral Health Homes activated by the Urgent Engagement process are required to enroll members and non-eligible members refusing services during the COE (Court Ordered Evaluation) process. Once the member is Court Ordered, the Behavioral Health Home is required to proceed with engagement and service delivery; including, an SMI screening.

The Health Home shall transmit the Urgent Engagement Disposition form to AzCHDISPO@azcompletehealth.com within 24-hours of completing assessment.

24-hour Urgent Engagements at a Physical Health Inpatient Facility
Every Care1st enrolled or State Only individual who resides in The Health Plan covered service area and meets the requirements (listed below) are eligible for an Urgent Engagement.

- Member is hospitalized at a Physical Health Inpatient Facility
- Member is not in active care with a Behavioral Health Home

Behavioral Health Homes are required to arrive at the facility or call and complete the urgent engagement assessment within 24 hours of the request. The Behavioral Health Home shall complete the Urgent Engagement assessment within 24-hours and transmit the Urgent Engagement Disposition form to AzCHDISPO@azcompletehealth.com within 24-hours of completing the assessment. In the event the individual is sleeping or otherwise unable to

participate in the urgent engagement process, the Behavioral Health Home shall reschedule the urgent engagement assessment within 24-hours and inform The Health Plan of the status.

24-hour SMI Evaluation at a Behavioral Health Facility (BHIF)
Every Care1st enrolled or State Only individual who resides in the Health Plan covered service area and meets the requirements (listed below) are eligible for an Urgent Engagement.

- Member is hospitalized at a Behavioral Health Inpatient Facility for psychiatric reasons
- Member is not in active care with a Behavioral Health Home
- Member presents with a need for an SMI evaluation, is eligible to be assessed for an SMI diagnosis.

The Behavioral Health Home shall complete the Urgent Engagement assessment within 24-hours and transmit the Urgent Engagement Disposition form to AzCHDISPO@azcompletehealth.com within 24-hours of completing assessment.

The Behavioral Health Home shall submit the SMI evaluation packet within seven days of the Urgent Engagement assessment to the designated SMI Evaluation provider, Solari.

SMI Evaluation at the Arizona State Hospital (ASH)
The purpose of the SMI evaluation services, for persons from The Health Plan geographic area admitted to ASH, are for discharge planning. The Behavioral Health Home has seven calendar days to complete the assessment and submit the Urgent Engagement Disposition form to AzCHDISPO@azcompletehealth.com within 24-hours.

The Behavioral Health Home shall submit the SMI evaluation packet within seven days of the Urgent Engagement assessment to the designated SMI Evaluation provider, Solari.

Capacity to Travel
Behavioral Health Homes must maintain capacity to travel to locations within Arizona to complete Urgent Engagements. Where travel distance is a barrier, telephonic response is acceptable but not preferred.

Computer and Wireless Specifications

Behavioral Health Homes must verify Urgent Engagement staff have access to a laptop, mobile printer, and wireless web connectivity to allow access to electronic medical information in the field. The computer and wireless specifications meet or exceed The Health Plan requirements.

SECTION VII: Behavioral Health Services

CRISIS LINE PROVIDER PROGRAM REQUIREMENTS

General Requirements for Crisis Line providers

Referrals
Crisis Line providers must comply with the requirements outlined in Provider Manual Section, Substance Use Disorder Treatment Requirements.

After Hours
Crisis Line providers must maintain an administrator–on-call to address any after-hours, weekend or holiday concerns or issues.

Services
Services must be individualized to meet the needs of Members and families. Crisis Line providers must incorporate the Member's perspective on treatment progress. This is to verify that the Member's perspectives are honored, they are effectively engaged in treatment planning, and in the process of care. Crisis Line providers must provide monitoring, feedback, and follow up after the crisis based on the changing needs of the individual. The family must be treated as a unit and included in the treatment process, when determined to be clinically appropriate. Crisis Line providers must obtain and document child, family, and Member input in treatment decisions.

Substance Use Disorders (SUD) Services
Crisis Line providers providing SUD services must develop services that are designed to reduce the intensity, severity and duration of substance use and the number of relapse events, including a focus on life factors that support long-term recovery as appropriate.

Coordination of Care
Crisis Line providers must contact the Behavioral Health Home following a member's utilization of crisis services. Crisis Line providers must verify coordination and continuity within and between service providers and natural supports to resolve initial crisis and to reduce further crisis episodes over time.

Community-Based Alternatives
Crisis Line providers must promote community-based alternatives instead of treatments that remove Members from their family and community. In situations where a more restrictive level of care is temporarily necessary, Crisis Line providers must work with Members to transition back into community-based care settings as rapidly as is clinically feasible and must partner with community provider agencies to develop and offer services that are alternatives to more restrictive facility-based care.

Staff Requirements and Training
All Clinical Supervisors must meet the appropriate Arizona Board of Behavioral Health Examiners requirements to conduct clinical supervision. Crisis Line providers must demonstrate

completion of all Arizona Department Health Services Division of Licensing training requirements are met for all direct care staff. All staff Members must complete an annual training in Cultural Competency and annual Fraud & Abuse Training, and providers must maintain documentation verifying completion of the training. In addition, providers must verify that all staff and family of Members who provide Peer Support or Family Support have adequate training to support them in successfully fulfilling the requirements of their position.

Crisis Line providers must notify The Health Plan of any staff changes or incidents impacting credentialing involving Behavioral Health Professionals or Behavioral Health Medical Professionals within forty-eight (48) business hours of any additions, terminations, or changes.

Quality Improvement
Crisis Line providers must participate in clinical quality improvement activities that are designed to improve outcomes for Arizona Members.

Electronic Health Record (EHR)
Crisis Line providers are highly encouraged to have in place a fully operational EHR; including, electronic signature, and remote access, as required to meet Federal Medicaid and Medicare requirements. In addition, Crisis Line providers must allow State and Health Plan staff access to the EHR for the purpose of conducting audits.

Service Requirements

Crisis Line providers must maintain a twenty-four (24) hours per day, seven (7) days per week crisis response system that has a single toll-free crisis telephone number and additional specialty toll-free numbers or local crisis telephone number. The Crisis Line must:

- Be widely publicized within the covered service area and included prominently on The Health Plan website, the Member Handbook, Member newsletters, and as a listing in the resource directory of local telephone books;
- Be staffed with a sufficient number of staff to manage a telephone crisis response line to comply with the requirements of the Agreement;
- Be answered within three (3) telephone rings, or within 15 seconds on average, with an average call abandonment rate of less than 3% for the month.
- Include triage, referral and dispatch of service providers and patch capabilities to and from 911 and other crisis providers as applicable;
- Offer interpretation or language translation services to persons who do not speak or understand English and for the deaf and hard of hearing; and

Staff Requirements
Crisis Line providers must follow the requirements below:

- Establish and maintain the appropriate ADHS Division of Licensing license to provide required services.

- Maintain appropriate Arizona licensed medical staff, Arizona licensed Behavioral Health Professionals, ADHS Division of Licensing facility licenses, qualified Behavioral Health Technicians and Paraprofessionals, and Peer Support staff to adequately address and triage Member calls and verify the safe and effective resolution of calls.
- Maintain bilingual (Spanish/English) capability on all shifts and employee interpreter services to facilitate crisis telephone counseling for all callers.
- Provide consistent clinical supervision to verify services are in compliance with the Arizona Principles and all ADHS Division of Licensing, and State supervision requirements are met.
- Employ adequate staff to implement the Crisis AfterCare Recovery program.

Telephone Call Response Requirements
Crisis Line providers must verify that all calls for Crisis Mobile Teams are answered within three telephone rings, or within fifteen (15) seconds, as measured by the monthly Average Speed of Answer. All crisis calls must be live answered.

Crisis Line providers must report monthly, quarterly, and annually, all phone access statistics to include: total number of calls received, number and percent abandoned, average speed of answer, and number of calls outside standards. Crisis Line providers must report daily a phone access report that identifies number of calls outside standards, amount of time to answer call for each call outside standards, and number of abandoned calls associated with call outside standards.

Crisis Counseling, Triage, Tracking, Mobile Team Dispatch and Resolution
Crisis Line providers must meet the following requirements:

- Provide crisis counseling, triage and telephonic follow-up 24/7/365. All crisis calls must be live answered. Crisis callers must not receive a prompt, voice mail message, or be placed in a phone queue.
- Provide crisis counseling and triage services to all persons calling The Health Plan Crisis Line, regardless of the caller's eligibility for Medicaid services.
- Review Crisis Plans identified in The Health Plan data system to assist with crisis resolution and suggest appropriate interventions.
- Dispatch mobile team services delivered by provider agencies and must track mobile team intervention resolution in compliance with protocols established or approved by The Health Plan. Crisis Line providers must report on a weekly and monthly basis these dispatches in a format approved by The Health Plan. Daily reports may be required as needed.
- Assess the safety of a crisis scene prior to mobile team dispatch and track mobile teams to monitor the safety of the mobile team staff.
- Follow-up with Members, crisis mobile team staff, Integrated Care Managers, and system partners to verify appropriate follow-up and coordination of care.
- Assess Member dangerousness to self and others and provide appropriate notification to The Health Plan, Behavioral Health Home Health Care Coordinator, and obtain

information on Member's consistent use of medications to minimize dangerousness and promote safety to the Member and community.

- Follow community standards of care and best practice guidelines to warn and protect Members, family members and the community due to threats of violence.
- Document all interactions and triage assessments to facilitate effective crisis resolution and validate interventions.
- Conduct a follow-up call within seventy-two (72) hours to make sure the caller has received the necessary services ensuring at least three attempts to connect by phone for follow up are made. Verify Members are successfully engaged in treatment before closing out the crisis episode and follow-up to verify system partner and Member satisfaction with the care plan.
- Support the Crisis Mobile Teams and arrange for transports, ambulance, etc.
- Provide reports that track and summarize the requests for, daily call statistics report, CMT timeliness report, urgent response report, acute health plan inquiry log, crisis indicator data report, client activity report, and 24 Hour Mobile Urgent Intake requests the disposition of such assessments in a format established or approved by The Health Plan.
- Make reasonable attempts to verify that the dispositions are completed.
- Document and report any delay reasons to The Health Plan in real time for all Urgent Response requests.

Member Outreach, Engagement

Safety Net
Crisis Line providers must serve as a "safety net" to The Health Plan Members by re-engaging Members into treatment, as identified by The Health Plan and per data provided by The Health Plan.

Documentation and Monitoring
Crisis Line providers must document and monitor consistent use of crisis services for persons identified as High Need by The Health Plan, provider agencies or by family report. All High Need situations involving danger to self or others must be staffed immediately with an independent licensed supervisor and the supervision must be documented in the record.

Grievances and Service Gaps
Crisis Line providers must notify The Health Plan through The Health Plan data systems of any service delivery problems, grievances, service gaps and concerns raised by Members, family members, and system partners.

Encounters
Crisis Line providers must encounter and document all services in compliance with the AHCCCS Covered Behavioral Health Service Guide.

SECTION VII: Behavioral Health Services

Quality Improvement
Crisis Line providers must conduct outreach calls to facilitate quality improvement initiatives, as determined by The Health Plan, such as but not limited to the timely completion of Service Plans, use of medications, Health Care Coordinator selection and Member satisfaction, consistent use of treatment services, and frequency of treatment team meetings. Crisis Line providers must participate in satisfaction surveys sponsored by the State and The Health Plan as requested and must conduct satisfaction surveys from reports generated by The Health Plan.

Coordination of Care
Crisis Line providers must facilitate effective coordination of care with provider agency staff to promote effective recovery for Members. Crisis Line providers must track resolution until Member reports being successfully engaged in care and consistently engages in treatment.

Member Assistance and Providing Information
Crisis Line providers must assist Members in getting their prescriptions filled, obtaining services, resolving access to care problems, and obtaining medically necessary transportation services. Crisis Line providers must also refer Members for outpatient services and warm transfer callers to agencies or service providers whenever possible upon completion of the call. Follow up calls shall be made to verify referred caller made and kept appointment. Crisis Line providers must explain to callers the process to access services, authorization process for Behavioral Health Inpatient and Hospital services and provide names and locations of intake agencies accessible to the caller.

Members must be informed about The Health Plan website, Member rights and grievance and appeal procedures as appropriate. Crisis Line providers must assist Members in addressing third party liability and "payer of last resort" issues related to accessing services including pharmacy services.

Crisis Line providers must assist Members in managing their own care, in better understanding their rights, in identifying and accessing resources, and in more effectively directing their care.

Member Eligibility
Crisis Line providers must research Member eligibility for services on behalf of providers and Members and make available eligibility information to callers to assist access to care. Crisis Line providers must make available to Members, family members, and provider agencies treatment information about Evidenced Based Practices and shall assist callers in becoming better informed about services and recovery.

Peer Outreach and Coordination
Crisis Line providers must successfully coordinate services with PFROs; including, Peer Crisis AfterCare Programs, Peer Warm Lines, Peer Community Reentry Programs, and Peer Hospital Discharge Programs.

SECTION VII: Behavioral Health Services

Crisis
Crisis Line providers must participate in all trainings and crisis coordination meetings required or requested by the State and/or The Health Plan. Crisis Line providers must successfully implement a Crisis AfterCare Recovery Team, employing program staff during peak hours Monday through Friday. The Crisis After-Care Recovery Team must conduct outreach, service coordination and crisis stabilization services to Members following mobile crisis team visits, crisis telephone calls, hospitalization, and The Health Plan coordination of care requests. In addition, Crisis Line providers must document coordination efforts in The Health Plan software systems.

Online Scheduling System
Crisis Line providers must participate in and use the selected 24/7 online scheduling system to schedule emergent follow-up appointments and urgent intake assessments with an outpatient provider following a crisis episode.

CRISIS MOBILE TEAM PROVIDER PROGRAM REQUIREMENTS
Crisis Mobile Team providers must provide CMT services in the assigned geographic areas and in accordance to State and The Health Plan requirements.

Supervision by Independently Licensed Behavioral Health Professional
Crisis Mobile Team providers must verify that the Crisis Mobile Team Program is clinically supervised by a The Health Plan Credentialed Independently Licensed Behavioral Health Professional. Crisis Mobile Team providers must verify all Risk Assessments and crisis notes are reviewed and signed off by a The Health Plan Credentialed Independently Licensed Behavioral Health Professional within 24 business hours.

Crisis Mobile Team Provider
Crisis Mobile Team providers must coordinate all services through The Health Plan Crisis Mobile Team provider and follow crisis protocols established by The Health Plan and community stakeholders. Crisis Mobile Team providers must work collaboratively with The Health Plan Crisis Line Provider to receive mobile team dispatches, coordinate all services, and facilitate crisis resolution planning. Crisis Mobile Team providers must report all staffing changes to The Health Plan Network Development Department through the specified deliverable. Crisis Mobile Team providers are required to carry, and use as required, GPS enabled phones provided by crisis line provider. Crisis Mobile Team Agencies are required to have a super-user available within their agency for technical support. GPS phones will enable one number electronic dispatching from the crisis line provider. GPS phones must be kept with crisis mobile team staff on shift at all times. Crisis Mobile Team staff must be trained in appropriate use of the GPS phones. Crisis Mobile Team providers are required to cover the cost of damaged or lost GPS phones as requested by The Health Plan crisis phone provider. If you are assigned a GPS enabled cellular device, it is a condition precedent that you read and sign your specific User Agreement prior to receiving any such cellular device or devices.

Coordination Calls and Coordination with Outpatient Providers
Crisis Mobile Team providers must participate in crisis coordination calls and meetings to facilitate effective working relationships. Crisis Mobile Team providers must verify CMT services are closely linked to the provider's outpatient provider and that coordination of care is occurring with outpatient providers for members who have been in a crisis. If the crisis occurs during business hour, the expectations is that the coordination occurs in real time.

Staffing and Training
Crisis Mobile Team providers must employ adequate staff to consistently meet the requirements for crisis mobile teams. Crisis mobile teams must have the capacity to serve specialty needs of population served including youth and children, Tribal members, and developmentally disabled. Crisis Mobile Team providers must ensure adequate coverage to maintain full crisis team capacity as a result of staff illnesses and vacations. All direct care crisis staff must be Critical Incident Stress Management (CISM) trained. Crisis Mobile Team providers must participate in training events sponsored by The Health Plan and the State to enhance the performance of the crisis system.

Mobile Crisis Vehicles
Crisis Mobile Teams must be able travel to the place where the individual is experiencing the crisis. Crisis Mobile Team providers must provide and maintain mobile crisis vehicles to facilitate transports and field interventions.

Title 36 Screenings
Crisis Mobile Team providers must ensure Title 36 screenings are conducted by staff other than mobile team staff unless The Health Plan holds a contract with the applicable County, in which case the mobile crisis team should follow the requirements specified in that contract. See Pre-Petition Screening.

Telephone and Internet Connectivity
Crisis Mobile Team providers shall be provided GPS enabled cell phones for all crisis staff on duty and must verify effective connectivity. Crisis Mobile Team providers must provide internet and telephone connectivity through cell phone technology to verify staff have the capacity to communicate spontaneously by phone and the internet while in the field. Crisis Mobile Team providers must verify each mobile team has the capability to wirelessly connect and access the electronic medical information in the field as well as email. In addition, Provider must verify the computer and wireless specifications meet or exceed The Health Plan requirements.

Safety
Crisis Mobile Team providers must verify the safety of Members under the care of the Crisis Mobile Team at all times, and verify at-risk Members are monitored and supervised by professional staff in person as long as the person remains a Danger to Self/Danger to Others (DTS/DTO).

14.7.9 Follow Up Care

Crisis Mobile Team providers must record referrals, dispositions, and overall response time. Crisis Mobile Team providers must verify all Members are effectively engaged in follow up care before terminating crisis services.

Services

Crisis Mobile Team assessment and intervention services in the community are available to any person in the county regardless of insurance or enrollment status. Upon dispatch, Crisis Mobile Team response time expectations are as follows: No Crisis Mobile Team response should be greater than 90 minutes; or if the Crisis Mobile Team is presently located in the same town/city as the law enforcement call, the response time will be no greater than 30 minutes; or if the Crisis Mobile Team is not presently located in the same town/city as the law enforcement call, the response time is no greater than 90 minutes

Crisis Mobile Teams must have the ability to assess and provide immediate crisis intervention and make reasonable efforts to stabilize acute psychiatric or behavioral symptoms, evaluate treatment needs, and develop individualized plans to meet the individual's needs. Crisis Mobile Team providers must deliver crisis response, crisis assessment and crisis stabilization services that facilitate resolution, not merely triage and transfer. Crisis Mobile Team providers must initiate and maintain collaboration with fire, law enforcement, emergency medical services, hospital emergency departments, AHCCCS Complete Care Health plans and other providers of public health and safety services to inform them of how to use the crisis response system, to coordinate services and to assess and improve the crisis services.

Tracking

Crisis Mobile Teams must maintain adequate licenses to allow each team to utilize and update The Health Plan Risk Management/High Needs Tracking System to effectively coordinate care for Members in crisis.

CRISIS TRANSPORTATION PROVIDER PROGRAM REQUIREMENTS

Crisis Transportation providers must provide medically necessary transportation services in the assigned geographic areas and in accordance to State and the Health Plan requirements. Crisis Transportation providers must establish and maintain appropriate licenses to provide transportation services identified in the Scope of Work.

Coordination

Crisis Transportation providers must coordinate all services through the Health Plan Crisis Line Provider and follow crisis protocols established by the Health Plan. Crisis Transportation providers must participate in crisis coordination calls and meetings to facilitate effective working relationships as requested.

Staff Requirements

Staffing must consistently meet AHCCCS, the State, ADHS Division of Licensing, and The Health Plan requirements. Crisis Transportation providers must verify staff capacity to meet

availability requirements as identified in provider's contract with The Health Plan. Crisis Transportation providers must maintain appropriately trained, supervised, and ADHS Division of Licensing and AHCCCS qualified transportation professionals to conduct transports.

Crisis Transportation providers must provide consistent supervision to verify services are in compliance with the Arizona Principles, and verify all ADHS Division of Licensing regulations and State supervision requirements are met. In addition, all staff transporting Members must maintain DES Fingerprint Clearance cards and maintain copies in Personnel files.

Training
Crisis Transportation providers must participate in training events sponsored by The Health Plan and the State as requested, and verify staff complete all required trainings and document trainings.

Vehicles and Cell Phones
Crisis Transportation providers must provide and maintain safe, clean and updated vehicles to facilitate transportation. Crisis Transportation providers must provide cell phones for all transportation staff on duty to verify effective connectivity and safety.

Billing and Paperwork
Crisis Transportation providers must bill all medically necessary transportation services utilizing transportation service codes, through the Health Plan's contracted broker/vendor. Crisis Transportation providers must maintain appropriate paperwork in accordance with State and AHCCCS regulations. Crisis Transportation providers must encounter and document all services in compliance with the AHCCCS Covered Behavioral Health Service Guide.

CRISIS STABILIZATION UNITS/23-HR OBSERVATION UNITS

Purpose of Program
To provide facility-based crisis services for the purpose of stabilizing or preventing a sudden, unanticipated, or potentially dangerous behavioral health condition, episode, or behavior. These intensive and time limited services are designed to prevent, reduce, or eliminate a crisis situation and are provided 24 hours a day, 7 days a week.

Services To Be Provided

Health, Risk and Acuity Assessments for Triage
All individuals entering the facility (based on Arizona Division of Licensing approval to accept members) shall have a basic health, risk and acuity screening completed by a qualified behavioral health staff member as defined by ACC R9-10-114. Triage assessments shall be completed within fifteen (15) minutes of an individual's entrance into the facility. Any individual demonstrating an elevated health risk shall be seen by appropriate staff to meet the member's needs.

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Comprehensive Screening and Assessment
Comprehensive screenings and assessments shall be completed on all individuals presenting at the facility to determine the individual's behavioral health needs and immediate medical needs. Assessments are required to be completed by a qualified behavioral health professional as defined by ARS Title 32 and ACC R9-10-101. Screening and assessment services may result in a referral to community services, enrollment in The Health Plan system of care, admittance to crisis stabilization services, or admittance to inpatient services. At minimum, a psychiatric and psychosocial evaluation, diagnosis and treatment for the immediate behavioral crisis shall be provided. Breathalyzer analysis of Blood Alcohol Level and/or specimen collections for suspected drug use may be provided as clinically appropriate.

Crisis Intervention Services
Crisis intervention services (stabilization) is an immediate and unscheduled behavioral health service provided in response to an individual's behavioral health issue, to prevent imminent harm, to stabilize, or resolve an acute behavioral health issue. Crisis stabilization services are able to be provided for a maximum of 23 hours and designed to restore an individual's level of functioning so that the individual might be returned to the community with coordinated follow up services. Services provided include assessment, counseling, intake and enrollment, medical services, nursing services, medication and medication monitoring, and the development of a treatment plan. Discharge planning and coordination of care shall begin immediately upon admission and shall be developed through coordination with the Behavioral Health Home.

Provider Title 36 Emergency Petition
If licensed to provide court ordered evaluation and treatment, the provider shall verify that services and examinations necessary to fulfill the requirements of ARS §36-524 through ARS §36-528 for emergency applications for admission for involuntary evaluation are provided in the least restrictive setting available and possible with the opportunity for the individual to participate in evaluation and treatment on a voluntary basis. Prior to seeking an individual's admission to a Behavioral Health Inpatient Facility for Court Ordered Evaluation (COE) Provider shall make all reasonable attempts to engage the individual in voluntary treatment and discontinue the use of the involuntary evaluation process.

Provider shall verify that staff members are available to provide testimony at Title 36 hearings upon the request of County courts.

Reporting Requirements
Provider shall submit all documents, reports and data in accordance with the Deliverable Schedule noted in the Deliverable Requirements. All deliverables shall be submitted in the format prescribed by The Health Plan and within the time frames specified. Provider is required to submit any additional documents and/or ad hoc reports as requested by The Health Plan.

PARTNERSHIPS WITH FAMILIES AND FAMILY-RUN ORGANIZATIONS IN THE CHILDREN'S BEHAVIORAL HEALTH SYSTEM

Effective Family Participation in Service Planning and Delivery

Through the Child and Family Team (CFT) process, parents/caregivers and youth are treated as full partners in the planning, delivery and evaluation of services and supports. Parents/caregivers and youth are equal partners in the local, regional, tribal and state representing the family perspective as participants in systems transformation. Care1st subcontracted providers must:

- Ensure that families have access to information on the CFT process and have the opportunity to fully participate in all aspects of service planning and delivery.
- Approach services and view the enrolled child in the context of the family rather than isolated in the context of treatment.
- Recognize that families are the primary decision-makers in service planning and delivery.
- Provide culturally and linguistically relevant services that appropriately respond to a family's unique needs.
- Assess the family's need for a family support partner and make family support available to the CFT when requested.
- Provide information to families on how they can contact staff at all levels of the service system
- Work with Care1st to develop training in family engagement and participation, roles and partnerships for provider staff, parents/caregivers, youth and young adults.

Responsibilities of Care1st and Providers

Family members, youth and young adults must be involved in all levels of the behavioral health system, whether it is serving on boards, committees and advisory councils or as employees with meaningful roles within the system. To ensure that family members, youth and young adults are provided with training and information to develop the skills needed, Care1st and its subcontracted providers must:

- Support parents/caregivers, youth and young adults in roles that have influence and authority.
- Establish recruitment, hiring and retention practices for family, youth and young adults within the agency that reflect the cultures and languages of the communities served.
- Provide training for families, youth and young adults in cultural competency.
- Assign resources to promote family, youth and young adult involvement including committing money, space, time, personnel and supplies; and
- Demonstrate a commitment to shared decision making.
- Ensure that service planning and delivery is driven by family members, youth and young adults.

- Support requests for services from family members, youth and young adults that respond to their unique needs, including providing information/educational materials to explore various service options.
- Obtain consent, which allows families, youth and young adults to opt out of some services and choose other appropriate services.
- Provide contact information and allow contact with all levels of personnel within the agency for families, youth and young adults.
- Make a Family Support Partner (FSP) available to the family when requested by the CFT.

Responsibilities of Care1st

- Support family, youth and young adults in roles that have influence and promote shared responsibility and active participation.
- Assign resources to promote family, youth and young adult involvement including committing money, space, time, personnel and supplies;
- Involve parents/caregivers, youth and young adults as partners at all levels of planning and decision making, including delivery of services, program management and funding; and
- Develop and make available to providers, policies and procedures specific to these requirements.

Organizational Commitment to Employment ~~to~~ of Family Members

Care1st subcontracted providers must demonstrate commitment to employment of parents/caregivers, and young adults by:

- Providing positions for parents/caregivers and young adults that value the first person experience.
- Providing compensation that values first-person experience commensurate with professional training.
- Establishing and maintaining a work environment that values the contribution of parents/caregivers, youth and young adults.
- Providing supervision and guidance to support and promote professional growth and development of parent/caregivers and young adults in these roles.
- Providing the flexibility needed to accommodate parents/family members and young adults employed in the system, without compromising expectations to fulfill assigned tasks/roles.
- Promoting tolerance of the family, youth and young adult roles in the workplace.
- Committing to protect the integrity of these roles.
- Developing and making available to providers, policies and procedures specific to these requirements

Adherence Measurements

Adherence to this section will be measured through the use of one or more of the following:

- Analysis of the behavioral health system, including the Annual Network Inventory and Analysis of Family Roles and System of Care Practice Reviews.
- Other sources as required by the AHCCCS/ACC contracts

MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES; INCLUDING, FEDERAL GRANT AND STATE APPROPRIATIONS REQUREMENTS

AHCCCS receives Federal grants and State appropriations to provide services to Non-Title XIX/XXI eligible populations in addition to Federal Medicaid (Title XIX) and the State Children's Health Insurance Program (Title XXI) funding. The federal grants are awarded by a Federal agency, typically by the Substance Abuse and Mental Health Services Administration (SAMHSA), and made available to the State. The Arizona State legislature annually issues appropriations targeting specific needs in the State. The grants and State appropriations may vary significantly from year to year. AHCCCS disburses the grant and State appropriations funding throughout Arizona for the delivery of covered services in accordance with the requirements of the fund source.

The Substance Abuse Block Grant (SABG), the Mental Health Block Grant (MHBG) are annual formula grants authorized by the United States Congress. The Substance Abuse and Mental Health Services Administration (SAMHSA) facilitates these grant awards to states in support of a national system of mental health and substance use disorder prevention and treatment services.

Federal grant funds can be used to provide behavioral health and substance use services to the Non-Title XIX/XXI parent/guardian/custodian of a Title XIX/XXI, Non-Title XIX/XXI, or Title XIX/XXI child/children who is/are at risk of being removed from their home by the Department of Child Safety (DCS) and is/are eligible under the Block Grant SED or SUD eligibility criteria. The grant-funded provider is required to ensure the Non-Title XIX/XXI parents, guardians, or custodians of a child who is at risk of being removed from the family receive the services and supports needed to preserve the family unit and enable the child with SED or SUD to remain in the home. These services should include, but are not limited to, life skills training such as parenting classes, skill building, and anger management. The provider shall adhere to eligibility requirements as specified in Sections of this Provider Manual for eligibility criteria for the MHBG/SABG Grants.

Federal Grant and State Appropriation funding shall not be used to supplant other funding sources; if funds from the Indian Health Services and/or Tribal owned/or operated facilities are available, the IHS/638 funds shall be treated as the payor of last resort.

All the requirements of the SABG and MHBG provisions outlined in The Health Plan Provider Manual apply to SABG and MHBG funded-providers. Many of the service provisions in this section are Best Practices for the delivery of SUD and MHD services and apply to all providers delivering SUD and MHD services to Title XIX/XXI and Non-Title XIX/XXI members, including those providers who do not receive Block Grant or State Appropriation funds.

SECTION VII: Behavioral Health Services

Non-Title XIX/XXI Contracted Provider Requirements (Federal Block Grant and State Appropriation Funds)

Providers receiving Federal Block Grant funds and/or State Appropriation funds are required to use funds for authorized purposes as directed by The Health Plan, account for funds in a manner that permits separate reporting by fund source and track and report expenditures, including unexpended funds. Unexpended or inappropriately used funds are subject to recoupment.

Providers receiving grant and/or State Appropriation funding are required to ensure all members receiving Federal Grant and/or State Appropriation funded services are screened for Title XIX/XXI eligibility at intake and annually, documenting the eligibility screening in the medical record. Providers shall enroll the individual in Non-Title XIX/XXI funded services immediately, while continuing to assist the individual with the processes to determine Title XIX/XXI eligibility. If the individual is deemed eligible for Title XIX/XXI funding, the Member can choose a Contractor and American Indian Members may choose either a Contractor, or AIHP, or a TRBHA if one is available in their area, and receive covered services through that Contractor or AIHP or a TRBHA.

The provider shall work with the Care Coordination teams of all involved Contractors or payers to ensure each Member's continuity of care. Members designated as SMI are enrolled with a RBHA. American Indian Members designated as SMI have the choice to enroll with a TRBHA for their behavioral health assignment if one is available in their area. If a Title XIX/XXI Member loses Title XIX/XXI eligibility while receiving behavioral health services, the provider shall attempt to prevent an interruption in services. The provider shall work with the care coordinators of the Contractor or RBHA in the GSA where the Member is receiving services, or Contractor enrolled or AIHP enrolled Members, or the assigned TRBHA, to determine whether the Member is eligible to continue services through available Non-Title XIX/XXI funding. If the provider does not receive Non-Title XIX/XXI funding, the provider and Member shall work, together to determine where the Member can receive services from a provider that does receive Non-Title XIX/XXI funding. The provider shall then facilitate a transfer of the Member to the identified provider and work with the Care Coordination teams of all involved Contractors or payors.

Providers will be paid for treating Members while payment details between entities are determined. If a Title XIX/XXI Member, whether Contractor or AIHP enrolled, requires Non-Title XIX/XXI services, the provider shall work with the RBHA in the GSA where the Member is receiving services, or the assigned TRBHA, to coordinate the Non-Title XIX/XXI services. Behavioral health providers are required to assist individuals with applying for Arizona Public Programs (Title XIX/XXI, Medicare Savings Programs, Nutrition Assistance, and Cash Assistance), and Medicare Prescription Drug Program (Medicare Part D), including the Medicare Part D "Extra Help with Medicare Prescription Drug Plan Costs" low income subsidy program prior to receiving Non-Title XIX/XXI covered behavioral health services, at the time of intake for behavioral health services.

An individual who is found not eligible for Title XIX/XXI covered services may still be eligible for Non-Title XIX/XXI services. An individual may also be covered under another health insurance plan, including Medicare. Individuals who refuse to participate in the AHCCCS screening/application process are ineligible

for state funded behavioral health services. Refer to A.R.S. §36-3408 and AMPM Policy 650. The following conditions do not constitute an individual's refusal to participate:

- An individual's inability to obtain documentation required for the eligibility determination[MRL1] , and/or;
- An individual is incapable of participating as a result of their mental illness and does not have a legal guardian. Pursuant to the U.S. Attorney General's Order No. 2049–96 (61 Federal Register 45985, August 30, 1996), individuals presenting for and receiving crisis, mental health or SUD treatment services are not required to verify U.S. citizenship/ lawful presence prior to or in order to receive crisis services.

Members can be served through Non-Title XIX funding while awaiting a determination of Title XIX/XXI eligibility. However, upon Title XIX eligibility determination the covered services billed to Non-Title XIX, that are Title XIX covered, will be reversed by the Contractor and charged to Title XIX funding for the retro covered dates of Title XIX eligibility. This does not apply to Title XXI Members, as there is no Prior Period Coverage for these Members.

If there are any barriers to care, the provider shall work with the Care Coordination teams of all involved health plans or payers. If the provider is unable to resolve the issues in a timely manner to ensure the health and safety of the Member, the provider shall contact AHCCCS/DHCM, Clinical Resolutions Unit (CRU). If the provider believes that there are systemic problems, rather than an isolated concern, the provider shall notify AHCCCS/DHCM, CRU of the potential barrier v. AHCCCS will conduct research and work with the Contractors and responsible entities to address or remove the potential barriers.

Providers receiving Non-Title XIX/XXI funds (Federal Block Grant and/or State Appropriation Funds) are required to meet the following additional service delivery and reporting requirements:

- Develop and maintain internal policies and procedures related to the type of funds received. The policies and procedures must meet grant and funding guidelines and be approved by The Health Plan. The policies and procedures are subject to audits by the Health Plan at least annually;
- Ensure grant and state appropriation funds are expended in conformance with grant and/or state appropriation rules;
- Employ and document strategies and monitoring of targeted interventions to improve health outcomes including, but not limited to Social Determinants of Health (SDOH) and National Outcome Measures (NOMS);
- Employ and document the use of and expansion of Evidence Based Practices and Programs (EBPPs) and demonstrate ongoing fidelity;
- Deliver evidence-based services to special populations requiring substance use interventions and supports; including, homeless individuals, individuals with sight limitations, who are deaf or hard of hearing, persons with criminal justice involvement and persons with co-occurring mental health disorders;
- Provide specialized, evidence-based treatment and recovery support services for all populations as contracted;

- Providers of treatment services that include clinical care to those with a SUD shall also be designed to have the capacity and staff expertise to utilize FDA approved medications for the treatment of SUD/OUD and/or have collaborative relationships with other providers for service provision;
- Specific requirements regarding preferential access to services and the timeliness of responding to a Member's identified needs;
- Report program descriptions, service utilization, outreach activities, total enrolled members and similar data upon request to the Health Plan to effectively identify programs available in the community, measure capacity, unmet needs and respond to requests from AHCCCS;
- Treat the family as a unit, admitting women and their children into treatment as appropriate;
- Arrange and coordinate primary medical care for women who are receiving SUD services, including prenatal care;
- Arrange for gender-specific SUD treatment and other therapeutic interventions for women that address issues of relationships, sexual abuse, physical abuse, parenting and childcare while women are receiving services;
- Arrange for childcare while women receive SUD services to facilitate access to care;
- Make available and document continuing education in the delivery of grant or State appropriation funded services or activities (or both, as the case may be) to employees of the facility who provide the services or activities;
- Submit specific data elements and record limited information in the AHCCCS DUGless Portal Guide (Reference: AHCCCS DUGless Portal Gide for requirements).
- Providers are required to comply with AHCCCS demographic requirements, submitting demographic data to AHCCCS through the AHCCCS DUGLess portal. The AHCCCS Demographic & Outcomes Data Set User Guide and describes the minimum required data elements that comprise the demographic data set, in part.

Mental Health Room and Board Funded Through Grants and State Appropriation Funds

Mental Health Room and Board is not a Medicaid reimbursable service. Specialized populations may be eligible to receive Federal grant or State appropriation funding to cover the cost of Mental Health Room and Board. Room and Board includes the provision of lodging and meals to an individual residing in a residential facility or supported independent living setting which may include but is not limited to:

- Housing costs;
- Services such as food and food preparation;
- Personal laundry; and
- Housekeeping.

For providers who own the properties, room and board comprises real estate costs (debt service, maintenance, utilities, and taxes) and food and food preparation, personal laundry, and housekeeping. Room and Board may also be used to report bed hold/home pass days in Behavioral Health Residential facilities.

Room and Board services do not require prior-authorization for payment. Contracted providers are required to verify member eligibility and maintain accurate accounting of expenses and utilization. For room and board services (H0046 SE), the following billing limitations apply:

- All other fund sources (e.g. Arizona Department of Child Safety (DCS) funds for foster care children, SSI) shall be exhausted prior to billing this service; and
- Room and Board services funded by the SABG are limited to children/adolescents with a Substance Use Disorder (SUD), and adult priority population Members (pregnant females, females with dependent child(ren), and people who use drugs by injection with a Substance Use Disorder) to the extent in which funding is available. Room and Board services may be available for a Member's dependent child(ren) as a support service for the Member when they are receiving medically necessary residential treatment services for a SUD. The Room and Board would apply to a Member with dependent children, when the child(ren) reside with the Member at the Behavioral Health Residential Facility. The use of this service is limited to: Members receiving residential services for SUD treatment where the family is being treated as a whole, but the child is not an enrolled Member receiving billable services from the provider.
- Room and Board Services funded by the MHBG are limited to youth with SED qualifying diagnoses.
- Room and Board Services funded through State Appropriation Funds are limited to members meeting eligibility requirements for State Appropriation Funds and requires prior approval by The Health Plan.

Federal Block Grant Specific Requirements

Providers receiving MHBG and/or SABG funds are required to obtain and maintain an Inventory of Behavioral Health Services (I-BHS) number through SAMHSA. Grant funded providers may not discriminate against members receiving services on the basis of religion, a religious belief, a refusal to hold a religious belief, or a refusal to actively participate in a religious practice. If a member objects to the religious nature or religious practice of a provider organization, the provider must give the member the right to a referral to another provider of substance use disorder treatment that provides a service of at least equal value and facilitate the receipt of services from the other provider within seven (7) days of the request or earlier based on the member's condition (see AMPM Policy 320-T1, Attachment A.)

Providers receiving Federal Block Grant funds are required to meet all the applicable requirements outlined in the AHCCCS Policy Manual, AMPM 320 T1-Block Grants and Discretionary Grants and 2 CFR Part 200 ; including demonstrating full knowledge and adherence to the following:

- Member eligibility criteria to receive services through these funding sources;
- Prioritization of funding;
- Federal grant requirements and notifications;
- Prohibited use of the funds;
- Separate reporting, single audit requirements, subaward information; and
- Available services through each funding source.

Providers may not use grant funds, directly or indirectly, to purchase, prescribe, or provide marijuana or treatment using marijuana. Treatment in this context includes the treatment of opioid use disorder. Grant funds also cannot be provided to any individual or organization that provides or permits marijuana use for the purpose of treating substance use or mental disorders. For example, refer to 45 CFR 75.300(a) which

requires Health and Human Services HHS to ensure that federal funding is expended in full accordance with U.S. statutory requirements; and 21 U.S.C. 812(c) (10) and 841 which prohibits the possession, manufacture, sale, purchase, or distribution of marijuana. This prohibition does not apply to those providing such treatment in the context of clinical research permitted by the Drug Enforcement Administration (DEA) and under the Food and Drug Administration (FDA) approved investigational new drug application where the article being evaluated is marijuana or a constituent thereof that is otherwise a banned controlled substance under federal law.

Grant funded providers are required to ensure expenditures are in accordance with 2 CFR Part 200, Grants and Agreements, and ensure compliance with approved indirect cost agreements and/or use of a de minimis rate (Reference: 2 CFR 200.414). The policies and procedures must be comprehensive regarding SABG, MHBG, and other federal grants that include, but are not limited to, a listing of prohibited expenditures, references to the SABG and MHBG FAQs, AMPM 320-T1, Exhibit 300-2b, monitoring and separately reporting of funds by SABG, MHBG and other federal grant funding categories. Provider grant recipients are required to utilize the AHCCCS Federal Grant FAQs document to educate staff about the grants (Reference document: AHCCCS FAQs- Substance Abuse Block Grant (SABG) and Mental Health Block Grant (MHBG).

SUBSTANCE ABUSE BLOCK GRANT (SABG) SPECIFIC REQUIREMENTS – CFDA #93.959

SABG Services and Prioritization

The SABG and SABG Coronavirus Response and Relief Supplemental Appropriations Act (CRRSAA) funds support primary prevention services, early intervention services, and treatment services for persons with substance use disorders. SABG treatment services shall be designed to support the long-term treatment and substance-free recovery needs of eligible Members. The funds are used to plan, implement, and evaluate activities to prevent and treat substance use disorders. Grant funds are also used to provide referral and early intervention services for HIV, tuberculosis disease, hepatitis C and other communicable diseases in high-risk substance users.

The SABG CRRSAA program is designed to provide funds to States, Territories, and one Indian Tribe for the purpose of planning, implementing, and evaluating activities to prevent and treat substance use disorder (SUD). States may use this supplemental COVID-19 Relief funding to:

- Promote effective planning, monitoring, and oversight of efforts to deliver SUD prevention, intervention, treatment, and recovery services; and
- Promote support for providers; and
- Maximize efficiency by leveraging the current infrastructure and capacity; and
- Address local SUD related needs during the COVID-19 pandemic.

The Goals of the SABG include, but are not limited to the following:

- To ensure access to a comprehensive system of care, including employment, housing services, case management, rehabilitation, dental services, and health services, as well as SUD services and supports;
- To promote and increase access to evidence-based practices for treatment to effectively provide information and alternatives to youth and other at-risk populations to prevent the onset of substance use or misuse;
- To ensure specialized, gender-specific, treatment as specified by AHCCCS and recovery support services for females who are pregnant or have dependent children and their families in outpatient/residential treatment settings;
- To ensure access for underserved populations, including youth, residents of rural areas, veterans, Pregnant Women, Women with Dependent Children , People Who Inject Drugs (PWID) and older adults, e. to promote recovery and reduce risks of communicable diseases; and
- To increase accountability through uniform reporting on access, quality, and outcomes of services.

Substance use treatment services shall be available to all eligible Members with a SUD based upon medical necessity and the availability of funds; including youth and adults with Opioid Use Disorders. SABG funds are used to ensure access to treatment and long-term supportive services for the following populations (in order of priority):

- Pregnant individuals/teenagers who use drugs by injection,
- Pregnant individuals/teenagers with a SUD;
- Other persons who use drugs by injection;
- Individuals and teenagers with a SUD, with dependent children and their families, including individuals who are attempting to regain custody of their children; and
- All other individuals with a SUD, regardless of gender or route of use, (as funding is available).

Families involved with DCS who are in need of substance use disorder treatment and are not Title XXI/XXI eligible, can receive services paid for with SABG funds as long as funds are available.

All Members receiving SABG-funded services are required to have a Title XIX/XXI eligibility screening and application completed and documented in the medical record at the time of intake and annually thereafter. Members shall be required to indicate active substance use within the previous 12-months to be eligible for SABG treatment services. This includes individuals who were incarcerated and reported using while incarcerated. The 12-month standard may be waived for individuals on medically necessary methadone maintenance upon assessment for continued necessity, and/or incarcerated for longer than 12 months that indicate opioid use in the 12 months prior to incarceration.

Choice of SABG Substance Use Disorder Providers (Charitable Choice)
Members receiving SUD treatment services under the SABG have the right to receive services from a provider to whose religious character they do not object. Behavioral health providers providing SUD treatment services under the SABG shall notify Members at the time of intake of this right as required in AHCCCS AMPM Policy 320-T1 Attachment A. Providers shall document that the Member has received notice in the Member's medical record. If a Member objects to the religious character of a behavioral health provider, the provider shall refer the Member to an alternate provider within seven days, or earlier when

clinically indicated, after the date of the objection. Upon making such a referral, providers shall notify the RBHAs, of the referral and ensure that the Member makes contact with the alternative provider.

Substance Use Disorder Services and Provider Program Requirements
Substance Use Disorder treatment services must be designed to support the long-term recovery needs of eligible persons and meet the applicable requirements set forth in the Health Plan Provider Manual. Specific requirements apply regarding preferential access to services and the timeliness of responding to a person's identified needs (see Section on Appointment Standards and Timeliness of Service).
Substance Use Disorder treatment programs must include the following minimum core components: outreach, screening, referral, early intervention, case management, relapse prevention, childcare services and continuity of addiction treatment. These are critical components for treatment programs targeting substance-using individuals. In addition, medical providers must be included in the treatment planning process from the initial contact for services to verify continuity and coordination of care. The overall goal in a continuum of comprehensive addiction treatment is improved life functioning and wellbeing, as measured by: an increase in medical wellness and improved psychosocial, spiritual, social and family relationships.

- Additional non-Medicaid reimbursable services available to Title XIX/XXI and Non-Title XIX/XXI members through SABG funding include:

Auricular acupuncture to the pinna, lobe or auditory meatus to treat alcoholism, substance use disorders or chemical dependency by a certified acupuncturist practitioner pursuant to A.R.S. 32-3922

- Mental Health Services (Traditional Healing Services) for mental health or substance use provided by qualified traditional healers. These services include the use of routine or advanced techniques aimed to relieve the emotional distress evident by disruption to the person's functional ability.
- Childcare Services (also referred to as child sitting services): Childcare supportive services are covered when providing medically necessary Medicated Assisted Treatment or outpatient (non-residential) SUD treatment or other supportive services for SUD to Members with dependent children, when the family is being treated as a whole. The following limitations apply:
    - The amount of Childcare services and duration shall not exceed the duration of MAT or Outpatient (non-residential) treatment or support services for SUD being provided to the Member whose child(ren) is present with the Member at the time of receiving services;
    - Childcare services shall ensure the safety and well-being of the child while the Member is receiving services that prevent the child(ren) from being under the direct care or supervision of Member;
    - The child is not an enrolled Member receiving billable services from the provider; and
    - Other means of support for childcare for the children are not readily available or appropriate.
- Supported housing services provided by behavioral health professionals, behavioral health technicians, or behavioral health paraprofessionals, 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 owned or leased by a provider;
- Mental Health Services, Room and Board;

- Other Non-Title XIX/XXI Behavioral Health Services: For Non-Title XIX/XXI eligible populations, most behavioral health services that are covered through Title XIX/XXI funding are also covered through Non-Title XIX/XXI funding including but not limited to: services provided in a residential setting, counseling, case management, and supportive services, but Non-Title XIX/XXI funded services may be restricted to certain Members as described in The Health Plan Provider Manual and as specified in AMPM Exhibit 300-2B, and are not an entitlement.

Services provided through Non-Title XIX/XXI funding are limited by the availability of funds.

Additional SABG Contracted Provider Requirements
The following SABG contracted provider requirements are applicable to all SABG contracted SUD treatment providers:

- Ensure preference is given to pregnant women who are seeking SUD treatment;
- Notify the Health Plan Behavioral Health department immediately when the provider has reached capacity and can no longer accept more pregnant women into the program;
- Arrange interim services within 48 hours of a pregnant woman not being able to be accepted into the program;
- Clearly indicate on program materials that pregnant women are the first priority for referral into the program;
- SABG funded providers are required to maintain service utilization, attendance and capacity records and report the information utilizing the AHCCCS SABG Capacity Management Report template (AMPM 320-T1, Attachment J) as required by AHCCCS;
- Provide HIV Activity Reports, training materials and Ad hoc reports as requested;
- Participate in the annual AHCCCS Independent Case Review process; providing treatment and documentation in compliance with the AHCCCS Substance Abuse Block Grant (SABG) Case File Review Tool
    - SABG treatment providers are required to train and educate provider staff and audit staff performance related to the most recent Case File Review Tool standards; correcting deficiencies to promote ongoing performance improvement. (Reference: AHCCCS Substance Abuse Prevention Case File Review Findings).
    - SABG treatment providers are required to respond timely to record requests to facilitate the annual audit.

Waitlist and Interim Services for Pregnant and Parenting Women/Teenagers and People Who Use Drugs By Injection (Non-Title XIX/XXI only)
BHRF providers serving members with substance use disorders and receiving SABG funding are required to promptly submit information for Priority Population Members (i.e. Pregnant Women/Teenagers, Women/Teenagers with Dependent Children, and People Who Use Drugs by Injection who are waiting for placement in a Behavioral Health Residential Facility (BHRF), to the AHCCCS online Residential Waitlist System. Title XIX/XXI Members may not be added to the Residential Waitlist. Priority Population Members who are not pregnant, parenting women/teenagers, or People Who Use Drugs by Injection shall be added to the Residential Waitlist if the provider is not able to place the Member in a BHRF within the Response Timeframes for Designated Behavioral Health Services as outlined herein. For women/teenagers

who are pregnant, the requirement is within 48 hours, for women with dependent children the requirement is within 5 calendar days and for individuals who use drugs by injection the requirement is within 14 calendar day.

The purpose of interim services is to reduce the adverse health effects of substance use disorders, promote the health of the individual, and reduce the risk of transmission of disease. Interim services must be made available for Non-Title XIX/XXI priority populations who are maintained on an actively managed wait list. Provision of interim services must be documented in the Member's chart as well as reported to the State through the State SABG Waitlist System. The minimum required interim services include education that covers the following:

- Prevention of and types of behaviors which increase the risk of contracting HIV, Hepatitis C, and other sexually transmitted diseases;
- Effects of substance use on fetal development;
- Risk assessment/screening;
- Referrals for HIV, Hepatitis C, and tuberculosis screening and services; and
- Referrals for primary and prenatal medical care.

Provider Program Requirements Related to Gender-Specific Services and SABG Priority Populations and Parents with Children

SABG funded providers are required to disseminate information about Priority Population eligibility by posting and advertising at community provider locations and through strategic methods; including, but not limited to street outreach programs, posters placed in targeted community areas and other locations where pregnant women, women with dependent children, persons who inject drugs, and uninsured or underinsured people with SUD who do not meet eligibility for Title XIX/XXI are likely to attend, in accordance with the specifications in 45 CFR 96.131(a)(1-4). SABG providers shall publicize admission preferences by frequently disseminating information about treatment availability to community-based organizations, healthcare providers, and social services agencies.

Providers shall publicize the availability of gender-based substance use disorder treatment services for pregnant women or women who have dependent children. Publication must include, at minimum, the posting of fliers at each SABG service delivery site notifying pregnant women or women with dependent children of the availability and right to receive substance use disorder treatment services at no cost.

SUD treatment providers serving parents with dependent children shall:

- Deliver the following services as needed: referral for primary medical care for women and primary pediatric care for children; gender-specific substance use treatment; therapeutic interventions for children; and case management and medically-necessary transportation to access medical and pediatric care.
- Eliminate barriers to access treatment through incorporation of childcare, case management and medically-necessary transportation to medical and pediatric care and treatment services.
- Prioritize services available for substance use disorder treatment services for pregnant women pursuant to A.R.S. § 36-141.

Specific goals of women-focused treatment include reducing fetal exposure to alcohol/drugs, verifying a healthy birth outcome as an immediate priority, and addressing issues relevant to women; such as, domestic abuse and violence, demands of child-rearing, vocational and employment skills.

- SUD treatment providers are required to ensure that case management, childcare and transportation do not pose barriers to access to obtaining substance use disorder treatment. Contracted providers with approved funding may bill "Childcare T1009 - for Dependent Children" to provide childcare support services for a member who meets the criteria for SABG funding as defined in the Health Plan Provider Manual and the AMPM 320-T1.

SABG contracted treatment providers must comply with Program Requirements for Pregnant Women and Women with Dependent Children in accordance with this Provider Manual as follows:

- Engage, retain, and treat pregnant women and women with dependent children who request and are in need of substance use disorder treatment.
- Deliver outreach, specialized evidence-based treatment, and recovery support services for pregnant women, women with dependent children or women attempting to regain custody of children.
- Deliver services to the family as a unit and for residential treatment programs, admit both women and their children into treatment.
- Deliver medically necessary covered services to each pregnant individual who requests and is in need of substance use disorder treatment within forty-eight (48) hours of the request.
- Deliver medically necessary covered services for women with dependent children within five (5) days.

SABG Funded Childcare Supportive Services (Amount, Duration, and Scope of SABG Funded Childcare Support Services)

- The amount of services and duration is dependent upon the BHRF or Outpatient (non-residential) treatment or recovery support services for SUD being provided to the member and whose child is present with the member at the time of the treatment. Childcare supportive services are covered when providing medical necessary BHRF or outpatient (non-residential) treatment or other supportive services for SUD to Members with dependent children, when the family is being treated as a whole, the following limitations apply:
    - The amount of Childcare services and duration shall not exceed the duration of BHRF or Outpatient (non-residential) treatment or support services for SUD being provided to the Member whose child(ren) is present with the Member at the time of receiving services;
    - Childcare services shall ensure the safety and well-being of the child while the Member is receiving services, which prevent the child(ren) from being under the direct care or supervision of Member;
    - The child is not an enrolled Member receiving billable services from the provider, and;
    - Other means of support for childcare for the children are not readily available or appropriate.

- The scope of the Childcare Recovery Support Services should be what is necessary to ensure the safety and well-being of the child while the member is in treatment services, which prevent the child(ren) from being under the direct care or supervision of the member.
- The service is to be billed in 15 minute increments not to exceed the amount of time the enrolled member received services.

The use of SABG Funded Childcare Support Services is limited to:

- Enrolled members receiving BHRF or Outpatient (non-residential) treatment or recovery support services for SUD treatment where the family is being treated as a whole, but the child is not an enrolled member receiving billable services from the provider.
- Where other means of supports for childcare for the child are not readily available or appropriate.
- Only Provider Types that provide BHRF or Outpatient (non-residential) SUD treatment or recovery support services are eligible for this service.

Each Provider providing SUD treatment services to parents with Dependent Children shall have policies and procedures that address: informed consent, case management, transportation, facilities, staffing, supervision, monitoring, documentation, service description, safety measures, ages accepted, and schooling/service accessibility to the children. The content of the policies and procedures must be included in the informed consent documentation that must be reviewed and signed by the member acknowledging the potential benefits and risks associated with receiving the Childcare Recovery Support Service as a part of the member's treatment.

Program Requirements for Persons Involved with Injection Drug Use

Providers must engage in evidence-based best practice outreach activities to encourage individuals in need of services to undergo treatment and deliver medically necessary covered services to persons involved with injection drug use who request and are in need of substance use disorder treatment. SABG contracted providers must ensure that each individual who requests, and is in need of treatment for intravenous drug abuse is admitted to a program of such treatment not later than 14 days after making the request for admission to such a program; or 120 days after the date of such request, if no such program has the capacity to admit the individual on the date of such request and if interim services, including referral for prenatal care, are made available to the individual not later than 48 hours after such request. MAT providers must notify the Health Plan when an intravenous drug use program has reached ninety percent (90%) of its capacity. Providers are prohibited from using SABG funds to supply individuals with hypodermic needles or syringes to use illegal drugs.

Human Immunodeficiency Virus (HIV) , Tuberculosis (TB), Hepatitis C and Other Communicable Diseases (Referral, Screening and Early Intervention Services)

SUD treatment providers must refer persons with substance use disorders for HIV, tuberculosis, hepatitis C and other communicable disease screening. In addition, providers must deliver services to persons with HIV in accordance to requirements in this Provider Manual.

Because individuals with substance use disorders are considered at high risk for contracting HIV-related illness, the SABG requires the use of HIV intervention services to reduce the risk of transmission of this disease. SABG funded HIV Early Intervention services are available exclusively to Members receiving substance use disorder treatment. SABG funded HIV services may not be provided to incarcerated populations per 45 CFR 96.135.2.

SUD treatment providers are required to establish linkages with a comprehensive community resource network of related health and social services organizations to ensure a wide-based knowledge of the availability of these services and must provide locations and specified times for Members to access HIV Early Intervention services. Providers shall inform Members of the opportunity to receive HIV education, screenings and early intervention services and facilitate Members' access to the services. Substance use treatment providers must make their facilities available for HIV Early Intervention providers contracted with the Health Plan and verify Members have access to HIV Early intervention services. Providers may contact the Health Plan customer service for assistance in locating and obtaining access to HIV Early Intervention Services.

Requirements for Providers Offering HIV Early Intervention Services

HIV early intervention service providers who accept funding under the SABG must provide HIV testing services. Providers must administer HIV testing services in accordance with the Clinical Laboratory Improvement Amendments (CLIA) requirements, which requires that any agency that performs HIV testing must register with Centers for Medicare and Medicaid (CMS) to obtain CLIA certification. However, agencies may apply for a CLIA Certificate of Waiver, which exempts them from regulatory oversight if they meet certain federal statutory requirements.

Many of the Rapid HIV tests are waived. For a complete list of waived Rapid HIV tests please see (http://www.fda.gov/cdrh/clia/cliawaived.html). Waived rapid HIV tests can be used at many clinical and non-clinical testing sites, including community and outreach settings. Any agency that is performing waived rapid HIV tests is considered a clinical laboratory. Any provider planning to perform waived rapid HIV tests must develop a quality assurance plan, designed to verify any HIV testing will be performed accurately. (See Centers for Disease Control Quality Assurance Guidelines).

HIV early intervention service providers cannot provide HIV testing until they receive a written HIV test order from a licensed medical doctor, in accordance with A.R.S. § 36-470. HIV rapid testing kits must be obtained from the ADHS Office of HIV Prevention.

HIV early intervention providers are required to collect and report early intervention activities to the Health Plan utilizing the AHCCCS SABG HIV Activity Report (AMPM Policy 320-T, Attachment E). In addition, HIV early intervention providers are required to regularly provide education and training to members and staff at SUD treatment facilities; collecting and reporting education and training site visits utilizing the AHCCCS SABG HIV site visit Report (AMPM Policy 320-T, Attachment F).

Contracted HIV early intervention providers are required to administer a minimum of one test per $600 in HIV funding.

SECTION VII: Behavioral Health Services

HIV Education and Pre/Post-Test Counseling
The HIV Prevention Counseling training provided through Arizona Department of Health Services must be completed by all the Health Plan HIV Coordinators, provider staff and provider supervisors whose duties are relevant to HIV services. Staff must successfully complete the training with a passing grade prior to performing HIV testing. HIV education and pre/post-test counseling. The Health Plan HIV Coordinators and provider staff delivering HIV Early Intervention Services for the SABG also must attend an HIV Early Intervention Services Webinar issued by the State on an annual basis, or as indicated by the State. The Webinar will be recorded and made available by the State. New staff assigned to duties pertaining to HIV services must view the Webinar as part of their required training prior to delivering any HIV Early Intervention Services reimbursed by the SABG. HIV early intervention service providers are required to actively participate in regional community planning groups to verify coordination of HIV services.

Reporting Requirements for HIV Early Intervention Services
For every occurrence in which an oral swab rapid test provides a reactive result, a confirmatory blood test must be conducted and the blood sample sent to the Arizona State Lab for confirmatory testing. Therefore, each provider who conducts rapid testing must have capacity to collect blood for confirmatory testing whenever rapid testing is conducted.

The number of the confirmatory lab slip shall be retained and recorded by the provider. This same number will be used for reporting in the Luther data base as required by the CDC. The HIV Early Intervention service provider must establish a Memorandum of Understanding (MOU) with their local County Health Department to define how data and information will be shared. Providers must use the Luther database to submit HIV testing data after each test administered.

Monitoring Requirements for HIV Early Intervention Services
HIV early intervention services providers are required to submit monthly progress reports to the Health Plan. The Health Plan will conduct bi-annual site visits to providers offering HIV Early Intervention Services. The State HIV Coordinator, the Health Plan HIV Coordinator, provider staff, and supervisors relevant to HIV services must be in attendance during site visits. As part of the site visit, provider must make available a budget review and a description/justification for use of the SABG funding.

Oxford House Program Requirements
Providers contracted to provide Oxford House services are required to employ evidence based practices and abide by all approved program description requirements and applicable grant requirements as outlined in The Health Plan Provide Manual and by AHCCCS. Providers are required to maintain processes to demonstrate continuing fidelity to the model. Oxford House providers are required to collect, analyze and report service utilization, outcomes, financial and program data as requested by The Health Plan and AHCCCS; including completing the Oxford House Model Report (AMPM 320-T1, Attachment H) and the Oxford House Financial Report (AMPM 320-T1, Attachment F-1).

SABG Program and Financial Management Policies
SABG contracted providers must establish program and financial management policies and procedures for services funded by the SABG to meet all requirements in the provider agreement, the Provider Manual and the requirements of the Children's Health Act of 2000, P.L. 106-310 Part B of Title XIX of the Public

Health Service Act (42 USC 300 et seq.) and 45 CFR Part 96 as amended. The policies and procedures should include, but are not limited to, a listing of prohibited expenditures, references to the SABG FAQs, monitoring and reporting of funds by priority populations and funding category.

All providers who receive SABG funding are required to submit their SABG Policy and Procedure to the Health Plan annually, each November. As applicable, Procedures should include reporting and monitoring requirements to track encountering of SABG funds and to verify that treatment services are delivered at a level commensurate with funding under the SABG. Providers must submit SABG related program reports. These reports must be submitted in a format prescribed by the Health Plan.

The Health Plan must submit an annual plan regarding outreach activities and coordination efforts with local substance use disorder coalitions. Providers receiving SABG funds are required to provide the Health Plan with requested information to complete the report.

Grant funding is the payor of last resort for Title XIX/XXI behavioral health covered services which have been exhausted (e.g. respite), Non-Title XIX/XXI covered services, and for Non-Title XIX/XXI eligible Members for any services. Grant funding shall not be used to supplant other funding sources, if funds from the Indian Health Services and/or Tribal owned/or operated facilities are available, the IHS/638 funds shall be treated as the payor of last resort. Copayments, or any other fee, are prohibited for the provision of services funded by SABG Block Grants.

Restrictions on the Use of SABG Grant Funds
Providers may not expend SABG funds on the following activities:

- Inpatient hospital services,
- Acute Care or physical health care services including payment of copays, unless otherwise specified for Priority Populations,
- Make cash payments to intended recipients of health services,
- Purchase or improvement of land, purchase, construct, or permanently improve any building or facility except for minor remodeling with written approval from AHCCCS,
- Purchase of major medical equipment,
- To satisfy any requirement for the expenditure of non-federal funds as a condition for the receipt of federal funds,
- Provide financial assistance (grants) to any entity other than a public or nonprofit private entity,
- Provide individuals with hypodermic needles or syringes for illegal drug use, unless the Surgeon General of the Public Health Service determines that a demonstration needle exchange program would be effective in reducing drug use and the risk that the public will become infected with the etiologic agent for Acquired Immune Deficiency Syndrome (AIDS),
- Pay the salary of an individual through a grant or other extramural mechanism at a rate in excess of Level I of the Executive Salary Schedule for the award year, see https://grants.nih.gov/grants/policy/salcap_summary.htm,
- Purchase of treatment services in penal or correctional institutions in the State of Arizona,
- Flex funds purchases, or
- Sponsorship for events and conferences.

ADDITIONAL MENTAL HEALTH BLOCK GRANT (MHBG) CONTRACTED PROVIDER REQUIREMENTS – CFDA #93.958

The MHBG and MHBG Coronavirus Response and Relief Supplemental Appropriations Act (CRRSAA) provides funds to establish or expand an organized community-based system of care for providing Non-Title XIX/XXI mental health services to children with serious emotional disturbances (SED), youth and young adults experiencing First Episode Psychosis (FEP) and adults with a Serious Mental Illness (SMI). MHBG funding may be used to provide Non-Title XIX/XXI services for Title XIX/XXI members meeting the above criteria. The MHBG Block Grant funds are used to: (1) carry out the State plan contained in the federal grant application; (2) evaluate programs and services; and (3) conduct planning, administration, and educational activities related to the provision of services. The goals of the MHBG include, but are not limited to the following:

- Ensuring access to a comprehensive system of care, including employment, housing services, case management, rehabilitation, dental services, and health services, as well as mental health services and supports;
- Promoting participation by consumer/survivors and their families in planning and implementing services and programs, as well as in evaluating State mental health systems;
- Ensuring access for underserved populations, including people who are homeless, residents of rural areas, and older adults;
- Promoting recovery and community integration for adults with SMI and children with SED; and
- Increasing accountability through uniform reporting on access, quality, and outcomes of services.

MHBG CRRSAA is designed to provide comprehensive community mental health services to adults with serious mental illness (SMI) or children with serious emotional disturbance (SED). States may use this supplemental COVID-19 Relief funding to prevent, prepare for, and respond to SMI and SED needs and gaps due to the on-going COVID-19 pandemic. The COVID-19 pandemic has significantly impacted people with mental illness. Public health recommendations, such as social distancing, are necessary to reduce the spread of COVID-19. However, these public health recommendations can at the same time negatively impact those with SMI/SED. The COVID-19 pandemic can increase stress, anxiety, feelings of isolation and loneliness, the use of alcohol or illicit substances, and other symptoms of underlying mental illness.

The MHBG Block Grant requires AHCCCS to maintain a statewide planning council with representation by Members, family members, State employees and providers.

Populations Covered and Prioritization

To be eligible for services under MHBG, Members shall be determined to have an SMI, an SED, or ESMI/FEP. Screenings/assessments may be covered for Non-Title XIX/XXI eligible Members when they are conducted to determine SMI or SED eligibility, for block grant funding regardless of the assessment's determination. Providers are required to verify and document that members indicate active mental health symptoms in the previous 12-months to be eligible for MHBG federal block services.

Other funding sources, such as the State General Fund appropriations for SMI shall be utilized before block grant funding to ensure block grants are the payor of last resort. Refer to AMPM 320-O for additional information on behavioral health assessments and treatment/service planning.

In serving children with SED, youth and young adults experiencing FEP, and adults with SMI, MHBG funds may be used for the following:

- To ensure access to a comprehensive system of care, including employment, housing, case management, rehabilitation, dental, and health services, as well as mental health services and supports;
- To promote participation by Member/survivors and their families in planning and implementing services and programs, as well as in evaluating State mental health systems;
- To verify access for underserved populations, including people who are homeless, residents of rural areas, and older adults;
- To promote recovery and community integration for adults with a SMI youth and young adults experiencing FEP, and children with SED;
- To provide for a system of integrated services to include:
    - Social services;
    - Educational services;
    - Juvenile justice services;
    - Substance use disorder services; and
    - Health and services.
- To provide for training of providers of emergency health services regarding behavioral health.

MHBG Specific Provider Requirements

- MHBG funded providers are required to ensure members receiving services under the MHBG are given access to comprehensive system of care services offered through the Health Plan provider network or community; including, employment, housing services, case management, rehabilitation, dental, health services as well as mental health services;

- MHBG funded providers must account for funds separately; and ensure staff resources are appropriately allocated and employed according to grant requirements; including:
    - Ensuring MHBG funded positions or interventions are not used to fulfill the requirement of other contracts; including Title XIX/XXI contract requirements;
    - Ensuring MHBG funded positions do not simultaneously bill for services, unless specified in the Health Plan award letter.

First Episode Psychosis (FEP) Programs

Providers delivering FEP programs funded through MHBG and Title XIX/XXI funding are required to develop an annual Program Description and Operating Plan and obtain approval of the Plan from the Health Plan and AHCCCS. Once approved the provider must implement the Plan as written and document adherence and performance of the Plan; including, conducting outreach as outlined in the Plan and serving the required number of members outlined in the Plan. The provider must collect, analyze and timely report all data required in the Plan. All FEP programs must be based on Evidence Based Practices approved by

AHCCCS. FEP providers must develop, implement and demonstrate a process to verify ongoing fidelity to the model. FEP providers are required to develop and execute an Annual Community Education and Marketing Plan to educate families, high schools, and institutions of higher learning, first responders and communities about the early signs and symptoms of FEP. The provider is required to document and report educational and marketing efforts; including dates, venues, attendees or recipients training and education. In addition, the FEP provider is required to collect, analyze and report data required in the First Episode Psychosis Program Status Report (See AMPM 320-T1, Attachments C and C-1).

The following are diagnoses that qualify under ESMI/FEP. These are not intended to include conditions that are attributable to the physiologic effects of an SUD, are attributable to an intellectual/developmental disorder, or are attributable to another medical condition:

- Delusional Disorder;
- Brief Psychotic Disorder;
- Schizophreniform Disorder;
- Schizophrenia;
- Schizoaffective Disorder;
- Other specified Schizophrenia Spectrum and Other Psychotic Disorder;
- Unspecified Schizophrenia Spectrum and Other Psychotic Disorder;
- Bipolar and Related Disorders, with psychotic features; and
- Depressive Disorders, with psychotic features.

Members do not have to be or designated as SMI or SED to be eligible for FEP services. Individuals who are accessing FEP MHBG services can be GMH at the beginning, or throughout their FEP episode of care.

Adolescents in Detention

Most adjudicated youth from secure detention do not have community follow-up or supervision, therefore, risk factors remain unaddressed. Youth in juvenile justice systems often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. MHBG services to adolescents in detention is contingent upon funding availability, and Health Plan and AHCCCS approval.

MHBG funded providers may deliver services to Adolescents with SED in detention in accordance to the following requirements:

- Services may only be provided in juvenile detention facilities meeting the description provided by the OJJDP;
- Juvenile detention facilities are used only for temporary and safe custody, are not punitive, and are not correctional or penal institutions.

Services shall be provided:

- Only to voluntary members with SED;

- By qualified BHPs/BHTs/BHPPs;
- Based upon assessed need for SED services;
- Utilizing EBPPs;
- Following an individualized service plan;
- For a therapeutically indicated amount of duration and frequency; and
- With a transition plan completed prior to transfer to a community based provider.

Non-Encounterable MHBG Activities or Positions
Contracted MHBG SED services for outreach activities or positions that are non-encounterable can be an allowable expense, but they shall be tracked, activities monitored, and outcomes collected on how the outreach is getting access to care for those Members with SED.

The use of MHBG SED funds in schools is allowable as long as the following requirements are met:

- Funded positions or interventions cannot be used to fulfill the requirement for the same populations as the funds for Behavioral Health Services for School-Aged Children listed in the Title XIX/XXI Contract;
- Funded positions cannot bill for services provided;
- Funded positions or interventions need to focus on identifying those with SED and getting those who do not qualify for Title XIX/XXI engaged in services through the MHBG; and
- This funding shall be utilized for intervention, not Prevention, meaning that Members who are displaying behaviors that could be signs of SED can be assisted, but MHBG funding shall not be used for general Prevention efforts to children who are not showing any risks of having SED.

Provider Management of MHBG Funds
Providers must comply with all terms, conditions, and requirements of the MHBG including the Children's Health Act of 2000, P.L. 106-310 Part B of Title XIX of the Public Health Service Act (42 U.S.C. 300 et seq.) and 45 CFR Part 96 as amended. Providers must retain documentation of compliance with Federal requirements, and produce upon the Health Plan request, financial, performance, and program data that is subject to audit. These services will be available based upon medical necessity and the availability of funds. Providers must report MHBG and SABG funds and services separately and report or produce information related to block grant expenditures to the Health Plan upon request. Providers must manage the MHBG funds during each fiscal year to make funds available for obligation and expenditure until the end of the fiscal year for which the funds were paid.

Providers must have internal MHBG policies and procedures that should include, but are not limited to, a listing of prohibited expenditures, references to the MHBG FAQs, monitoring and reporting of funds by priority populations and funding category. All providers who receive MHBG funding are required to submit their MHBG Policy and Procedure to the Health Plan annually, each November. Copayments, or any other fee, are prohibited for the provision of services funded by MHBG Block Grants.

Restrictions on the Use of MHBG Block Grant Funds

SECTION VII: Behavioral Health Services

Providers must ensure that MHBG Block Grant funds are not expended on the following activities:

- Inpatient hospital services,
- Acute Care or physical health care services including payment of copays, unless otherwise specified for priority populations,
- Cash payments to intended recipients of health services,
- Purchase or improvement of land, purchase, construct, or permanently improve any building or other facility, except for minor remodeling with written approval from AHCCCS
- Purchase major medical equipment,
- To satisfy any requirement for the expenditure of non-Federal funds as a condition for the receipt of Federal funds,
- Provide financial assistance (grants) to any entity other than a public or nonprofit private entity,
- Provide individuals with hypodermic needles or syringes so for illegal drug use, unless the Surgeon General of the Public Health Service determines that a demonstration needle exchange program would be effective in reducing drug use and the risk that the public will become infected with the etiologic agent for Acquired Immune Deficiency Syndrome (AIDS),
- Pay the salary of an individual through a grant or other extramural mechanism at a rate in excess of Level I of the Executive Salary Schedule for the award year (see National Institutes of Health (NIH) Grants & Funding Salary Cap Summary),
- Purchase treatment services in penal or correctional institutions of the State of Arizona,
- Flex fund purchases,
- Sponsorship for events and conferences,
- Childcare Services.

For Non-TXIX/XXI eligible persons court ordered for DV treatment, the individual can be billed for the DV services (ACOM Policy 423).

State Opioid Response Grant (SOR) - CFDA #93.788

The SOR program aims to address the opioid crisis by increasing access to medication assisted treatment using the three FDA-approved medications including: methadone, buprenorphine products, including single-entity buprenorphine products, buprenorphine/naloxone tablets, films, buccal preparations, long-acting injectable buprenorphine products, buprenorphine implants, and injectable extended-release naltrexone for the treatment of Opioid Use Disorder (OUD). The overarching goal of the SOR project is to increase access to MAT treatment, coordinated and integrated care, opioid use disorder (OUD)/stimulant use disorder recovery support services and prevention activities to reduce the prevalence of OUDs, stimulant use disorder and opioid-related overdose deaths. The grant provides for the provision of prevention, treatment and recovery activities for OUD (including illicit use of prescription opioids, heroin, and fentanyl and fentanyl analogs). This program also supports evidence-based prevention, treatment, and recovery support services to address stimulant misuse and use disorders, including for cocaine and methamphetamine.

Eligible populations are individuals with OUD, stimulant use disorder, and populations at risk for developing either and related behavioral health consequences.

SECTION VII: Behavioral Health Services

SOR Grant funded providers are required to:

- Implement evidence-based treatments, practices, and interventions for OUD and make available FDA-approved MAT to those diagnosed with OUD
- Implement and maintain a robust peer support program and support sustained recovery
- Coordinate with the Health Plan and correctional facilities to sustain and identify early MAT eligible individuals re-entering the community
- Coordinate care with hospitals and emergency departments to facilitate warm handoffs and entry into treatment
- Provide street-based outreach
- Provide or coordinate access to supportive housing services
- Implement FDA-approved MAT for OUD. Medical withdrawal (detoxification) is not the standard of care for OUD, is associated with a very high relapse rate, and significantly increases an individual's risk for opioid overdose and death if opioid use is resumed. Therefore, medical withdrawal (detoxification) when done in isolation is not an evidence-based practice for OUD. If medical withdrawal (detoxification) is performed, it shall be accompanied by injectable extended-release naltrexone to protect such individuals from opioid overdose in relapse and improve treatment outcomes
- Employ effective prevention and recovery support services to ensure that individuals are receiving a comprehensive array of services across the spectrum of prevention, treatment, and recovery
- Implement evidence-based prevention, treatment, and recovery support services to address stimulant misuse and use disorders
- Collect and report outreach activities and treatment data as requested by the Health Plan and/or AHCCCS
- Develop and maintain internal policies and procedures for federal grant tracking, including the SOR grant, which should include, but are not limited to, a listing of prohibited expenditures, monitoring and reporting of funds. All providers who receive SOR funding are required to submit their SOR Policy and Procedure to the Health Plan annually, each November.

Restrictions on the Use of SOR Grant Funds

- Pay the salary of an individual at a rate in excess of Executive Level II. The Executive Level II salary can be found in SAMHSA's standard terms and conditions for all awards at https://www.samhsa.gov/grants/grants-management/notice-award-noa/standard-terms-conditions. This amount reflects an individual's base salary exclusive of fringe and any income that an individual may be permitted to earn outside of the duties to the applicant organization.
- Pay for any lease beyond the project period.
- Pay for the purchase or construction of any building or structure to house any part of the program.
- Provide residential or outpatient treatment services when the facility has not yet been acquired, sited, approved, and met all requirements for human habitation and service provision. (Expansion or enhancement of existing residential services is permissible.)
- Provide detoxification services unless it is part of the transition to MAT with extended-release naltrexone

- Make direct payments to individuals to enter treatment or continue to participate in prevention or treatment services. Note: A recipient or treatment or prevention provider may provide up to $20 non-cash incentive to individuals to participate in required data collection follow-up. This amount may be paid for participation in each required follow up interview.
- Meals are generally unallowable unless they are an integral part of a conference grant or specifically stated as an allowable expense in the FOA. Grant funds may be used for light snacks, not to exceed $3.00 per person.
- Support non-evidence-based treatment.

Non-Title XIX/XXI Services and Funding (Excluding Block Grant and Discretionary Grants)

AHCCCS receives specific appropriations of the general fund for Non-Title XIX/XXI behavioral health services from the Arizona State Legislature. The goals of the funding are:

To ensure access to a comprehensive system of care for children and adults; including

- Employment;
- Housing services;
- Case management;
- Rehabilitation;
- Mental health and substance abuse services and support.

Non-Title XIX/XXI eligible populations include:

- Non-Title XIX/XXI Persons with SMI;
- Non-Title XIX/XXI individuals in the GMH behavioral health category;
- Non-Title XIX/XXI individuals in the SUD behavioral health category.

AHCCCS covers Non-Title XIX/XXI behavioral health services (mental health and/or substance use) within certain limits for Title XIX/XXI and Non-Title XIX/XXI Members when medically necessary. Payment for behavioral health services covered under Non-Title XIX/XXI Funds (excluding federal grants) are limited to providers contracted to deliver the services and subject to availability of funds and the approval of The Health Plan.

- Auricular Acupuncture Services is the application b of auricular acupuncture needles to the pinna, lobe, or auditory meatus to treat mental health, alcoholism, substance use or chemical dependency by a certified acupuncturist practitioner as specified in A.R.S. §32-3922. 2;
- Mental Health Services (Traditional Healing Services) Treatment services for mental health or substance use problems provided by traditional healers;
- Supported Housing services provided by behavioral health professionals, behavioral health technicians, or behavioral health paraprofessionals, 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 owned or leased by a subcontracted provider;
- Mental Health Services, Room and Board;
- Other Non-Title XIX/XXI Behavioral Health Services For Title XIX/XXI Eligible Populations;
- Crisis Services; and
- Assessments for Non-Title XIX/XXI Members when they are conducted to determine SMI eligibility. Non-Title XIX/XXI SMI General Funds may be used for the assessment, regardless of whether the individual is found to have a SMI and includes individuals who are assessed at 17.5 years old and older.

Restrictions on the Use of Non-Title XIX/XXI State Appropriation Funds

Non-Title XIX/XXI Funding may not be utilized for the following:

- Cash payments to members receiving or intending to receive health services;
- Purchase or improvement of land, purchase, construct, or permanently improve any building or facility except for minor remodeling with written approval from AHCCCS;
- Purchase of major medical equipment;
- Flex funds purchases of non-medically necessary services and supports that are not reimbursable or covered under Title XIX/XXI or Non-Title XIX/XXI;
- Sponsorship for events and conferences; or
- Childcare Services.

American Rescue Plan Act (ARPA) Supplemental Block Grant

The American Rescue Plan Act of 2021 (ARPA) provides additional funds to support states through Block Grants to address the effects of the COVID-19 pandemic for Americans with substance use disorders. The COVID-19 pandemic has created health and social inequities in America, including the critical importance of supporting people with substance use disorders. Additionally, societal stress and distress over this newly emerging disaster created the need for nimble and evolving policy and planning in addressing mental and substance use disorder services.

ARPA Substance Abuse Block Grant (SABG)

The substance use disorder (SUD) prevention, intervention, treatment, and recovery support services continuum includes various evidence-based services and supports for individuals, families, and communities. Integral to the SABG are its efforts to support health equity through its priority focus on the provision of SUD prevention, treatment, and recovery support services to identified underserved populations.

These populations include, but are not limited to:

- Pregnant women and women with dependent children,

- Persons who inject drugs,
- Persons using opioids and/or stimulant drugs associated with drug overdoses,
- Persons at risk for HIV, TB, and Hepatitis,
- Persons experiencing homelessness,
- Persons involved in the justice system,
- Persons involved in the child welfare system,
- Black, Indigenous, and People of Color (BIPOC),
- LGBTQ individuals,
- Rural populations,
- Other underserved groups.

ARPA Mental Health Block Grant (MHBG)

Funds must be used for:

- Adults designated to have a serious mental illness (SMI),
- Children determined to have a serious emotional disturbance (SED), and first-episode psychosis (FEP) or early SMI programs.

Funding is focused on supporting behavioral health crisis continuum. An effective statewide crisis system which affords equal access to crisis support that meets needs anytime, anyplace, and for anyone. This includes those living in remote areas and underserved communities as well as youth, older adults, persons of diverse backgrounds, and other marginalized populations; the crisis service continuum will need to be able to equally and adeptly serve everyone.

Refer to Sections for SABG and MHBG for additional block grant requirements.

NON-TITLE XIX/XXI INDIVIDUALS WITH SUDS

The State receives some funding for services through the Federal Substance Abuse Block Grant (SABG). SABG funds are used to provide substance abuse services for Non-Title XIX/XXI eligible persons. As a condition of receiving this funding, certain populations are identified as priorities for the timely receipt of designated services. Any providers contracted with The Health Plan for SABG funds must follow the requirements found in this Section. For all other providers that do not currently receive these funds, the following expectations do not apply. Please refer to section regarding MHBG and State Funding Services for more information.

SABG Block Grant Populations

The following populations are prioritized and covered under the SABG Block Grant:

- First: Pregnant females who use drugs by injection;

- Then: Pregnant females who use substances;
- Then: Other injection drug users;
- Then: Substance-using females with dependent children, including those attempting to regain custody of their child(ren); and
- Finally: All other persons in need of substance abuse treatment.

Response Times for Designated Behavioral Health Services under the SABG Block Grant:

WHEN	WHAT	WHO
Behavioral health services provided within a timeframe indicated by clinical need, but no later than 48 hours from the referral/initial request for services.	Any needed covered behavioral health service, including admission to a residential program if clinically indicated; If a residential program is temporarily unavailable, an attempt shall be made to place the person within another provider agency facility, including those in other geographic service areas. If capacity still does not exist, the person shall be placed on an actively managed wait list and interim services must be provided until the individual is admitted. Interim services include: counseling/education about HIV and Tuberculosis (include the risks of transmission), the risks of needle sharing and referral for HIV and TB treatment services if necessary, counseling on the effects of alcohol/drug use on the fetus and referral for prenatal care.	Pregnant individuals/teenagers referred for substance abuse treatment (includes pregnant injection drug users and pregnant substance abusers) and substance-using females with dependent children, including those attempting to regain custody of their child(ren).
Behavioral health services provided within a timeframe indicated by clinical need but no later than 14 days following the	Includes any needed covered behavioral health services; Admit to a clinically appropriate substance abuse treatment program	All other injection drug users

initial request for services/referral. All subsequent services must be provided within timeframes according to the needs of the person.	(can be residential or outpatient based on the person's clinical needs); if unavailable, interim services must be offered to the person. Interim services shall minimally include education/interventions with regard to HIV and tuberculosis and the risks of needle sharing and must be offered within 48 hours of the request for treatment.	
Behavioral health services provided within a timeframe indicated by clinical need but no later than 23 days following the initial assessment. All subsequent behavioral health services must be provided within timeframes according to the needs of the person.	Includes any needed covered behavioral health services.	All other persons in need of substance abuse treatment

WORKFORCE DEVELOPMENT AND TRAINING REQUIREMENTS

Workforce Development (WFD) All Lines of Business

This following information applies to care providers contracted with Care1st for the Arizona Health Care Cost Containment System (AHCCCS) to include AHCCCS Complete Care (ACC). It discusses the requirements, expectations, and recommendations in developing the workforce. The initiatives align with Workforce Development Policy ACOM 407.

Care1st Workforce Development Operation (WFDO) implements, monitors, and regulates Provider WFD activities and requirements. In addition, Care1st evaluates the impact of the WFD requirements and activities to support Providers in developing a qualified, knowledgeable, and competent workforce.

SECTION VII: Behavioral Health Services

In collaboration with AHCCCS, ACC, and AWFDA's, ensures that all course content is culturally appropriate, has a trauma informed approach and is developed using adult-learning principles and guidelines. Additionally, it is aligned with company guidelines and WFD industry standards, the Substance Abuse and Mental Health Services Administration (SAMHSA) core competencies for WFD, federal and state requirements and the requirements of several agencies, entities, and legal agreements.

Workforce Groups

Arizona Association of Health Plans (AzAHP) unites the companies that provide health care services to the almost two million people that are members of the (AHCCCS). AzAHP supplies assistance and resources to enhance the long-term care workforce through our ALTCS AzAHP Workforce Development Alliance, and they offer valuable training programs through the ACC/RHBA AzAHP Workforce Development Alliance.

Arizona Healthcare Workforce Development Coalition (AHWFDC) is organized by the WFD Department at AHCCCS and includes members from the eight MCOs. This group represents ACC, ALTCS, DCS CHP,
DES/DDD and RBHA lines of business. Together we ensure that initiatives across the state of Arizona align with all lines of business.

AzAHP Workforce Development Alliance (AWFDA) A name given to the WFD Administrators from each Contractor that jointly plan and conduct WFD activities for a particular line of business.

- The **ACC/RBHA AWFDA** includes the WFD Administrators from ACC, RBHA, and CMDP Contractors. In addition to conducting joint WFD planning, the ACC/RBHA/CMDP AWFDA collectively manages the contract between the AzAHP and the Learning Management System (LMS) vendor.

Definitions

Competency is defined as worker's demonstrated ability to perform the basic requirements of a job intentionally, successfully, and efficiently, multiple times, at or near the required standard of performance.

Competency Development is a systematic approach for ensuring that workers are adequately prepared to perform the basic requirements of their jobs. Competency based WFD.

Workforce Capability is the interpersonal, cultural, clinical/medical, and technical competence of the collective workforce or individual worker.

Workforce Capacity is the number of qualified, capable, and culturally representative personnel required to sufficiently deliver services to members.

Workforce Connectivity is 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

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Workforce Development is an approach to improve outcomes by enhancing the knowledge, skills, and competencies of the workforce in order to create, sustain, and retain a viable workforce. It aids in changes to culture, changes to attitudes, and changes to people's potential to influence outcomes.

Training/Compliance Requirements

1. **Prevention of Abuse and Neglect**
    a. The Provider workforce shall have access to and be compliant with all workforce training and/or competency requirements specified in federal and state law, AHCCCS policies, guidance documents, manuals, contracts, plans such as network development, quality improvement, corrective action, etc., and/or special initiatives.
    b. Providers shall have processes for documenting training, verifying the qualifications, skills, and knowledge of personnel; and retaining required training and competency transcripts and records.
2. **Residential Care (24-Hour Care Facilities) Annual Requirements**
    a. Crisis prevention/de-escalation training for all member-facing staff prior to serving members.
    b. For facilities where restraints are approved, a nationally approved restraint training for all member-facing staff. This curriculum should include non-verbal, verbal and physical de-escalation techniques.
3. **Division of Licensing Services (DLS) Required Training**
    a. DLS agencies must be aware of all training requirements to be completed and documented based on all additional licensing or accrediting licensing agencies. This includes the Bureau of Medical Facilities Licensing (BMFL) / Bureau of Residential Facilities Licensing (BRFL), Joint Commission, grant requirements and other entities, as applicable.
4. **Community Service Agencies Community service agencies (CSAs)**
    a. CSAs must submit documentation as part of the first and annual CSA application. The documentation must show that all direct service staff and volunteers have completed CSA training before providing services to members. For a list of all required CSA-specific training, see the AMPM Policy 961-C – Community Service Agencies.

Network Workforce Data Collection

It is the responsibility of the Contractor to produce a Network Workforce Development Plan for each line of business to include ACC. A portion of this data will be supported by the Provider Workforce Development Plan (as applicable to LOB), the ACOM 407 Attachment A Survey, and any additional means that are identified.

ACOM 407, Attachment A Survey

Care1st requires that all contracted provider types listed below complete the ACOM 407 Attachment A Survey annually to fulfill the requirements from ACOM 407. To meet this requirement, all Health Plans and lines of business have collaborated extensively to create a single provider survey that will be

disseminated from one source (AZAHP vs. seven separate surveys being disseminated and duplicated). The survey will remain open for one month for providers to complete.

Provider types include: Nursing Homes, Home Health Agencies, Personal Care Attendant, Group Homes (DD), Adult Day Health, Assisted Living Homes, Homemaker, Attendant Care, Assisted Living Center, Supervisory Care Homes, Respite, Day Programs, Developmental Homes, Employment Programs, Habilitation Provider, In-home Nursing Services, Occupational Therapist, Physical Therapist, Speech/Hearing Therapist, ACC Core Codes, Integrated Clinics, Community Service Agency, Rural Substance Abuse Transitional Agency, Crisis Services Provider, Behavioral Health Residential Facility, Level I Residential Treatment Center – Secure (IMD), Level I Residential Treatment Center – Secure, Level I Residential Treatment Center – Nonsecure (non-IMD), Level I Residential Treatment Center – Nonsecure (IMD), Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), Behavioral Health Outpatient Clinic, and additional BH providers to be considered.

Survey Link: https://form.jotform.com/210889281159162

ADHOC Initiatives

Care1st will promote optional WFD initiatives with ACC Providers that support the growth of business practices, improve member outcomes, and increase the competency of the workforce.

Workforce Development Technical Assistance Needs

The Care1st Workforce Development Administrator is available to provide technical assistance for various workforce development related needs. Technical Assistance needs could include:

- WFDP Guidance
- Recruitment Assistance
- Competency Review
- Workforce Development Goal Review
- Career Path Development
- Training Needs
- Metrics Review
- Relias
- Technology Assistance
- Network Capacity Review
- Cultural Competency
- Diversity/Equity/Inclusion Support
- Community Resources
- Other

For additional information on the Provider Workforce Development Plan (P-WFDP) requirement, training plans and the provider forums, or to discuss technical assistance needs, please reach out to our WFDO.

Behavioral Health (BH) ACC Providers:

Training/Compliance Requirements

Relias Learning Management System (LMS)

The ACC/RBHA AWFDA Providers, under the provider types listed at the link below, ensure that all staff who work in programs that support, oversee, or are paid by the Health Plan contract have access to Relias and are enrolled in the AzAHP Training Plans listed in this addendum. This includes, but is not limited to, full time/part time/on-call, direct care, clinical, medical, administrative, leadership, executive and support staff.

Provider types:

https://azahp.org/azahp/azahp-wfda/resources-2/

Exceptions:

- Any staff member(s) hired for temporary services working less than 90 days is required to complete applicable training at the discretion of the Provider.
- Any staff member(s) hired as an intern is required to complete applicable training at the discretion of the Provider.
- Any Independent Contractor (IC) is required to complete applicable training at the discretion of the Provider.
- Behavioral Health Hospitals
- Federally Qualified Healthcare providers (FQHCs), may request exemption from their contracted Health Plan(s). Exemptions may be granted on a case-by-case basis and will take into account the following: Portion of AHCCCS Members

enrolled in the network and served by that provider, geographic area serviced, and number of other service providers in the surrounding area.
- Housing Providers
- Individually Contracted Practitioners
- Prevention Providers
- Transportation Providers

Agencies must manage and maintain their Relias Learning portal. This includes activating and deactivating users as well as enrollment and disenrollment of courses/events.

To request access to Relias, please contact your Care1st Workforce Development Administrator for further assistance. The request should include the following information:
- Provider Agency Name
- Contract Start Date
- Address
- Key WFD Contact
  - Name
  - Phone Number
  - Email Address
- Contract Type (ACC/RBHA)
- Provider Type (GMH/SU, Children's, Integrated Health Home, etc.)
- Number of Users (# employees at the agency who need Relias access)
- List of Health Plans provider is contracted with (if known)

BH provider agencies with 20 or more users will be required to purchase access to Relias Learning for a one-time fee of $1500 for full-site privileges. A full-site is defined as a site in which the agency may have full control of course customizations and competency development.

Provider agencies with 19 or fewer users will be added to AzAHP Relias Small Provider Portal at no cost with limited-site privileges. A limited-site is defined as one in which the courses and competencies are set-up according to the standard of the plan with no customization or course development provided. Contact workforce@azahp.org to do so.

Provider agencies that expand to 20 or more users will be required to purchase full site privileges to Relias Learning immediately upon expansion.

*Fee is subject to change if a Provider requires additional work beyond a standard sub-portal implementation.

AzAHP Core Training Plans

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AzAHP–Core Training Plan (90 Days)
The Training Plan below is set to auto-enroll all NEW Relias users in your system who have been assigned one (or more) of the 7 Health Plans under the "Plan" field in their user profile. If the employee hired has a previous account under another agency, please ensure that you have their transcripts transferred (there is a job aid available at www.azahp.org).

1. Welcome to Relias (Due within 7 days of hire date)
2. *AHCCCS –Health Plan Fraud (0.75hrs)
3. *AHCCCS –NEO –Rehabilitation Employment (0.5hrs)
4. *AzAHP –AHCCCS 101 (2.0hrs)
5. *AzAHP –Client Rights, Grievances and Appeals (1.25hrs)
6. *AzAHP –Cultural Competency in Health Care (1.0hrs)
7. *AzAHP –Quality of Care Concern (1.0hr)
8. Corporate Compliance: The Basics (0.5hrs)
9. Customer Service (0.5hrs)
10. Ethical Decision Making: The Basics (0.5hrs)
11. Integrating Primary Care with Behavioral Healthcare (1.25hrs)
12. Introduction to HIPAA (0.5hrs)

AzAHP –Core Training Plan (Annual)
The Training Plan below is set to auto-enroll all Relias users in your system who have been assigned one (or more) of the 7 Health Plans under the "Plan" field in their user profile.

1. Personalized Learning: Understanding the HIPAA Regulations Due: January 31st
2. Ethical Decisions Making: The Basics (0.5hrs) Due: March 31st
3. Abuse and Neglect: What to Look For and How to Respond (1.5hrs) Due: April 30th
4. Corporate Compliance: The Basics (0.5hrs) Due: May 31st
5. *AzAHP –Cultural Competency in Health Care (1.0hrs) Due: June 30th
6. *AHCCCS –Health Plan Fraud (0.75hrs) Due: October 31st
7. *AzAHP –Quality of Care Concern (1.0hr) Due: December 31st

Quarterly Reports
The ACC/RBHA AWFDA will run Quarterly Learner/Course Status Reports on the two AzAHP Training Plans: *AzAHP – Core Training Plan (90 Days) & *AzAHP – Core Training Plan (Annual). The goal for Providers is to hold a 90% (or higher) completion rate for this group of courses, within the specified reporting period. Reporting time frames for this initiative are listed below:

- **01/01-03/31 – ACC/RBHA AWFDA will run this report on 4/30**
- **04/01-06/30 – ACC/RBHA AWFDA will run this report on 7/31**
- **07/01- 09/30 – ACC/RBHA AWFDA will run this report on 10/31**
- **10/01-12/31 – ACC/RBHA AWFDA will run this report on 1/31**

If either of those dates falls on a weekend or holiday, the ACC/RBHA AWFDA reserves the right to run the report on the following business day.

Provider agencies falling at 75% or below on the above completion reports will be required to have at least 1 Relias Administrator/Supervisor from their agency complete the course titled: **AzAHP – Navigating & Managing Your Relias Portal*

Provider agencies falling below 90% on the above completion reports may be subject to corrective action and/or sanctions (including suspension, fines or termination of contract) by their contracting Health Plan(s).

General Mental Health (GMSH)/Substance Use (SU)

Staff members completing assessments of substance use disorders and subsequent levels of care must complete the American Society of Addiction Medicine (ASAM) criteria-specific training. This training is required before staff may use the assessment tool with members. They must also complete any approved substance use/abuse course every year. The assessment should align with the most recent ASAM criteria.

Network Workforce Data Collection

Provider Workforce Development Plan (P-WFDP)

The ACC/RBHA AWFDA Providers, under the provider types listed at the link below, complete the annual Provider Workforce Development Plan (P-WFDP).

Provider types:

https://azahp.org/azahp/azahp-wfda/resources-2/

The P-WFDP Template is provided for this deliverable by the ACC/RHBA AWFDA to providers. Due dates for these plans will be determined by the ACC/RHBA AWFDA and communicated to Providers.

Failure to submit your completed annual P-WFDP deliverable by the annual due date may result in corrective action and/or sanctions (including suspension, fines, or termination of contract).

Exceptions to the above include: Behavioral health hospitals, Individual practitioners, prevention and transportation agencies. Federally Qualified Health Centers (FQHCs) may request exemption from their contracted Health Plan(s). Exemptions may be granted on a case-by-case basis and will take into account the following: Portion of AHCCCS members enrolled in the network and served by that provider, geographic area serviced and number of other service providers in the surrounding area.

Miscellaneous

ACC/RBHA AWFDA Provider Forums

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The ACC/RHBA AWFDA consists of representatives from the AzAHP, Relias, and the Workforce Development Administrators from all seven ACC Health Plans. On the second Thursday of each month, the ACC/RBHA AWFDA hosts a virtual provider forum to update the Behavioral Health Network on Workforce Development related issues, training, and Relias. We encourage providers to attend the forums for up to date information on WFD related topics.

PEER/RECOVERY SUPPORT SPECIALIST TRAINING, CREDENTIALING, AND SUPERVISION REQUIREMENTS

Peer/Recovery Support Specialist and Trainer Qualifications
Trainers of Peer and Recovery Support Specialists, and individuals seeking to be credentialed and employed as Peer and Recovery Support Specialists shall:

- Meet the requirements to qualify as a behavioral health paraprofessional, behavioral health technician, or behavioral health professional, and
- Self-identify as an individual who:
    - Is or has been a recipient of behavioral health treatment for mental health disorders, substance use disorders, and/or other traumas associated with significant life disruption, and
    - Has an experience of recovery to share.

Individuals meeting the above criteria may be credentialed as a Peer/Recovery Support Specialist by completing training and passing a competency test with a minimum score of 80% through an AHCCCS/OIFA approved Peer Support Employment Training Program. AHCCCS/OIFA will oversee the approval of all credentialing materials including curriculum and testing tools. Individuals are credentialed by the agency in which he/she completed the Peer Support Employment Training Program; however, credentialing through an AHCCCS/OIFA approved Peer Support Employment Training Program is applicable statewide, regardless of which program a person has gone through for credentialing.

Some agencies may wish to employ individuals prior to the completion of credentialing through a Peer Support Employment Training Program however, an individual must be credentialed as a Peer Support Specialist/Recovery Support Specialist under the supervision of a qualified individual prior to billing Peer Support Services.

Peer Support Employment Training Program Approval Process
A Peer Support Employment Training Program must submit their program curriculum, competency exam, and exam scoring methodology (including an explanation of accommodations or alternative formats of program materials available to individuals who have special needs) to AHCCCS/DCIAR OIFA, and AHCCCS/DCIAR OIFA will issue feedback or approval of the curriculum, competency exam and exam scoring methodology in accordance with Peer Support Employment Training Curriculum Standards.

If a program makes substantial changes (meaning change to content, classroom time, etc.) to their curriculum or if there is an addition to required elements the program must submit the updated content to AHCCCS/OIFA for review and approval. AHCCCS/OFIA will base approval of the curriculum, competency exam and exam scoring methodology only on the elements included in this updated content. If a Peer Support Employment Training Program requires regional or culturally specific training exclusive to a GSA or tribal community, the specific training cannot prevent employment or transfer of Peer Support Specialist/Recovery Support Specialist approval based on additional elements or standards.

Competency Exam

Individuals seeking credentialing and employment as a Peer/Recovery Support Specialist must pass a competency exam with a minimum score of 80% upon completion of required training. Each Peer Support Employment Training Program has the authority to develop a unique competency exam. However, all exams must include at least one question related to each of the curriculum core elements listed in Subsection H of Peer Support Employment Training Curriculum Standards. If an individual does not pass the competency exam, the Peer Support Employment Training Program may require that the peer repeat or complete additional training prior to taking the competency exam again. For individuals certified in another state, credentials must be sent to AHCCCS/DCAIR OIFA, via email at oifa@azahcccs.gov. The individual must demonstrate their state's credentialing standards meet those of CMS's requirements prior to recognition of their credential.

Peer Support Employment Training Curriculum Standards

A Peer Support Employment Training Program curriculum must include the following core elements:

a. Concepts of Hope and Recovery
   i. Instilling the belief that recovery is real and possible,
   ii. The history of the recovery movement and the varied ways that behavioral health issues have been viewed and treated over time and in the present,
   iii. Knowing and sharing one's story of a recovery journey and how one's story can assist others in many ways,
   iv. Mind-Body-Spirit connection and holistic approach to recovery, and
   v. Overview of the Individual Service Plan (ISP) and its purpose.

b. Advocacy and Systems Perspective
   i. Overview of state and national behavioral health system infrastructure and the history of Arizona's behavioral health system,
   ii. Stigma and effective stigma reduction strategies: countering self-stigma; role modeling recovery and valuing the lived experience,

iii. Introduction to organizational change - how to utilize person-first language and energize one's agency around recovery, hope, and the value of peer support,
iv. Creating a sense of community; creating a safe and supportive environment.
v. Forms of advocacy and effective strategies – consumer rights and navigating the behavioral health system, and
vi. Introduction to the Americans with Disabilities Act (ADA).

c. Psychiatric Rehabilitation Skills and Service Delivery

i. Strengths based approach; identifying one's own strengths and helping others identify theirs; building resilience,
ii. Distinguishing between sympathy and empathy, emotional intelligence,
iii. Understanding learned helplessness; what it is, how it is taught and how to assist others in overcoming its effects,
iv. Introduction to motivational interviewing; communication skills and active listening,
v. Healing relationships – building trust and creating mutual responsibility,
vi. Combating negative self-talk: noticing patterns and replacing negative statements about one's self; using mindfulness to gain self-confidence and relieve stress,
vii. Group facilitation skills, and
viii. Introduction to Culturally & Linguistically Appropriate Services (CLAS) Standards. The role of culture in recovery.

d. Professional Responsibilities of the Peer Support Employee and Self Care in the Workplace

i. Professional boundaries and ethics - the varied roles of the helping professional, collaborative supervision and the unique role of the Peer/Recovery Support Specialist,
ii. Confidentiality laws and information sharing – understanding the Health Insurance Portability and Accountability Act (HIPAA),
iii. Responsibilities of a mandatory reporter; what to report and when,
iv. Understanding common signs and experiences of mental illness, substance abuse, addiction and trauma, orientation to commonly used medications and potential side effects,
v. Guidance on proper service documentation, billing and using recovery language throughout documentation,
vi. Self-care skills and coping practices for helping professionals, the importance of ongoing supports for overcoming stress in the workplace, resources to promote personal resilience; and,

understanding burnout and using self-awareness to prevent compassion fatigue, vicarious trauma and secondary traumatic stress.

a. Qualified peers must receive training on all of the elements listed above prior to delivering any covered healthcare services.

Peer support employment training programs must not duplicate training required of peers for employment with a licensed agency or Community Service Agency (CSA). Training elements in this section must be specific to the peer role in the public healthcare system and instructional for peer interactions.

Continuing Education and Ongoing Learning
It is required that individuals employed as Peer/Recovery Support Specialists complete a minimum of 2 hours of Continuing Education and Ongoing Learning each calendar year. Access to training relative to Peer/Recovery Support can be obtained by contacting Care1st's Individual and Family Affairs Department via email at oifa@care1staz.com, and the health plan has designated our Manager of Individual and Family Affairs Debra Jorgensen as SME regarding Peer Support Employment Training. The Manager of Individual and Family Affairs is authorized to request a review of any contracted providers' curriculum they are using to credential their Peer/Recovery Supports. It is expected that all requested material will be provided within 14 calendar days of the request.

Supervision of Peer/Recovery Support Specialists
Supervision is intended to provide support to Peer/Recovery Support Specialists in meeting the needs of members receiving Peer/Recovery Support. Supervision provides an opportunity for growth within the agency and encouragement of recovery efforts.

Agencies employing Peer/Recovery Support Specialists must have a qualified individual (behavioral health professional (BHP) or behavioral health technician (BHT)) level staff member designated to provide Peer/Recovery Support Specialist supervision. Supervision must be appropriate to the services being delivered, documented, and inclusive of both clinical and administrative supervision.

Individuals providing supervision must receive training and guidance to ensure current knowledge of Evidence Based Practices in providing supervision to Peer/Recover Support Specialists.

Process for Submitting Evidence of Credentialing
Agencies employing Peer/Recovery Support Specialists who are providing peer support services are responsible for keeping up to date records of required qualifications and credentialing for these individuals. Care1st will ensure through audits that Peer/Recovery Support Specialists meet qualifications and have credentialing, as described in this section.

PARENT/FAMILY SUPPORT PROVIDER TRAINING, CREDENTIALING, AND SUPERVISION REQUIREMENTS

Peer/Recovery Support Specialist and Trainer Qualifications

1. Children's System
   a. Individuals seeking certification and employment as a Parent/Family Support Provider or Trainer in the children's system must:
      i. Be a parent or primary caregiver with lived experience who has raised or is currently raising a child with emotional, behavioral, mental health or substance use disorder needs; and
      ii. Meet the requirements to function as a behavioral health professional, behavioral health technician, or behavioral health paraprofessional.
2. Adult System
   a. Individuals seeking certification and employment as a Parent/Family Support Provider or Trainer in the adult system must:
      i. Have lived experience as a primary natural support for an adult with emotional, behavioral, mental health or substance use disorder needs; and
      ii. Meet the requirements to function as a behavioral health professional, behavioral health technician, or behavioral health paraprofessional.

Individuals meeting the above criteria may be certified as a Parent/Family Support Specialist by completing training and passing a competency test through an AHCCCS/OIFA approved Parent/Family Support Training Program. AHCCCS/OIFA will oversee the approval of all certification materials including curriculum and testing tools. Certification through AHCCCS/OIFA approved Parent/Family Support Employment Training Program is applicable statewide.

Credentialed Parent/Family Support Provider Training Program Approval Process

A Parent/Family Support Provider Training Program must submit their program curriculum, competency exam, and exam-scoring methodology (including an explanation of accommodations or alternative formats of program materials available to individuals who have special needs) to AHCCCS/OIFA. AHCCCS/OIFA will issue feedback or approval of the curriculum, competency exam, and exam-scoring methodology.

Approval of curriculum is binding for no longer than three years. Three years after initial approval and thereafter, the program must resubmit their curriculum for review and re-approval.

- If a program makes substantial changes (meaning change to content, classroom time, etc.) to their curriculum or if there is an addition to required elements during this three-year period, the program must submit the updated content to AHCCCS/OIFA for review and approval no less than 60 days before the changed or updated curriculum is to be utilized.

AHCCCS/OIFA will base approval of the curriculum, competency exam, and exam-scoring methodology only on the elements included in this policy. If a Parent/Family Support Provider Training Program requires regional or culturally specific training exclusive to a GSA or specific population, the specific training cannot prevent employment or transfer of family support certification based on the additional elements or standards

Competency Exam

Individuals seeking certification and employment as a Parent/Family Support Provider must complete and pass a competency exam with a minimum score of 80% upon completion of required training. Each Parent/Family Support Provider Training Program has the authority to develop a unique competency exam. However, all exams must include questions related to each of the curriculum core elements listed next. Agencies employing Parent/Family Support Providers who are providing family support services are required to ensure that their employees are competently trained to work with their population.

Individuals certified or credentialed in another state must submit their credential to AHCCCS/OIFA. The individual must demonstrate their state's credentialing standards meet those of AHCCCS prior to recognition of their credential. If that individual's credential/certification doesn't meet Arizona's standard the individual may obtain certification after passing a competency exam. If an individual does not pass the competency exam, the Parent/Family Support Provider Training Program shall require that the individual complete additional training prior to taking the competency exam again.

Credentialed Parent/Family Support Provider Employment Training Curriculum Standards

a. Communication Techniques:
   i. Person first, strengths-based language; using respectful communication; demonstrating care and commitment;
   ii. Active listening skills: The ability to demonstrate empathy, provide empathetic responses and differentiate between sympathy and empathy; listening non-judgmentally;
   iii. Using self-disclosure effectively; sharing one's story when appropriate.

b. System Knowledge:

i. Overview and history of the Arizona Behavioral Health System: Jason K., Arizona Vision and 12 Principles and the Child and Family Team (CFT) process; Guiding Principles for Recovery-Oriented Adult Behavioral Health Services and Systems, Adult Recovery Team (ART), and Arnold v. Sarn; Introduction to the Americans with Disabilities Act (ADA); funding sources for behavioral health systems,
ii. Overview and history of the family and peer movements; the role of advocacy in systems transformation,
iii. Rights of the caregiver/enrolled member
iv. Transition Aged Youth: Role changes when bridging the Adult System of Care (ASOC) and Children's System of Care (CSOC) at transition for an enrolled member, family and Team.

c. Building Collaborative Partnerships and Relationships:
i. Engagement; Identifies and utilizes strengths;
ii. Utilize and model conflict resolution skills, and problem solving skills,
iii. Understanding individual and family culture; biases; perceptions; system's cultures;
iv. The ability to identify, build and connect individuals and families, including families of choice to natural, community and informal supports;

d. Empowerment:
i. Empower family members and other supports to identify their needs, and promote self-reliance,
ii. Identify and understand stages of change and
iii. Be able to identify unmet needs.

e. Wellness:
i. Understanding the stages of grief and loss; and
ii. Understanding self-care and stress management;
iii. Understanding compassion fatigue, burnout, and trauma;
iv. Resiliency and recovery;
v. Healthy personal and professional boundaries.

Some curriculum elements may include concepts that are part of AMPM/ACOM policies and the Behavioral Health Practice Tool on Unique Needs of Children, Youth and Families Involved with Department of Children's Services. Credentialed Parent/Family Support Provider training programs must not duplicate training required of individuals for employment with a licensed agency or Community Service Agency (CSA). Training elements in this section must be specific to the Family Support role in the public behavioral health system and instructional for family support interactions.

Supervision of Credentialed Parent/Family Support Provider

Agencies employing Parent/Family Support Providers must provide supervision by individuals qualified as Behavioral Health Technicians or Behavioral Health Professionals. Supervision must be appropriate to the services being delivered and the

qualifications of the Parent/Family Support Provider as a Behavioral Health Technician, Behavioral Health Professional, or Behavioral Health Paraprofessional. Supervision must be documented and inclusive of both clinical and administrative supervision.

Individuals providing supervision must receive training and guidance to ensure current knowledge of best practices in providing supervision to Parent/Family Support Providers

Process for Submitting Evidence of Credentialing
Agencies employing Credentialed Parent/Family Support Providers who are providing family support services are responsible for keeping up to date records of required qualifications and credentialing for these individuals. Care1st will ensure through audits that Credentialed Parent/Family Support Providers meet qualifications and have credentialing, as described in this section.

TELEPHONIC CONSULTATION SERVICES

A Care1st psychiatrist may provide a telephonic psychiatric consultation for PCPs who have diagnostic or treatment concerns or questions of a general nature. The PCP initiates this type of consult by calling Member Services Line and requesting a general psychiatric consultation.

FACE-TO-FACE CONSULTATION SERVICES

A PCP can arrange for a member to have a face-to-face consultation with a Care1st psychiatrist if clinically indicated. The expectation is that the PCP will continue to manage the member's psychotropic medications following the consultation if deemed appropriate. The member must have been seen by the PCP prior to requesting this type of consultation. The PCP may use the Behavioral Health Services Referral Form and check the "One Time Consultation" box for assistance in referring the member for consultation.

COORDINATION OF CARE

In addition to treating physical health conditions, PCPs are able to treat behavioral health conditions within their scope of practice. For purposes of medication management, it is not required that the PCP be the member's assigned PCP. PCPs who treat members with behavioral health conditions may provide medication management services including prescriptions, laboratory and other diagnostic tests necessary for diagnosis and treatment. A member who is receiving medication management services from the PCP can also receive non-medication management services (i.e. counseling) through the behavioral health system, assuming there is close coordination of care and regular communication between the PCP and the behavioral health provider.

SECTION VII: Behavioral Health Services

Close coordination of care and regular communication between the PCP and the behavioral health provider is essential. AHCCCS requires PCPs to respond to a behavioral health provider's requests for information within 10 business days of receiving the request. The response should include all pertinent clinical information regarding diagnoses, medication, laboratory results, last PCP visit and any recent hospitalizations.

Conversely, relevant behavioral health information from a behavioral health provider should be forwarded to a member's PCP at the initiation of treatment, periodically during ongoing treatment, in response to sentinel events such as a suicide attempt or a psychiatric hospital admission, and upon discharge from behavioral health services. PCPs must document or initial signifying review of a member's behavioral health information when received from a behavioral health provider. PCPs are responsible for establishing a detailed and comprehensive medical record. Medical records will be maintained in a manner, which conforms to professional standards, complies with records retention requirements, and permits effective medical review and audit processes, and which facilitates an adequate system for follow up treatment. The maintenance of medical records are documented accurately and in a timely manner, are readily accessible, and permit prompt and systematic retrieval of information and which comply with AMPM Policy 940 and AMPM Policy 550. Providers are to maintain and share a member health record in accordance with professional standards [42 CFR 457.1230(c), 42 CFR 438.208(b)(5)].

When a PCP receives behavioral health information, a medical record will be established even if the PCP has not yet seen the assigned member. In lieu of actually establishing a medical record, such information may be kept temporarily in an appropriately labeled file but must be associated with the member's medical record as soon as one is established.

TRANSFER OF CARE

Transition from PCP to Behavior Health Provider

A transfer of care referral should be initiated from the PCP to a behavioral health provider for evaluation and continued medication management services when the member has not responded to treatment within six months, has experienced an acute increase in the severity of symptoms, or has presented with additional behavioral health symptoms that are outside of the scope of practice of the PCP. Transfer of care to behavioral health should also occur following a sentinel event, such as a suicide attempt or psychiatric hospitalization, when there are co-morbid emotional, physical, sexual or substance abuse issues or at the member's request.

PCPs should use the Behavioral Health Services Referral Form, check the "Ongoing Behavioral Health Services" box, and fax to Care1st when transferring a member's care to a behavioral health provider. The referral form includes a "Reason for Referral" section where the PCP describes the reason for transfer, including all diagnostic information. Current psychotropic medications should be listed under "Additional Information" and the PCP should designate whether the member has an adequate supply of these medications

for the next 30 days. If not, the timeframes for dispensing and refilling medications during the transition period should be noted.

The PCP must ensure that a member has access to sufficient medication, by prescription or refill, until their first appointment with the behavioral health provider who will be continuing medication management services. PCPs may use the Pharmacy Prior Authorization Form located on our website under the Forms section of the Provider menu to request interim or "bridge" medication for the member until their first behavioral health medication appointment.

When a member attends the behavioral health intake appointment, the behavioral health provider may request medical records if clinically indicated. The behavioral health provider will fill out a request for medical records, have the member sign a release of information and fax or mail the request to the PCP. Upon receipt of a request for medical records or for additional medical information, the PCP must respond within 10 business days to ensure all pertinent information is received by the behavioral health provider prior to the member's first scheduled appointment with the behavioral health provider. This response should include all pertinent information regarding the reason for transfer, current diagnoses and medications, laboratory results, medication history, last date psychotropic medication was prescribed, last PCP visit and any recent hospitalizations.

Confidential medical records that are mailed to the behavioral health provider should be marked confidential and sealed appropriately. When medical records are faxed to the behavioral health provider, they are received on a confidential fax line and delivered directly to the assigned clinician and/or prescriber. Every precaution should be taken by the PCPs office staff to ensure the confidentiality of a member's medical record.

Note: A release of information from the member is required for any communication regarding substance abuse or HIV treatment.

Continuity of care is vital when transferring a member's behavioral health care from the PCP to a behavioral health provider, so PCPs are encouraged to call Care1st's Care Management Team to assist in the transition process. The Care Management Team will contact the member (or the member's parent or legal guardian) to verify that a behavioral health intake and medication appointment has been scheduled with the behavioral health provider. The care manager will discuss any member concerns regarding the transfer of care, confirm that sufficient medication is available, and if not, assist the member in obtaining a prescription for the required medication. After the intake and medication appointment has been scheduled, a follow up call will be made to the member and the behavioral health provider within 30 days to confirm that behavioral health services are in place. The member's behavioral health disposition will then be reported to their PCP by phone and/or fax.

Transfer from Behavioral Health Provider to a PCP

When a member is transitioning from a Behavioral Health Medical Professional (BHMP) to a PCP for a behavioral health medication management will continue on the medication(s) prescribed by the BHMP until the member can transition to their PCP. The BHMP/Behavioral Health Provider will coordinate the care and ensure that the member has a sufficient supply of behavioral health medications to last through the date of the member's first appointment with their PCP. Members receiving behavioral health medications from their PCP may simultaneously receive counseling and other medically necessary services.

OUT OF STATE PLACEMENT

It may be necessary to consider an out-of-state placement for a child or young adult to meet the member's unique circumstances or clinical needs.

The following circumstances must exist in order to consider an out-of-state placement for a member:

1. The CFT or ART will explore all applicable and available in-state services and placement options and,
    a. Determine that the services do not adequately meet the specific needs of the member, or
    b. In-state facilities decline to accept the member.
2. The member's family/guardian is in agreement with the out-of-state placement (for minors and members between 18 and under 21 years of age under guardianship),
3. The out-of-state placement is registered as an AHCCCS provider,
4. Prior to placement, ensure the member has access to non-emergent medical needs by an AHCCCS registered provider,
5. The out-of-state placement meets the Arizona Department of Education Academic Standards, and
6. A plan for the provision of non-emergency medical care must be established.

Prior authorization and approval from AHCCCS is required for all out-of-state placements.

PRE-PETITION SCREENING, COURT-ORDERED EVALUATION, AND COURT-ORDERED TREATMENT

At times, it may be necessary to initiate civil commitment proceedings to ensure the safety of a member, or the safety of other members, due to a member's mental disorder when that member is unable or unwilling to participate in treatment. In Arizona, state law permits any responsible member to submit an application for pre-petition screening when another member may be, as a result of a mental disorder:

- A danger to self (DTS);
- A danger to others (DTO);
- Persistently or acutely disabled (PAD); or

- Gravely disabled (GD).

If the person who is the subject of a court ordered commitment, proceeding is subject to the jurisdiction of an Indian Tribe rather than the state, the laws of that tribe, rather than state law, will govern the commitment process. Information about the tribal court process and the procedures under state law for recognizing and enforcing a tribal court order can be found in this section under Court-Ordered Treatment for American Indian Tribal Members in Arizona.

Pre-petition screening includes an examination of the member's mental status and/or other relevant circumstances by a designated screening agency. Upon review of the application, examination of the member and review of other pertinent information, a licensing screening agency's medical director or designee will determine if the member meets criteria for DTS, DTO, PAD, or GD as a result of a mental disorder.

If the pre-petition screening indicates that the person may be DTS, DTO, PAD, or GD, the screening agency will file an application for a court-ordered evaluation. Based on the immediate safety of the person or others, an emergency admission for evaluation may be necessary. The screening agency, upon receipt of the application shall act as prescribed within 48 hours of the filing of the application excluding weekends and holidays as described in A.R.S. §36-520.
Based on the court-ordered evaluation, the evaluating agency may petition the court-ordered treatment on behalf of the member. A hearing, with the member and his/her legal representative and the physician(s) treating the member, will be conducted to determine whether the member will be released and/or whether the agency will petition the court for court-ordered treatment. For the court to order ongoing treatment, the member must be determined, as a result of the evaluation, to be DTS, DTO, PAD, or GD. Court-ordered treatment may include a combination of inpatient and outpatient treatment. Inpatient treatment days are limited contingent on the member's designation as DTS, DTO, PAD, or GD. Members identified as:

- DTS may be ordered up to 90 inpatient days per year;
- DTO and PAD may be ordered up to 180 inpatient days per year; and
- GD may be ordered up to 365 inpatient days per year.

If the court orders a combination of inpatient and outpatient treatment, a mental health agency may be identified by the court to supervise the member's outpatient treatment. In some cases, the mental health agency may be the AHCCCS Complete Care (ACC) contractor; however, before the court can order a mental health agency to supervise the member's outpatient treatment, the agency medical director must agree and accept responsibility by submitting a written plan to the court.

At every stage of the pre-petition screening, court-ordered evaluation, and court-ordered treatment process, a member will be provided an opportunity to change his/her status to

voluntary. Under voluntary status, the member is no longer considered to be at risk for DTS/DTO and agrees in writing to receive a voluntary evaluation.

County agencies and Care1st contracted agencies responsible for pre-petition screening and court-ordered evaluations may use the following forms prescribed in 9 A.A.C. 21, Article 5:

- Application for Involuntary Evaluation
- Application for Voluntary Evaluation (English/Spanish)
- Application for Emergency Admission for Evaluation
- Petition for Court-Ordered Evaluation
- Petition for Court-Ordered Treatment
- Affidavit, Addendum No. 1 and Addendum No. 2

In addition to court ordered treatment as a result of civil action, an individual may be ordered by a court for evaluation and/or treatment upon: 1) conviction of a domestic violence offense; or 2) upon being charged with a crime when it is determined that the individual is court ordered to treatment, or programs, as a result of being charged with a crime and appears to be an "alcoholic."

Licensing Requirements
Behavioral health providers who are licensed by the Arizona Department of Health Services/Division of Public Health Licensing as a court-ordered evaluation or court ordered treatment agency must adhere to ADHS licensing requirements.

County Contracts
Pre-petition Screening
Arizona Counties are responsible for managing, providing, and paying for pre-petition screening and court-ordered evaluations and are required to coordinate provision of behavioral health services with Care1st for Care1st members.

Some counties contract with RBHAs to process pre-petition screenings and petitions for court-ordered evaluations. (See Arizona Revised Statutes A.R.S. §§ 36-545.04, 36-545.06 and 36-545.07). For additional information regarding behavioral health services refer to 9 A.A.C. 22, 2, &12. Refer to ACOM policy 437 for clarification regarding financial responsibility for the provision of medically necessary behavioral health services rendered after completion of a Court Ordered Evaluation.

The Northern Arizona Geographic Service Area is comprised of Apache, Navajo, Coconino, Yavapai, and Mohave Counties. Care1st is not contracted with the county governments in this GSA to provide pre-petition screenings and court-ordered evaluation services. Care1st has been informed either by the counties or by their subcontractors that

the counties have made the following arrangements for pre-petition screening and court ordered evaluation services:

- Apache County has made arrangements with Little Colorado Behavioral Health Services, Inc. to accept pre-petition screenings and to assist with the court ordered evaluation process
- Navajo County has contracted with ChangePoint Integrated Health, Inc. to provide pre-petition screenings and court-ordered evaluations
- Coconino County has an intergovernmental agreement with AHCCCS for these services. In-turn, AHCCCS contracts with Health Choice Integrated Care to provide pre-petition screening and court ordered evaluation services. HCIC has contracted with The Guidance Center, Inc. to be the lead provider for pre-petition screenings and court-ordered evaluations. Encompass Health Services may provide pre-petition screenings in the northern part of Coconino County
- Yavapai County has contracted with Polara Heal to provide pre-petition screenings and court-ordered evaluations
- Mohave County has contracted with Mohave Mental Health Centers, Inc. to provide pre-petition screening

The Central Arizona Geographic Service area is comprised of Maricopa, Gila, and Pinal county. Care1st has been informed either by the counties or by their subcontractors that the counties have made the following arrangements for pre-petition screening and court ordered evaluation services:

- Maricopa County has an intergovernmental agreement with AHCCCS for these services. In-turn, AHCCCS contracts with Mercy Maricopa to provide pre-petition screening and court ordered evaluation services.
- Pinal County has made arrangements with Horizon Health & Wellness to provide pre-petition screenings and court-ordered evaluations.
- In Gila County, Community Bridges Inc. is the designated screening agency; however other behavioral health agencies may be granted permission upon request to the Gila County Attorney's Office

Based upon the county of location of the person to be screened and or evaluated behavioral health providers should contact the entities listed above to refer for pre-petition screening or court-ordered evaluation.

Pre-Petition Screening

Any behavioral health provider that receives an application for court-ordered evaluation (see AMPM Policy 320-U, Exhibit 320-U-1) must immediately refer the applicant for pre-petition screening and petitioning for court-ordered evaluation to the Contractor designated pre-petition screening agency or county facility.

Pre-Petitioning Screening Processes:

The pre-petition screening agency must follow these procedures:

- Provide pre-petition screening within 48 hours excluding weekends and holidays.
- Prepare a report of opinions and conclusions.
- If pre-petition screening was not possible, the screening agency must report reasons why the screening was not possible, including opinions and conclusions of staff individuals who attempted to ensure Medical Director or designee review of the report in the event the report indicates that there is no reasonable cause to support the allegations for court-ordered Evaluation by the applicant.
- Prepare a petition for court-ordered evaluation and file the petition if the screening agency determines that the person, due to a mental disorder, including a primary diagnosis of dementia and other cognitive disorders, is DTS, OTO, PAD, or GD. AMPM Policy 320-U, Exhibit 320-U-3, documents pertinent information for court-ordered evaluation.
- Ensure completion of AMPM Policy 320-U, Exhibit 320-U-2, and take all reasonable steps to procure hospitalization on an emergency basis, if it determines that there is reasonable cause to believe that the person, without immediate hospitalization, is likely to harm themselves or others.
- Contact the county attorney prior to filing a petition if it alleges that a person is DTO.

Emergent/Crisis Petition Filing Process for Contractors Contracted as Evaluating Agencies

When it is determined that there is reasonable cause to believe that the person being screened is in a condition that without immediate hospitalization is likely to harm themselves or others, an emergent application can be filed. The petition must be filed at the appropriate agency as determined by the Evaluating Agency.

- Only applications indicating DTS and/or DTO can be filed on an emergent basis.
- The applicant must have personally seen or witnessed the behavior of the person that is a danger to self or others and not base the application on second hand information.
- The applicant must complete the Application for Involuntary Evaluation Exhibit 320-U-1 as per AMPM Policy 320-U.
- The applicant and all witnesses identified in the application as direct observers of the dangerous behavior, may be called to testify in court if the application results in a petition for COE Within 48 hours of receipt of AMPM Policy 320-U, Exhibit 320-U-2 and all corroborating documentation necessary to successfully complete a determination, the admitting physician will determine if enough evidence exists for an emergency admission for evaluation. If there is enough evidence to support the emergency admission for evaluation, the facility is not currently operating at

or above its allowable member capacity, and the person does not require medical transportation to the appropriate facility.

- If the person requires a medical facility, or if placement cannot be arranged within 48 hours after the approval of AMPM Policy 320-U, Exhibit 320-U-2, the Medical Director of the Contractor will be consulted arrange for a review of the case.
- An AMPM Policy 320-U, Exhibit 320-U-2, may be discussed by telephone with the facility admitting physician, the referring physician and a police officer to facilitate transportation of the person to be evaluated.
- A person proposed for emergency admission for evaluation may be apprehended and transported to the facility under the authority of law enforcement using the written AMPM Policy 320-U, Exhibit 320-U-2.
- A 23-hour emergency admission for evaluation begins at the time the person is detained involuntarily by the admitting physician who determines there is reasonable cause to believe that the person, as a result of a mental disorder, is a DTS or DTO and that during the time necessary to complete prescreening procedures the person is likely, without immediate hospitalization, to suffer harm or cause harm to others.
- During the emergency admission period of up to 23 hours the following will occur:
    a. The person's ability to consent to voluntary treatment will be assessed.
    b. The person shall be offered and receive treatment to which he/she may consent. Otherwise, the only treatment administered involuntarily will be for the safety of the person or others, i.e. seclusion/restraint or pharmacological restraint in accordance with A.R.S § 36-513.
    c. The psychiatrist will complete the Evaluation within 24 hours of determination that the person no longer requires involuntary evaluation.

Court-Ordered Evaluation

If the pre-petition screening indicates that the person may be DTS, DTO, PAD, or GD, the screening agency will file an application for a court-ordered evaluation. The procedures for court-ordered evaluations are outlined below:

Care1st and its subcontracted behavioral health provider must follow these procedures:

- A person being evaluated on an inpatient basis must be released within seventy-two hours (excluding weekends and holidays) if further evaluation is not appropriate, unless the person makes application for further care and treatment on a voluntary basis;
- A person who is determined to be DTO, DTS, PAD, or GD as a result of a mental disorder must have a petition for court-ordered treatment prepared, signed and filed by designated agency's medical director or designee; and

- Title XIX/XXI funds must not be used to reimburse court-ordered evaluation services.

Voluntary Evaluation

Any Care1st contracted behavioral health provider that receives an application for voluntary evaluation must immediately refer the member to the facility responsible for voluntary evaluations in the region/area where the member is located. The evaluation agency must obtain the member's informed consent prior to the evaluation (see AMPM Policy 320-U, Exhibit 320-U-7) and provide evaluation at a scheduled time and place within five days of the notice that the member will voluntarily receive an evaluation. For inpatient evaluations, the evaluation agency must complete evaluations in less than seventy-two hours of receiving notice that the person will voluntarily receive an evaluation; and if a behavioral health provider conducts a voluntary evaluation service as described in this section, the comprehensive clinical record must include:

- A copy of the application for voluntary evaluation, AMPM Policy 320-U, Exhibit 320-U-7 A completed informed consent form (see AMPM Policy 320-Q) and
- A written statement of the member's present medical condition.

Court-Ordered Treatment Following Civil Proceedings Under A.R.S. Title 36

Based on the court-ordered evaluation, the evaluating agency may petition for court-ordered treatment. The behavioral health provider must follow these procedures:

- Upon determination that an individual is DTS, DTO, GD, or PAD, and if no alternatives to court-ordered treatment exist, the medical director of the agency that provided the court-ordered evaluation must file a petition for court-ordered treatment (see AMPM Policy 320-U, Exhibit 320-U-4)
- Any behavioral health provider filing a petition for court-ordered treatment must do so in consultation with the person's clinical team prior to filing the petition;
- The petition must be accompanied by the affidavits of the two physicians who conducted the examinations during the evaluation period and by the affidavit of the applicant for the evaluation (see AMPM Policy 320-U, Exhibit 320-U-5);
- A copy of the petition, in cases of grave disability, must be mailed to the public fiduciary in the county of the patient's residence, or the county in which the person was found before evaluation, and to any person nominated as guardian or conservator; and
- A copy of all petitions must be mailed to the superintendent of the Arizona State Hospital.

Persons Who Are Title XIX/XXI Eligible And/or Determined To Have SMI

When a person referred for court-ordered treatment is Title XIX/XXI eligible and/or determined or suspected to have a Serious Mental Illness, the behavioral health provider will:

- Conduct an evaluation to determine if the person has a Serious Mental and conduct a behavioral health assessment to identify the person's service needs in conjunction with the person's clinical team
- Provide necessary court-ordered treatment and other covered behavioral health services in accordance with the person's needs, as determined by the person's clinical team, the behavioral health member, family members, and other involved parties; and
- Perform, either directly or by contract, all treatment required by A.R.S. Title 36, Chapter 5, Article 5 and 9 A.A.C. 21, Article 5.

AGENCY TRANSFERS FOR MEMBERS ON COURT ORDERED TREATMENT

This Section pertains to court ordered treatment under A.R.S. § 36, Chapter 5 and the Arizona Administrative Code R9-21-507.

Note: The following are general guidelines-each County has the right to request additional or different documentation. When the specific County process is known, it shall be included in this guide.

A person ordered by the court to undergo treatment and who is without a guardian may be transferred from one provider to another provider, as long as the medical director of the provider initiating the transfer has established that:

- The member's Court Ordered Treatment is not expiring within 90 days of the transfer,
- There is no reason to believe that the person will suffer more serious physical harm or serious illness as a result of the transfer;
- The person is being transitioned to a level and kind of treatment that is more appropriate to the person's treatment needs; and
- The medical director of the receiving provider has accepted the person for transition.

The medical director of the provider requesting the transition must have been the provider that the court committed the person to for treatment or have obtained the court's consent to transition the person to another provider as necessary.

The medical director of the provider requesting the transition must provide notification to the receiving provider allowing sufficient time (but no less than 3 days) for the transition to be coordinated between the providers. Notification of the request to transition must include:

- A summary of the person's needs;

- A statement that, in the medical director's judgment, the receiving provider can adequately meet the person's treatment needs;
- A modification to the individual service plan, if applicable;
- Documentation of the court's consent, if applicable;
- A written compilation of the person's treatment needs and suggestions for future treatment by the medical director of the transitioning provider to the medical director of the receiving provider. The medical director of the receiving provider must accept this compilation before the transition can occur; and

This is best accomplished by sending an email to the provider the member has requested to be transferred to and requesting a "Letter of Intent to Treat".
The receiving Provider's Title 36 liaison should be cc'd on any emails when a member on court ordered treatment is going to be transferred.

The Letter of Intent can be a letter from the Medical Director of the receiving Behavioral Health Clinic that includes:

- Name and DOB of the individual on COT
- COT start and end date
- The standard under which the person is court ordered (DTO; /DTS; PAD; GD)
- Printed name and signature of the receiving Provider's Medical Director
- Effective transfer date (date of intake)
- The letter can read simply: *"This letter is to verify that Dr. X and Provider Y has agreed to provide court ordered treatment to member Z"*
- The Behavioral Health Clinic must keep a copy of the letter in the clinical record.

The Medical Director of the receiving Provider notifies Court in writing that there has been a change in oversight of the individuals COT. It is recommended that an official document from the court be requested that reflects the current treatment Provider/Medical Director as the responsible party overseeing the court ordered treatment

MEMBERS CURRENTLY BEING SERVED BY A CLINIC WHO CANNOT PROVIIDE OUTPATIENT SERVICES FOR COURT ORDERED TREATMENT
This refers to those clinics who do not have a psychiatrist on staff to provide monitoring of the outpatient treatment plan. If a member is currently receiving services at such a clinic and due to distance cannot transfer to another clinic that can provide this service, the current clinic should outreach to the Care1st Court Coordinator.

Court-Ordered Treatment for Persons Charged With Or Convicted Of A Crime
Care1st or its providers may be responsible for providing evaluation and/or treatment services when an individual has been ordered by a court due to:

- Conviction of a domestic violence offense; or

- Upon being charged with a crime when it is determined that the individual is court ordered to treatment, or programs, as a result of being charged with a crime and appears to be an "alcoholic."

Domestic Violence Offender Treatment
Domestic violence offender treatment may be ordered by a court when an individual is convicted of a misdemeanor domestic violence offense. Although the order may indicate that the domestic violence (DV) offender treatment is the financial responsibility of the offender under A.R.S. § 13-3601.01, Care1st will cover DV services with Title XIX/XXI funds when the person is Title XIX/XXI eligible, the service is medically necessary, required prior authorization is obtained if necessary, and/or the service is provided by an in-network provider. For Non-TXIX/XXI eligible persons' court ordered for DV treatment, the individual can be billed for the DV services.

Court ordered substance abuse evaluation and treatment
Substance abuse evaluation and/or treatment (i.e., DUI services) ordered by a court under A.R.S. § 36-2027 is the financial responsibility of the county, city, town or charter city whose court issued the order for evaluation and/or treatment. Accordingly, if ADHS/AHCCCS or Care1st receives a claim for such services, the claim will be denied and the provider is to bill the responsible county, city or town.

Court-Ordered Treatment for American Indian Tribal Members in Arizona
Arizona tribes are sovereign nations, and tribal courts have jurisdiction over their members residing on reservation. Tribal court jurisdiction, however, does not extend to tribal members residing off the reservation or to state court ordered evaluation or treatment ordered because of a behavioral health crisis occurring off reservation. Although some Arizona tribes have adopted procedures in their tribal codes, which are similar to Arizona law for court ordered evaluation and treatment, each tribe has its own laws which must be followed for the tribal court process. Tribal court ordered treatment for American Indian tribal members in Arizona is initiated by tribal behavioral health staff, the tribal prosecutor or other person authorized under tribal laws. In accordance with tribal codes, tribal members who may be a danger to themselves or others and in need of treatment due to a mental health disorder are evaluated and recommendations are provided to the tribal judge for a determination of whether court ordered treatment is necessary. Tribal court orders specify the type of treatment needed.

Additional information on the history of the tribal court process, legal documents and forms as well as contact information for the tribes, Care1st liaison(s), and tribal court representatives can be found on the AHCCCS web page titled, Tribal Court Procedures for Involuntary Commitment -Information Center.

Since many tribes do not have treatment, facilities on reservation to provide the treatment ordered by the tribal court, tribes may need to secure treatment off reservation for tribal

members. To secure court ordered treatment off reservation, the court order must be "recognized" or transferred to the jurisdiction of the state.

The process for establishing a tribal court order for treatment under the jurisdiction of the state is a process of recognition, or "domestication" of the tribal court order (see A.R.S. § 12-136). Once this process occurs, the state recognized tribal court order is enforceable off reservation. The state recognition process is not a rehearing of the facts or findings of the tribal court. Treatment facilities, including the Arizona State Hospital, must provide treatment, as identified by the tribe and recognized by the state. AMPM Policy 320-U, Exhibit 320-U-6, A.R.S. § 12-136 Domestication or Recognition of Tribal Court Order is a flow chart demonstrating the communication between tribal and state entities. Care1st and its providers must comply with state recognized tribal court orders for Title XIX/XXI and Non-Title XIX SMI persons. When tribal providers are also involved in the care and treatment of court ordered tribal members, Care1st and its providers must involve tribal providers to ensure the coordination and continuity of care of the members for the duration of court ordered treatment and when members are transitioned to services on the reservation, as applicable.

This process must run concurrently with the tribal staff's initiation of the tribal court ordered process in an effort to communicate and ensure clinical coordination with the Care1st staff. This clinical communication and coordination with Care1st is necessary to assure continuity of care and to avoid delays in admission to an appropriate facility for treatment upon state/county court recognition of the tribal court order. The Arizona State Hospital should be the last placement alternative considered and used in this process.

A.R.S. § 36-540 (B) states, "The Court shall consider all available and appropriate alternatives for the treatment and care of the patient. The Court shall order the least restrictive treatment alternative available." Care1st will partner with American Indian tribes and tribal courts in their geographic service areas to collaborate in finding appropriate treatment settings for American Indians in need of behavioral health services. Due to the options, American Indians have regarding their health care, including behavioral health services, payment of behavioral health services for AHCCCS eligible American Indians may be covered through a T/RBHA, ACC, or IHS/638 provider. See on the AHCCCS website under Tribal Court Procedures for Involuntary Commitment-Tribal Court Procedures for Involuntary Commitment for a diagram of payment structures.

Tolling a Court Ordered Treatment

Per Statute 36.544; a member's Court Ordered Treatment is tolled during the unauthorized absence of the patient and resumes running only on the patient's voluntary or involuntary return to the treatment agency.

As defined by the Statute, an unauthorized absence is the following:

- if a member is no longer living in a placement or residence specified by the treatment plan without authorization OR
- leaving or failing to return to the county or state without authorization
- Absent from an inpatient treatment facility without authorization

The Statute indicates within five (5) days after notification of a patient's unauthorized absence, the Behavioral Health Provider shall file a motion with the Court to request a Toll of the Court Ordered Treatment. Behavioral Health Provider Title 36 Liaisons will be responsible for Filing Toll requests with the Courts, monitoring the number of days of the Toll and ensuring Status Reports for re-engagement efforts are filed every 60 days up to 180-Tolled Days. Tolled Orders will be reported to the Care1st Court Coordinators.

Should the member not be re-engaged voluntarily or involuntarily, the Behavioral Health Provider has the option to ask the Court to terminate the Court Ordered Treatment after 180 days on Toll. Tolling a Court Order will move forward the expiration date of the current Order based upon the number of days the member was absent.

Judicial Reviews A.R.S. § 36-546
Every 60 days the provider must inform the individual of his/her right to Judicial Review and must document this in the clinical record, however, the individual can request this at anytime Judicial Reviews are to be calendared and offered every 60 days from the date of the original court order. The provider on a monthly basis submits the date the judicial review was offered as well as supporting documentation demonstrating evidence this was offered (i.e. progress note, prescriber notes or established judicial review form). This process ensures monitoring of timely requests.

If an individual is hospitalized pursuant to an amendment the provider must offer the individual a Judicial Review within seventy-two (72) hours of admission. This Judicial Review does not change the count of the 60 days set from the date of the court order. It is considered an exception per statute and is permitted before the 60 days.
Court requires the psychiatric report to contain sufficient clinical information to render a decision regarding whether the individual needs continued court-ordered treatment or not. This psychiatric report can be in the form of a progress note. At a minimum the Judicial Review must include information regarding individual's insight regarding his/her mental illness and information regarding adherence to court-ordered treatment plan. If the individual does not attend the Judicial Review appointment, the prescriber must complete a chart review to provide this information. If an individual is hospitalized pursuant to an amended outpatient treatment plan and requests a Judicial Review, merely stating the individual is hospitalized is not enough factual information for Court to render a decision. The prescriber should attempt to contact the inpatient BHMP to gather information for the Judicial Review. Failure to provide sufficient evidence of need for continued treatment could result in Court requesting a hearing on the matter.

If an individual no longer needs COT or it is inappropriate for the individual to be on a COT, the Medical Director can request through Judicial Review for the court to terminate the COT. The court may or may not approve this request.
A hearing can be set by the Judge/Commissioner on his/her own or if requested by the defense attorney.

Annual Review A.R.S. § 36-543
Within 90 -45 days of the expiration of the court order, the provider must conduct an annual review of an individual who was court-ordered to treatment as Gravely Disabled or Persistently or Acutely Disabled (GD & PAD) to determine if continuation of COT is appropriate and assess the needs of the individual for guardianship or conservatorship or both. The annual review includes a review of the mental health treatment and clinical records contained in the individual's treatment file.
If the Medical Director believes that continuation of the court-ordered treatment is appropriate, the Medical Director appoints one or more psychiatrists (depending on the County) to carry out a psychiatric examination of the individual. Each psychiatrist participating in the psychiatric examination must submit a report to the Medical Director that includes the following:

1) The psychiatrist's opinions as to whether the individual continues to have a grave disability or persistent or acute disability as a result of a mental disorder and is in need of continued COT
2) A statement as to whether suitable alternatives to COT are available
3) A statement as to whether voluntary treatment would be appropriate
4) Review of the individual's need for a guardian or conservator or both
5) Whether the individual has a guardian with mental health powers that would not require continued COT
6) The result of any physical examination that is relevant to the psychiatric condition of the individual.

To ensure this review has taken place the provider submits on the month that the annual review is due progress notes indicating the BHMP met with the individual 45-90 days prior to expiration of the court order. Additionally, the individual's clinical team shall hold a service planning meeting, not less than 45 days prior to the expiration of the court-ordered treatment to determine if the court order should continue.

If the Medical Director believes after reviewing the annual review that continued COT is appropriate, the Medical Director files with Court, no later than forty-five days before the expiration of the court order for treatment, an application for continued court-ordered treatment and the psychiatric examination conducted as part of the annual review. If the individual is under guardianship, the Medical Director must mail a copy of the application to the individual's guardian.

The annual exam must have current contact information for the individual. This includes full address, zip code, and telephone number. If the individual's location and/or other contact. If any information changes, provider staff is required to contact the individual's attorney with this new information.

A hearing is conducted if requested by the individual's attorney on behalf of the request of the individual or otherwise ordered by Court.

For individuals determined DTS and/or DTO the provider must initiate the pre-petition screening process pursuant to Arizona Administrative Code.

TERMINATION/RELEASE FROM COURT ORDERED TREATMENT A.R.S. § 36-541.01

Upon written request of the individual's Behavioral Health Medical Provider, a Court may order an individual to be released from court-ordered treatment prior to the expiration of the court-ordered period.

Specifically, the Title 36 Statute states "A patient who is ordered to undergo treatment pursuant to this article may be released from treatment before the expiration of the period ordered by the court if, in the opinion of the medical director of the mental health treatment agency, the patient no longer is, as a result of a mental disorder, a danger to others or a danger to self or no longer has a persistent or acute disability or a grave disability. A person who is ordered to undergo treatment as a danger to others may not be released or discharged from treatment before the expiration of the period for treatment ordered by the court unless the medical director first gives notice of intention to do so as provided by this section."

TERMINATION FROM REPORTING A MEMBER WHO IS ON COURT ORDERED TREATMENT

There are certain circumstances when a Behavioral Health Home may no longer be required to report to The Health Plan a member who is on Court Ordered Treatment. These conditions would be as follows: 1) a member has been sentenced to the Department of Corrections, 2) a member has died, 3) the member has lost AHCCCS benefits and is NOT Severely Mentally Ill (SMI) and does not meet SMI criteria, 5) the member's Court Order has been Tolled for 180 days and the Court approves the Behavioral Health Home's request to terminate the Court Order, 6) the Order is dismissed during a Judicial Review hearing, and 7) the member has agreed to become voluntary.

SUPPENSION OF OUTPATIENT TREATMENT PLAN

In some Counties there are certain circumstances where a petition to request a suspension of the agency supervision of the outpatient treatment may be submitted to the Court. This is done on a case by case basis. Any agency wishing to use this petition must contact the Care1st Court Coordinator prior to requesting this petition.

REPORTING

SECTION VII: Behavioral Health Services

Per AHCCCS, monthly reporting is required for all persons on court ordered treatment. All providers must identify and track treatment engagement of Court Ordered Treatment (COT) individuals.

- Provider can complete/submit updates at any time during the reporting month, but all updates (updates include monthly excel workbook deliverable and required documentation) must be completed and submitted no later than the 2nd business day of the next month.
- Provider must submit initial or continuing COTs as soon as they are received from the Court.

COT TRACKING

The Behavioral Health Medical Director shall review the condition of a patient on conditional outpatient treatment via chart review at least once every thirty days and enter the findings in writing in the patient's file. In conducting the review, the medical director shall consider all reports and information received and may require the patient to report for further evaluation. If a COT member missed an appointment, the provider will follow up within 24 hours.

RESIDENTIAL FACILITIES SERVING JUVENILES

Contracted residential facilities that serve juveniles are required to comply with all relevant provisions in A.R.S. §36-1201.

FISCAL RESPONSIBILITY

Benefit Coordination for Behavioral Health Services and Physical Health Services is outlined in Policy 432 of the AHCCCS Contractor Operations Manual (ACOM). The policy is located at the following website:
http://www.azahcccs.gov/shared/ACOM/Chapter400.aspx > select policy 432.