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*

- Treatment Services
  - Behavioral Health Counseling & Therapy (Individual, Group, Intensive Outpatient Programming, and Family*)
  - Behavioral Health Screening, Mental Health Assessment and Specialized Testing
  - Psychophysiological therapy and biofeedback
- Rehabilitation Services
  - Skills Training and Development
  - Cognitive Rehabilitation
  - Health Promotion
  - 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 Outpatient and Behavioral Health Day Programs Behavioral Health Residential Facility Services
- Behavior Analysis
- Crisis Intervention Services
- Inpatient Services (Hospital, Behavioral Inpatient Facilities, Observation/Stabilization Services, Partial Hospitalization Programs)

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*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

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.
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- Competent individuals who are adequately trained and supervised provide behavioral health services. Behavioral health services utilize treatment modalities and programs that are evidenced based and supported by Substance Abuse and Mental Health Services Administration (SAMSHA) or other nationally recognized organizations. 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 member's lives, especially 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.

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.

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 Centene Pharmacy Services 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)

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All Antipsychotics 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 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.

The Health Plan Preferred Drug List (PDL)
Providers are required to abide by the Health Plan's Preferred Drug List (PDL) as applicable, when prescribing medications for members in accordance with this Provider Manual. Providers are also required to adhere to the requirements of the AHCCCS Psychotropic Medication informed consent requirements in accordance with this Provider Manual.

Quantity Limits

- Opioid prescriptions: For adult opioid naïve members, short-acting opioids are 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 opioid prescriptions are subject to an MME of < 90 MME (morphine milligram equivalents). Prior authorization is required for chronic opioid use.

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 :

- 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.

Registration with Controlled Substance Prescription Monitoring Program

All medical practitioners are required to register and utilize the Arizona Controlled Substance Prescription Monitoring Program (CSPMP, PMP). Practitioners must obtain a patient utilization report for the preceding 12 months from the controlled substances PMP

central database tracking system before prescribing opioid analgesics or benzodiazepines in schedules II-IV. Practitioners are not required to obtain a report if the patient is:

- Receiving hospice care or being treated for cancer or cancer-related illness;
- If the practitioner will administer the controlled substance;
- If the patient is receiving the controlled substance during the course of inpatient or residential treatment in a hospital, nursing care facility or mental health facility;
- If the medical practitioner, under specific legislation, prescribed controlled substances for no more than five days after oral surgery, and
- As outlined in AHCCCS AMPM Chapter 300, Policy 310-FF

https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/

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 1-866-560-4042 (option 5, then 5). 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 adult opioid naïve members, Short-acting opioids are limited to a 5-day supply or less for initial fill. For minors, except in case of cancer, other chronic disease 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

The referral process serves as the principal pathway by which persons are able to gain prompt access to publicly supported services. The intake process serves to collect basic member information in order to enroll members in the AHCCCS system, screen for Title XIX/XXI AHCCCS eligibility and determine the need for any copayments. It is critical that both the referral process and intake process are culturally sensitive, efficient, engaging, and welcoming to the member and/or family member seeking services, and leads to the provision of timely and appropriate services based on the urgency of the situation.

A "referral" is any oral, written, faxed or electronic request for services made by the Member, the Member's legal guardian or Health Care Decision Maker (HCDM), family member, an AHCCCS Acute Contractor, PCP, Hospital, Treat and Refer Provider, Jail, Court, Probation or Parole Officer, Tribal Entity, his/638 Tribally Operated Facility, School, or other state or community agency.

Providers must not arbitrarily or prematurely reject or disqualify a member from services/referrals without prior authorization by the Health Plan. Providers must resolve referral disputes promptly, relative to the urgency of the situation. The Health Plan will promptly intervene and resolve any dispute between a provider and a referring source when those parties cannot informally resolve disputes regarding the need for emergency, urgent, or routine appointments.

The Health Plan providers are responsible for managing referrals and wait lists for Non-Title XIX/XXI persons in accordance with the SABG Block Grant for identified priority populations when services are temporarily unavailable. See AMPM Policy 650 Behavioral Health Provider Requirements for Assisting Individuals with Eligibility Verification and Screening/Application for Public Health Benefits.

If The Health Plan network is unable to provide medically necessary services to Title XIX/XXI persons, The Health Plan will verify timely and adequate coverage of needed services through an out-of-network provider until a network provider is contracted.

OBJECTIVES
To facilitate a member's access to services in a timely manner, providers will maintain an effective process for the referral and intake for services that includes:

Communicating to potential referral sources the process for making referrals (e.g., centralized intake, identification of providers accepting referrals);

Collecting enough basic information about the person to determine the urgency of the situation and subsequently scheduling the initial assessment within the required timeframes and with an appropriate provider.

Adopting a welcoming, trauma-informed, and engaging manner with the member and/or member's legal guardian/family member;

Ensuring that intake interviews are culturally appropriate and delivered by providers who are respectful and responsive to the Member's cultural needs.

Keeping information or documents gathered in the referral process confidential and protected in accordance with applicable federal and State statutes, regulations and policies;

Informing, as appropriate, the referral source about the final disposition of the referral; and

Conducting intake interviews that ensure the accurate collection of all the required information necessary and ensure Members who have difficulty communicating because of a disability or who require language assistance are afforded appropriate accommodations to assist them in fully expressing their needs.

WHERE TO SEND REFERRALS

The Health Plan maintains a provider directory on its website that is available to AHCCCS Health Plans and Department of Economic Security District Program Administrators (DES). A printed copy can be made available upon request. The directory indicates which providers are accepting referrals and conducting initial assessments and intakes. It is important for providers to promptly notify The Health Plan of any changes that would impact the accuracy of the provider directory (e.g., change in telephone or fax number, no longer accepting referrals).

Individuals may access services by directly contacting a Behavioral Health Home. Contracted Behavioral Health Homes are identified on The Health Plan website (www.care1staz.com) and in The Health Plan Member Handbook. Members may also call The Health Plan Customer Service at 1-866-560-4042, 24 hours a day/7 day a week, and receive a referral to a contracted Health Home. During normal business hours, The Health Plan will transfer callers to an intake provider. After-hour referrals are provided to Health Home providers who are expected to follow up on the referral. The Crisis Call Center staff tracks referrals to verify the caller is appropriately connected with a Health Home. In addition, the Crisis Call Center has access to emergent and urgent psychiatric appointments at intake provider sites and can schedule these appointments on the Member's behalf.

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Providers are required to notify The Health Plan of any changes that would alter or change the information provided through the directory. A 30-day notice is required for changes in telephone number, fax number, email address, service changes, staff changes, service capacity changes or ability to accept new referrals.

CHOICE OF PROVIDERS

The Health Plan offers Members a choice in selecting providers, and providers are required to provide each Member a choice in selecting a provider of services, provider agency, and direct care staff. Providers are required to allow Members to exercise their right to services from an alternative In-Network provider and offer each Member access to the most convenient In-Network service location for the service requested by the Member. In addition, providers must make available all Covered Services to all Title XIX/XXI eligible American Indians, whether they live on or off reservation. Eligible American Indian Members may choose to receive services through a RBHA/MCO/Health Plan, Tribal and Regional Behavioral Health Authorities, or through an IHS or 638 tribal providers.

REFERRALS TO A PROVIDER FOR A SECOND OPINION

Title XIX/XXI Members are entitled to a second opinion and providers are required to provide proof that each Member is informed of the right to a second opinion.

Upon a Title XIX/XXI eligible Member's request or at the request of the provider's treating physician, the provider must—at no cost to the Member—make available a second opinion from a qualified health care professional either within the network or arrange for the Member to obtain a second opinion from a qualified health care professional outside the network (42 CFR 438.206(b)(3)). For purposes of this section, a "qualified health care professional" is (a) an AHCCCS registered provider of covered health services (b) who is a physician, a physician assistant, a nurse practitioner, a psychologist, or an independent master's level therapist.

A behavioral health provider can arrange for a second opinion in-network or can contact the Health Plan Customer Service at 1-866-560-4042, 8:00 a.m. – 5:00 p.m. Monday – Friday, for assistance. Out-of-Network requests should be submitted to The Health Plan Utilization Management department for review and processing. A provider must maintain a record identifying both (1) the date of service for the second opinion and (2) the name of the provider who provided the second opinion. There must be documentation in the clinical chart of the following:

- 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.

SECTION VII: Behavioral Health Services

REFERRALS INITIATED BY DEPARTMENT OF ECONOMIC SECURITY/DEPARTMENT OF CHILD SAFETY (DES/DCS) PENDING THE REMOVAL OF A CHILD

Upon notification from DES/ Department of Child Safety (DCS) that a child has been or is at risk of being taken into the custody of DES/Department of Child Safety (DCS), providers are expected to respond in an urgent manner.

ACCEPTING REFERRALS

Providers must establish written procedures for accepting and acting upon referrals, including emergency referrals. Providers must accept referrals for services as identified in the provider's contract with the Health Plan unless The Health Plan grants a written waiver or suspension of this requirement. Providers must not arbitrarily or prematurely reject or eject a member from services/referrals without prior authorization of the Health Plan. Providers must accept referrals, regardless of diagnosis, level of functioning, age, Member's status in family, or level of service needs. (See 42 CFR 438.210 (a)(3)(iii))

The process for making referrals, including self-referrals, is clearly communicated to members and providers. The process shall ensure the engagement of the member/HCDM or the Designated Representative (DR) to maximize family voice and choice of service providers. Providers must accept and respond to emergency referrals of Title XIX/XXI eligible Members and Non-Title XIX/XXI Members with SMI twenty-four (24) hours a day, seven (7) days a week. An acknowledgement of receipt of a referral shall be provided to the referring entity within 72 hours from the date it was received.

Emergency referrals do not require prior authorization. Emergency referrals include those initiated for Title XIX/XXI eligible and Non-Title XIX/XXI with SMI Members admitted to a hospital or treated in the emergency room. Providers must respond within twenty-four (24) hours upon receipt of an emergency referral.

The following information shall be collected from referral sources:

- Date and time of referral;
- Information about the referral source including name, telephone number, fax number, affiliated agency, and relationship to the person being referred;
- Name of person being referred, address, telephone number, gender, age, date of birth and, when applicable, name and telephone number of parent or legal guardian;
- Whether or not the person, parent, or legal guardian is aware of the referral;
- Transportation and other special needs for assistance due to impaired mobility, blindness/low vision or being deaf or hard of hearing, or developmental or cognitive impairment;
- Accommodations due to cultural uniqueness and/or the need for interpreter services;

- Information regarding payment source (i.e., AHCCCS, private insurance, Medicare or self-pay) including the name of the AHCCCS health plan or insurance company;
- Name, telephone number, and fax number of AHCCCS primary care provider (PCP) or other PCP as applicable;
- Reason for referral including identification of any potential risk factors such as recent hospitalization, evidence of suicidal or homicidal thoughts, pregnancy, and current supply of prescribed psychotropic medications;
- Medications prescribed by the Member's PCP or other medical professional including the reason why the medication is being prescribed; and
- The names and telephone numbers of individuals the Member, parent, or guardian may wish to invite to the initial appointment with the referred Member.
- Sufficient information is collected through the referral to:
- Assess the urgency of the member's needs,
- Track and document the disposition of referrals to ensure subsequent initiation of services. The Contractor shall comply with timeliness standards 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 appointments and flexible scheduling options based upon the needs of the member.

Providers should act on a referral regardless of how much information they obtained. While the information listed above will facilitate evaluating the urgency and type of practitioner the Member may need to see, timely triage and processing of referrals must not be delayed because of missing or incomplete information.

When psychotropic medications are a part of a member's treatment or have been identified as a need by the referral source, providers must respond in accordance with Appointment Standards and Timeliness of Service guidelines.

When individuals seek services, or their family member, legal guardian, or significant other contacts a provider directly about accessing services, provider shall ensure that the protocol used to obtain the necessary information about the person seeking services is engaging and welcoming.

When an SMI eligibility determination is being requested as part of the referral or by the person directly, providers must conduct an eligibility determination for SMI. The SMI assessment and pending determination will not delay behavioral health service delivery to the Member.

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RESPONDING TO REFERRALS

Follow-Up: When a request for services is initiated but the Member does not appear for the initial appointment, the provider must attempt to contact the Member and implement engagement activities. The provider must also attempt to notify the entity that made the referral.

Final Dispositions: Within 30 days of receiving the initial assessment, or if the person declines services, within 30 days of the initial request for services, the provider must notify the following referral sources of the final disposition:

- AHCCCS health plans;
- AHCCCS PCPs;
- Arizona Department of Economic Security;
- Arizona Department of Child Safety;
- Arizona Department of Economic Security/Division of Developmental Disabilities;
- Arizona Department of Corrections;
- Arizona Department of Juvenile Corrections;
- County Adult and Juvenile Detention Centers;
- Administrative Offices of the Court;
- Arizona Department of Economic Security/Rehabilitation Services Administration; and
- Arizona Department of Education and affiliated school districts.

The final disposition must include:

1. The date the Member was seen for the initial assessment; and
2. The name and contact information of the provider who will assume primary responsibility for the Member's behavioral health care, or
3. If no services will be provided, the reason why.

When required, authorization to release information will be obtained prior to communicating the final disposition to the referral sources referenced above.

DOCUMENTING AND TRACKING REFERRALS

The Health Plan provider shall document and track all referrals for services including, at a minimum, the following information:

- Person's name and, if available, AHCCCS identification number;
- Name and affiliation of referral source;
- Date of birth;
- Type of referral (immediate, urgent, routine)
- Date and time the referral was received;

- If applicable, date and location of first available appointment and, if different, date and location of actual scheduled appointment; and
- Final disposition of the referral.

ELIGIBILITY SCREENING AND SUPPORTING DOCUMENTATION

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:

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

If an individual's Title XIX/XXI eligibility status cannot be determined using one of the above methods, the provider will:

- Call Care1st for assistance during normal business hours or
- Call the AHCCCS Verification Unit, which is open Monday through Friday, from 8:00-5:00 p.m.

Interpret eligibility information.

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,

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 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:

- Upon initial request for behavioral health services
- At least annually, if still receiving behavioral health services, and
- 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.

- 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,
- 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
- 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,
- 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,

- 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.
- 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.

INTAKE INTERVIEWS

Providers must conduct intake interviews in an efficient and effective manner that is both "person friendly," trauma-informed, and verifies the accurate collection of all required information necessary for enrollment into the system or for collection of information for AHCCCS eligible individuals who are already enrolled. The intake process must:

- Be flexible in terms of when and how the intake occurs. For example, in order to best meet the needs of the person seeking services, the intake might be conducted over the telephone prior to the visit, at the initial appointment prior to the assessment and/or as part of the assessment; and
- Make use of readily available information (e.g., referral form, AHCCCS eligibility screens) in order to minimize any duplication in the information solicited from the person and family members.

During the intake, the provider will collect, review, and disseminate certain information to persons seeking services. Examples can include:

- The collection of contact information, insurance information, the reason why the person is seeking services and information on any accommodations the person may require to effectively participate in treatment services (i.e., need for oral interpretation or sign language assistance, consent forms in large font, etc.).
- The collection of required member information and completion of client member information sheet, including the Member's primary/preferred language;
- The completion of any applicable authorizations for the release of information to other parties;
- Advising the member that The Health Plan Member Handbook is available to them;
- The review and completion of a general consent to treatment;
- The collection of financial information, including the identification of third-party payers and information necessary to screen and apply for AHCCCS health insurance, when necessary;
- Advising Non-Title XIX/XXI persons determined to have a SMI that they may be assessed a copayment;

- The review and dissemination of The Health Plan Notice of Privacy Practices and the AHCCCS HIPAA Notice of Privacy Practices in compliance with 45 CFR 164.520 (c)(1)(B) (PDF); and
- The review of the person's rights and responsibilities as a member of services, including an explanation of the appeal process.

The person and/or family members may complete some of the paperwork associated with the intake, if acceptable to the person and/or family members.

Providers conducting intakes must be appropriately trained, approach the person and family in an engaging manner, and possess a clear understanding of the information that needs to be collected.

SPECIALTY BEHAVIORAL HEALTH AGENCY REFERRALS

All Health Plan contracted providers are responsible for ensuring timely and appropriate service delivery as requested by the member and/or as determined necessary to meet the member's needs. Specialty Behavioral Health Agencies (i.e., ABA, Support and Rehabilitation Services, Employment, etc.) are responsible for determining medical necessity for specialty services and regularly reporting progress to Behavioral Health Homes and PCPs as appropriate.

REFERRALS FOR SCREENING AND/OR DIAGNOSIS OF AUTISTM SPECTRUM DISORDERS

The Health Plan covers medically necessary behavioral health services for all AHCCCS-eligible children and adults, including the diagnosis and treatment for individuals who may have an Autism Spectrum Disorder (ASD). Care1st maintains a Center of Excellence (COE) for Autism Spectrum Disorder. For additional information refer to The Plan website (www.care1staz.com) and/or contact member services for information.

AHCCCS-eligible families who are engaged in services within the Health Plan, and who believe an adult or child may have ASD, should schedule an appointment with their psychiatrist, primary care or behavioral health provider.

Children and adults not currently engaged with a behavioral health provider in the Health Plan can contact their primary care provider, who can then refer the child and family to a specialized ASD diagnosing provider and/or a member can contact Care1st or contact a local behavioral health provider to schedule an appointment. Members are able to self-refer directly for services. Providers and/or members can find a list of diagnosing providers on The Plan website (www.care1staz.com) and/or can also contact member services for information.

In addition, if there is a diagnosis of Autism, per AMPM 310B families may choose to seek Applied Behavior Analysis (ABA) services. Behavior Analysts utilize contextual factors,

motivating operations, antecedent stimuli, positive reinforcement, and other consequences to help people develop new behaviors, increase, or decrease existing behaviors, and emit behaviors under specific environmental conditions. Refer to AMPM Policy 320-S for more information. Providers and/or members can find a listing of providers who deliver ABA on The Plan website (www.care1staz.com) and/or can also contact member services for information.

Members who need any assistance with establishing and/or connecting with services, or require any support, may receive this help through the Care1st Care Management Program. Please refer to Care Management section in the provider manual for additional information on how to refer.

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

PCPs are required to comply with The Health Plan, AHCCCS and RBHA or T/RBHA guidelines for referring their assigned members for behavioral health services. Referrals are based on, but not limited to:

- member request (members may also self-refer to a behavioral health provider);
- sentinel event, such as a member-defined crisis episode;
- psychiatric hospitalization;
- identification of behavioral health diagnosis outside the scope of the PCP or substance abuse disorder issues.

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: https://www.care1staz.com/find-a-doctor.html

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://www.care1staz.com/providers/resources/care-management.html
6. Establishing a collaborative relationship with neighboring contracted behavioral health providers

PCPs must transfer the member to a behavioral health provider contracting with The Health Plan (for dual- eligible members) or the Regional Behavioral Health Authority (RBHA) or Tribal/Regional Behavioral Health Authority (T/RBHA) if symptoms become severe or if the member needs additional behavioral health services. PCPs must ensure members are not simultaneously receiving behavioral health medication from both the behavioral health provider and PCP. When the member is identified to be simultaneously receiving medications from the PCP and behavioral health provider, the PCP must immediately contact the behavioral health provider to coordinate care and agree on who will continue to medically manage the person's behavioral health condition.

PCPs must use step therapy as needed for ADHD, anxiety disorder, mild depression, postpartum depression, and opioid use disorder (OUD). Step therapy is required for medication not on the Arizona Health Care Cost Containment System (AHCCCS) preferred drug list or behavioral health preferred drug list. This includes the requirement that if the PCP receives documentation from The Health Plan, or T/RBHA behavioral health providers regarding completion of step therapy, the PCP continues prescribing the same brand and dosage of current medication unless a change in medical condition is clearly evident.

Psychotropic medications are listed in The Health Plan Preferred Drug List, available on the provider website at www.care1staz.com. For additional information regarding pharmacy benefits, contact the Health Plan Pharmacy Department.

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, Support and Rehabilitation Services for children, youth, and young adults, or Employment Network Providers. Care1st maintains a list of TIC-certified therapists. For additional information contact the Behavioral Health department and/or Member 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 primary Behavioral Health provider for inclusion in the member's comprehensive Behavioral Health clinical record.

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SECTION VII: Behavioral Health Services

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
Providers must provide services in a culturally competent manner in accordance with The Health Plan Cultural Competency Plan.

Providers are required to:

- Provide a courteous, welcoming environment that provides persons with the opportunity to explore, identify, and achieve their personal goals;

- Engage persons in an empathic, hopeful, and welcoming manner during all contacts;
- Provide culturally relevant care that addresses and respects language, customs, and values and is responsive to the person's unique family, culture, traditions, strengths, and age, to meet the needs of members with diverse cultural and ethnic backgrounds, including those with limited English Proficiency, disabilities, and regardless of gender, sexual orientation, or gender identity;
- Provide an environment in which consumers from diverse cultural backgrounds feel comfortable discussing their cultural health beliefs and practices in the context of negotiating treatment options;
- Provide care by communicating to Members in their preferred language and verifying that they understand all clinical and administrative information;
- Be aware of and seek to gain an understanding of persons with varying disabilities and characteristics;
- Display sensitivity to, and respect for, various cultural influences and backgrounds (e.g., ethnic, racial, gender identity, sexual orientation, and socio-economic class);
- Establish an empathic service relationship in which the person experiences the hope of recovery and is considered to have the potential to achieve recovery while developing hopeful and realistic expectations;
- Demonstrate the ability to welcome the person, and/or the person's legal guardian, the person's family members, others involved in the person's treatment and other service providers as collaborators in the treatment planning and implementation process;
- Demonstrate the desire and ability to include the person's and/or legal guardian's viewpoint and to regularly validate the daily courage needed to recover from persistent and relapsing disorders;
- Assist in establishing and maintaining the person's motivation for recovery; and
- Provide information on available services and assist the person and/or the person's legal guardian, the person's family, and the entire clinical team in identifying services that help meet the person's goals.
- For members with an SMI who are receiving Special Assistance, the person designated to provide Special Assistance per AHCCCS AMPM Policy 320-R.
- The Contractor shall ensure providers engage incarcerated members with high incidence or prevalence of behavioral health issues, or who are underserved as specified in AMPM Policy 1022.

See AMPM Policies:
1040, found at:
https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/1000/1040.pdf

310-B found at:
https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/300/310B.pdf

1022 found at:
https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/1000/1022.pdf

320-R found at:
https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/300/320R.pdf

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.
- For persons determined to have a Serious Mental Illness who are receiving Special Assistance (see AHCCCS AMPM section 320-R)

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

a. Members with an SMI or SED designation
b. Members on court ordered treatment,
c. Members with a history of justice involvement
d. Children, pregnant women, and/or teenagers with a substance use 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
g. Members experiencing, or at risk of experiencing homelessness.

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.

Re-Engagement for Members on Court Ordered Treatment

"For members who are on Court Ordered Treatment, it is the expectation that providers will re-engage within 24 hours of a missed appointment and continue frequent re-engagement efforts until such a time as the member is re-engaged and adherent with treatment, the court order is amended/revoked with the person placed in a psychiatric facility, or it has been confirmed that the member is now living in a different Regional Behavioral Health Authority/Managed Care Organization/Health Plan area or that the member has permanently moved out of state".

- If a member misses a Behavioral Health Medical Provider (BHMP) appointment, whether it is because the member canceled, no-showed, or the provider canceled the appointment, Re-engagement attempts should immediately be started to reschedule the missed BHMP appointment. The appointment should be rescheduled so that the requirement of a monthly appointment is met.
- BHMP emergency appointment slots should be utilized to accommodate this appointment.
- Missed appointments and non-adherence to the treatment plan should prompt the treatment team to re-evaluate the treatment plan to ensure that it is meeting the member's needs and goals. A member's input into the plan, with attention to achieving their goals as much as possible, will help with engagement. Any barriers to attending appointments should be assertively and creatively addressed, for example a member's difficulties with communication, transportation, competing commitments, childcare, managing schedules, etc. The treatment plan should be as flexible and personalized as possible to facilitate each member's adherence.
- If maximal effort to re-engage a member into outpatient treatment fails, the treatment team should file a revocation so that the member may be assessed in a crisis setting. This is especially important if the member has missed an injection as a result of missing their outpatient appointment. Whether or not the member is hospitalized as a result of the revocation, revocations are another opportunity to re-engage the member and amend the treatment plan with the member's input.
- If a provider does not reschedule the missed appointment within two business days, the provider should not revoke the member for this reason alone. Instead, the provider must make arrangements to reschedule the member as soon as possible.

Providers should not revoke a member due to a provider administrative or coordination issue.

Follow-Up After Missed Appointments
Providers are required to contact all persons who miss scheduled appointments without rescheduling. Providers must contact the person following a missed appointment or as soon as possible but no later than two workdays after the missed appointment. Documentation of all attempts to reach the person shall be documented in the person's medical record. At least three attempts shall be made to reschedule a missed appointment and shall include contacts made by certified mail and telephone. Face-to-face outreach shall be required for all persons receiving medication services, all individuals identified to be at risk, or to persons who have reported danger to self/danger to others thoughts in the last year. All outreach attempts shall be completed within thirty days of a missed appointment.

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

Additionally, for persons released from jail or hospital settings, outpatient providers must help establish priority prescribing clinician appointments based on the needs of the member but no later than 7 days of the person's release to ensure client stabilization, medication adherence, and to avoid re-hospitalization.

Ending Treatment for Members in Behavioral Health System
Providers may not end a member's treatment because of an adverse change in the member's health status or because of the member's utilization of medical services, diminished capacity, or uncooperative or disruptive behavior. Providers must not arbitrarily or prematurely reject or eject a member from services without prior authorization of The Health Plan. However, under certain circumstances, it may be appropriate or necessary to close a person's chart for administrative reasons, or after re-engagement efforts described above have been expended.

Children Held at County Detention Facilities
Providers must check the AHCCCS Pre-paid Medical Management Information System (PMMIS) to determine eligibility for treatment services prior to the delivery of each behavioral health service to a child who is held in a county detention facility.

Contact the Health Plan for assistance when a child loses their Title XIX/XXI eligibility while in detention. Children who lose their eligibility or have their eligibility suspended while temporarily in detention may be eligible for Mental Health Block Grant (MHBG) funded services, depending on availability of funds and prior approval of AHCCCS. Funding availability may vary from year to year based on the availability of applicable Non-Title XIX/XXI funds. Funding for services for Adolescents in detention must be approved by AHCCCS based on an approved Health Plan comprehensive work plan (Reference AMPM 320 T1 for additional information and requirements)

Even when funding is not available, Behavioral Health Homes are required to maintain contact with children in detention and during the 30-day period prior to release to facilitate appropriate release planning.

Inmates of Public Institutions
AHCCCS has implemented an electronic inmate of public institution notification system developed by the AHCCCS Division of Member Services (DMS). If a member is eligible for AHCCCS covered services during the service delivery period. The Health Plan is obligated to cover the services regardless of the perception of the members' legal status.

In order for AHCCCS to monitor any change in a member's legal status, and to determine eligibility, The Health Plan providers are required to notify The Health Plan and AHCCCS via e-mail, and if they become aware that an AHCCCS eligible member is incarcerated. AHCCCS has established an email address for this purpose. Notifications shall be sent via email to the following email address: MCDUJustice@azahcccs.gov. Notifications must include the following Member information:

- AHCCCS ID;
- Name;
- Date of Birth;
- Incarceration date; and
- Where incarcerated.

Behavioral Health Homes are required to maintain contact with persons in detention and during the 30-day period prior to release to facilitate appropriate release planning. These coordination of care services are funded through state funds and block grant funds.

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/AODA Information Management/Data Analytics Unit Manager and AODA Analytics Administrator for DHCM/AODA . In addition, technical support for the portal can be obtained at ISDCustomerSupport@azahcccs.gov or 602-417-4451.

Serving Members 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

All persons being served in the public behavioral health system must have a behavioral health assessment upon an initial request for services. For persons who continue to receive services, updates to the assessment must occur at least annually. Behavioral health assessments must be utilized to collect necessary information that will inform providers of how to plan for effective care and treatment of the individual.

AHCCCS does not mandate that a specific assessment tool or format be used but requires certain minimum elements. Providers must collect and submit all required member information in accordance with the criteria outlined in the AHCCCS Demographic and Outcome Data Set User Guide (DUG).

The initial and annual assessment must be completed by a behavioral health professional (BHP) or behavioral health technician (BHT) under the clinical oversight of a BHP, trained on the minimum elements of a behavioral health assessment and who meets the necessary training requirements.

Assessment Requirements

AHCCCS has established the following minimum elements that must be included in a comprehensive behavioral health assessment and documented in the comprehensive clinical record, in accordance with AHCCCS AMPM Section 320-O, Behavioral Health Assessment and Treatment Service Planning Providers are required to have policies in place to monitor accuracy and completion of the behavioral health assessment.

For persons referred 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, in accordance with Appointment Standards and Timeliness of Service. If the assessor is unsure regarding a person's need for psychotropic medications, then the assessor must review the initial assessment and treatment recommendations with their clinical supervisor or a licensed medical practitioner with prescribing privilege.

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.
D. The outpatient provider of behavioral health services is responsible for maintaining all behavioral health assessments within the medical record, and for ensuring periodic assessment updates are completed to meet the changing behavioral health needs for members who continue to receive behavioral health services.
E. If an assessment was completed by another provider or prior to outpatient treatment, the provider must review, update and document member's assessment information per A.A.C. R9-10-1011
F. All providers shall maintain an immediately accessible copy of the member's assessment (see AMPM Policy 940)

2. The Assessment, Service, and Treatment Plan are included in the medical record in accordance with AMPM Policy 940,
3. 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. Change in level of care
    vii. Incarceration, and
    viii. Any event which may cause a disruption of normal life activities, based on a member's identified perspective, and need.

Behavioral Health Assessments

Assessments

1. Individuals receiving behavioral health services receive a comprehensive behavioral health assessment. The assessment conducted is in compliance with the Rules set forth in A.A.C. Title 9, Chapters 10 and 21, and/or ACOM Policy 417, as applicable.

2. The outpatient provider of behavioral health 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.
    a. The behavioral health provider documents in the member's medical record that the assessment has been shared with the member's PCP.
        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.
    b. 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.
3. Additional Assessments

a. Children birth 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 Policy 461. The Early Childhood Service Intensity Instrument (ECSII) is not required, but may be utilized, as an additional option for identifying developmental concerns for children birth through five. This information shall be shared with the providers involved in the child's treatment and care, Tribal ALTCS case manager or the TRBHA.
b. Children Ages six through 17 – an age-appropriate assessment will be completed by the outpatient provider during the initial assessment and updated at least every six months. This information shall be shared with the providers involved in the child's treatment and care, Tribal ALTCS case manager or the TRBHA.
c. Children Ages six through 17 – Strengths, Needs and Culture Discovery Document will be completed and shared with the providers involved in the child's treatment and care, Tribal ALTCS case manager or the TRBHA.
d. Children Ages 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.

BEHAVIORAL HEALTH SERVICES FOR CHILDREN IN DCS CARE, KINSHIP PLACEMENT OR ADOPTED

The Health Plan and our contracted children's behavioral health providers, ensure the provision of timely behavioral health services to children enrolled with the Health Plan who may be residing with an out-of-home caregiver, may be adopted or may be placed in an out-of-home dependency with the Department of Child Safety (DCS). The Health Plan and our contracted children's providers coordinate care between the out-of-home caregiver or adoptive parent(s), all providers and DCS as appropriate.

1. Request for Behavioral Health Out-of-Home Treatment:
    a. After a request is made to place a child in a behavioral health out-of-home treatment setting, the Health Plan issues a determination as to that request no later than 72 hours or as expeditiously as the member's health condition warrants due to the member displaying dangerous or threatening behaviors directed towards themselves or others. These settings include behavioral

health residential facilities, therapeutic foster homes and behavioral health in-patient facilities. In the event the Health Plan determines there is insufficient information to make a determination, the behavioral health provider is required to assist the health plan to obtain required information within the 72-hour timeframe. In the event the request for behavioral out-of-home treatment is denied, the contracted behavioral health provider and the health plan ensures medically necessary alternative services are offered to the member and caregivers.

b. If the member is hospitalized due to threatening behaviors prior to a determination on the request for behavioral health out-of-home treatment, the Health Plan coordinates with the hospital and out-patient behavioral health provider to ensure an appropriate and safe discharge plan. The discharge plan includes recommended follow-up services including CFT recommendations in accordance with AMPM 1020.

c. The Health Plan issues a Notice of Adverse Benefit Determination (NOA) as specified in ACOM Policy 414 for any adverse action related to the request for behavioral health out-of-home treatment.

2. Behavioral Health Appointment Standard:
   a. Upon notification from an out-of-home caregiver or Adoptive Parent(s) that a recommended behavioral health service has not provided to a member (as specified in ACOM Policy 417), the Health Plan and contracted providers are aware of the requirement to also report the failure to receive the approved behavioral health services to the AHCCCS Clinical Resolution Unit at 602-364-¬4558 or 1-800-867-5808, or by email at DCS@azahcccs.gov.
      i. The Health Plan and contracted providers notifies the member's Health Care Decision Maker (HCDM) that the member may receive services directly from any AHCCCS registered provider, regardless of whether the provider is contracted with the Health Plan,
      ii. Obtain the name and contact information of the identified non-contracted provider of service, if applicable to verify their AHCCCS registration, and
      iii. Obtain information needed to determine medical necessity of requested services not received.
3. Education:
   a. The Health Plan and contracted children's out-patient behavioral health providers are responsible for providing education to providers, members, families, and other parties involved with the member's care, on an ongoing basis. This includes but is not limited to, the following areas:
      i. Rights and responsibilities as delineated in A.R.S. § 8-512.01.
      ii. Trauma-informed care.
      iii. Navigating the behavioral health system.
      iv. Coordination of Care with all providers.
      v. Covered services.

vi. Referral process including Arizona Families First (Family in Recovery Succeeding Together, AFF).
vii. The role of the health plan.
viii. The role of DCS, as applicable.
ix. Additional trainings identified by the Member Advisory Council or obtained via stakeholder input.

Social Determinants of Health and Specific Behavioral Health Home Housing Screening and Service Requirements

AHCCCS and the Health Plan collect and track member outcomes related to Social Determinants of Health. The use of specific International Classification of Diseases, 10th Edition, Clinical Modification (ICD-10-CM) diagnostic codes representing Social Determinants of Health are a valuable source of information related to member health.

The Social Determinants of Health codes identify conditions in which people are born, grow, live, work, and age. They are often responsible, in part, to health inequities. They include factors such as

- Education
- Employment
- Physical environment
- Socioeconomic status, and
- Social support networks.

As appropriate and within a scope of practice, providers should be routinely screening for, and documenting, the presence of social determinants. Any identified social determinant diagnosis codes should be provided on all claims for AHCCCS members in order to comply with state and federal coding requirements.

Behavioral Health Homes are required to coordinate with the AHCCCS Housing Administrator to secure a Housing Management Information System (HMIS) license in order to ensure that members are entered into the Care1st Health Plan Coordinated Entry. The Health Plan requires that providers complete a homeless assessment using the Vulnerability Index Service Prioritization Decision Assistance Tool (VI SPDAT) for all members experiencing homelessness, at risk of homelessness, or request assistance with housing.

The Behavioral Health Home must then enter the VI SPDAT assessment for each member into the Continuum of Care (CoC) Care1st Health Plan Coordinated Entry through the Homeless Management Information System (HMIS) database referring the member to the Health Plan Coordinated Entry Housing list. Members meeting the HUD definition of homelessness will also be entered into the CoC Coordinated Entry List. This step will open

housing opportunities beyond the Health Plan housing programs for members experiencing homelessness, assist providers in maintaining contact with those members, and ensure heightened coordination and collaboration with the full network of homeless and housing services available in local communities.

Behavioral Health Homes serving adults are required to identify and screen members; including members with SMI that satisfy Section 8 criteria and refer prospective tenant to the appropriate contracted Public Housing Authority. Providers are required to participate with the individual's treatment team in order to identify available housing units and to place the individual in an affordable appropriate living environment upon discharge from an institutional setting.

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 primary behavioral health agency 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.

Appeals or Service Plan Disagreements

Every effort should be taken to ensure that the service planning process is collaborative, solicits and considers input from each team member, and results in consensus regarding the type, mix, and intensity of services to be offered. In the event that a person and/or legal or designated representative disagree with any aspect of the service plan, including the inclusion or omission of services, the team should take reasonable attempts to resolve the differences and actively address the person's and/or legal or designated representative's concerns.

Despite a behavioral health provider's best effort, it may not be possible to achieve consensus when developing the service plan. In cases that the person and/or legal or designated representative disagree with some or all of the Title XIX/XXI covered services included in the service plan, the person and/or legal or designated representative must be given the opportunity to obtain a second opinion from an in-network provider or, if necessary, an out-of-network provider at no cost.

In cases that a person determined to have a SMI and/or legal or designated representative disagree with some or all of the Non-Title XIX/XXI covered services included in the service plan, the person and/or legal or designated representative must be given a copy of the Appeal or Serious Mental Illness Grievance Form located in the AHCCCS ACOM Chapter 400, Section 446, Attachment A by the behavioral health representative on the team.

In either case, the person and/or legal or designated representative may file an appeal within 60 days of the action.

Updates to the Assessment and Service Plan

Providers must complete an annual assessment update with input from the Member and family, if applicable, that records a historical description of the significant events in the person's life and how the person/family responded to the services/treatment provided during the past year. Following this updated assessment, the service plan should then be updated as necessary. While the assessment and service plan must be updated at least annually, the assessment and service plan may require more frequent updates to meet the needs and goals of the Member and their family. Providers must have a policy in place to monitor timely updates of both assessments and services plans.

Safety Planning

General Purpose of a Crisis and Safety Plan

A 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. A 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 the Safety Plan will be completed in alignment with the member's Service and Treatment Plan, and any existing Behavior plan if applicable. Safety Plans

will be considered when any of the following clinical indicators are identified in a member's treatment, service or behavioral plan:

a) Justice Involvement
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 or present concern of DTS/DTO
g) Members with an SMI designation,
h) Members identified as High Risk/High Needs, and/or
i) Children ages 6-17 with a CALOCUS Level of 4, 5, or 6.

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 Safety Plan will be distributed to the team members that assisted with development of the Safety Plan.

A 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 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) Realistic interventions that are most helpful to the individual and his/her family members or support system,
c) Guiding the support system toward ways to be most helpful to members and their families.
d) Multisystem Involvement Adherence to COT if applicable. 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, DR, environmental
    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, roommates, housing, financials, medical needs, schoolwork).

SECTION VII: Behavioral Health Services

Psychotropic Medications
For members 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)

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). Providers should coordinate medical and physical care, to include applying for medical and behavioral health care coverage, including how to select a health plan and a physician.
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. Children turning 18 years of age may also choose to remain with their current Behavioral Health Provider, transfer to another provider as desired or clinically indicated, or close out the behavioral health system entirely.

Providers are required to screen for the conditions of Social Determinants of Health with an approved AHCCCS SDOH screening tool before linking the Young Adult to community based organizations to address the needs.

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)

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. Courses are available online, which include Transition to Independence Process and AHCCCS Policy 280: Transition to Adulthood. 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.

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)
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.

SECTION VII: Behavioral Health Services

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.

REQUIREMENTS OF ORGANIZATIONS PROVIDING EMPLOYMENT SERVICES

All contracted behavioral health providers and integrated health care providers are required to deliver or assist members in obtaining employment and rehabilitation services. Provider Organizations delivering and billing employment and rehabilitation related activities shall employ at least one fully dedicated Employment Specialist. Provider Organizations delivering and billing for employment and rehabilitation services are required to employ an adequate number of fully dedicated Employment Specialists to meet the needs of the

members served in each clinic. It may be permissible for the employment/rehabilitation staff to cover more than one clinical team or split time with other duties, based on staffing, availability, regional locations and enrollment numbers, with prior approval from the Health Plan Employment Administrator and AHCCCS.

Provider Organizations delivering employment and rehabilitation services are required to:

- Monitor employment service utilization including job placement data and ensure accurate and reliable employment status within the Supplemental Member Data Provider Portal.
- Implement Supported Employment and meet SAMHSA Supported Employment fidelity.
- Fulfill the requirements listed in all employment Technical Assistance Documents and provide annual training to all clinical staff on the Technical Assistance Documents.
- Provide benefits planning utilizing Disability Benefits 101 (www.db101.org).
- Adhere to the guidelines within the Interagency Service Agreement (ISA) between AHCCCS and ADES/RSA.
- Provider Organizations serving adults determined Seriously Mentally Ill (SMI) are responsible for ensuring at least a 7% of members with SMI determinations are engaged with RSA/VR services versus the providers' overall enrollment of members with SMI determinations.
- Make all reasonable efforts to become mutually contracted with ADES/RSA.
- Adhere to ACOM Policy 447: (www.azahcccs.gov/shared/Dowloads/ACOM/PolicyFiles/400/447.pdf)

Employment Specialists must:

- Connect members to sustainable employment resources in the community including RSA/VR, AZ@Work, Linkages of Arizona, etc.
- Provide individualized supports to assist members in obtaining and maintaining competitive employment.
- Fulfill responsibilities listed in the ISA/Collaborative Protocol with ADES/RSA and refer all adults interested in employment services to the RSA/VR Program.
- Participate in Health Plan sponsored meetings/events and ad hoc coordination meetings with AHCCCS and ADES/RSA.

SMI AND SED ELIGIBILITY DETERMINATIONS

In order to ensure that persons with a serious mental illness(SMI) or serious emotional disturbance (SED) are promptly identified and enrolled for services, AHCCCS has developed a standardized process for the referral, evaluation, and determination for SMI

and SED eligibility. The requirements associated with the referral for a SMI or SED evaluation and eligibility determination are set forth in AHCCCS 320P Eligibility Determinations for Individuals with Serious Emotional Disturbance and Serious Mental Illness. Additionally, the SMI and SED Determination Forms are found at https://community.solari-inc.org/eligibility-and-care-services/provider-forms/.

CRITERIA FOR SMI AND SED ELIGIBILITY

1. All individuals from birth to 18 years old shall be evaluated for SED eligibility by a qualified clinician and have an SED eligibility determination made by the determining entity if the individual or their Health Care Decision Maker (HCDM) makes such a request.
2. Individuals 17.5 or older will be evaluated for SMI eligibility by a qualified clinician as defined in A.A.C. R9-21-101(B) , and have an SMI eligibility determination made by the determining entity if:
3. The individual makes such a request,
4. A HCDM makes a request on behalf of the individual,
5. An Arizona Superior Court issues an order for the individual to undergo and SMI evaluation/determination.
    a. Clinically indicated by the presence of a qualifying diagnosis, or
    b. There is reason to believe that the assessment may indicate the presence of a qualifying diagnosis and functional limitation(s).
6. The SMI assessment and evaluation process may begin for an individual at 17.5 years of age, while the SMI eligibility category will not become effective until age 18 years of age.
7. The SED or SMI eligibility record shall contain all of the documentation that was considered during the review including, but not limited to, current and/or historical treatment records. The record may be maintained in either hardcopy or electronic format.
8. The Health Plan, Tribal ALTCS, and TRBHA case manager shall develop and make available to providers any requirements or guidance on SED and SMI eligibility evaluation record location and/or maintenance.
9. Computation of time is as follows:
    a. Day Zero: The day the initial assessment is completed by a qualified clinician, regardless of time of the assessment,
    b. Day One: The next business day after the initial assessment is completed. The individual or organization completing the initial assessment must provide it to the determining entity as soon as practicable, but no later than 11:59 pm on day one.
    c. Day Three: The third business day after the initial assessment is completed. The determining entity will have at least two business days to complete the final SMI eligibility determination, but the final SMI eligibility determination will be completed no later than day three, and

d. Determination Due Date: Day Three (three business days after Day Zero, excluding weekends and holidays) is the date that the determination decision shall be rendered. This date may be amended if an extension is approved in accordance with this policy.

10. Tribal ALTCS or TRBHA program may delegate to the determining entity all the responsibilities specified in this Policy and/or as contained in their Intergovernmental Agreement (IGA) as it relates to eligibility determinations.

Process for Completion of the Initial SED or SMI Assessment:

1. Upon receipt of a referral, a request, or identification of the need for SED or SMI Eligibility Determination, the receiving party (Health Plan care coordinators, the individual's contracted Behavioral Health provider, Tribal ALTCS, TRBHA case manager, the FFS provider for members enrolled in AIHP, or designated Arizona Department of Corrections (ADC) or Arizona Department of Juvenile Corrections (ADJC) staff) will schedule an assessment with the individual and a qualified clinician if one has not been completed within the last six months. This will occur as expeditiously as the member's health condition requires, but no later than seven business days after receiving the request or referral.
2. For urgent eligibility determination referrals for individuals admitted to a hospital for psychiatric reasons, the determining entity can accept an assessment completed by the hospital, so long as it meets the criteria needed to render a decision.
3. During the assessment meeting with the individual, the clinician shall:
    a. Make a clinical judgment as to whether the individual is competent enough to participate in an evaluation,
    b. Obtain written consent to conduct the assessment from the individual or, if applicable, the individual's HCDM, unless the individual has been ordered to undergo evaluation as part of Court Ordered Treatment (COT) proceedings,
    c. Provide to the individual and, if applicable, the individual's HCDM, 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),
    d. Obtain authorization for the release of information, if applicable, (as specified in AMPM Policy 940) for any documentation that would assist in the determination of the individual's eligibility for SED or SMI designation,
    e. Conduct an assessment that is an accurate representation of the member's current level of functioning if one has not been completed within the last six months,
    f. Complete the SED or SMI eligibility determination packet on the SMI Provider Submission Portal, and
    g. Upon completion, submit all information to the Determining Entity within one business day.

Criteria for SED Eligibility:

1. The final determination of SED requires both a qualifying SED diagnosis and functional impairment because of the qualifying diagnosis. Refer to Prepaid Medical Management Information System (PMMIS) screen RF260 and the Medical Coding Page on the AHCCCS website for a list of qualifying diagnoses.
2. To meet the functional criteria for SED, an individual shall have, because of a qualifying SED diagnosis, dysfunction in at least one of the following four domains, as specified below, for most of the past six months, or for most of the past three months with an expected continued duration of at least three months:

a. 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 is at risk of confinement because of dangerous behavior. Persistently neglectful or abusive towards others. 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 individual's education or personal relationships,

b. Dysfunction in role performance. Frequently disruptive or in trouble at home or at school. Frequently suspended/expelled from school. Major disruption of role functioning. Requires structured or supervised school setting. Performance significantly below expectation for cognitive/developmental level. Unable to attend school or meet other developmentally appropriate responsibilities,

c. Child and Adolescent Level of Care Utilization System (CALOCUS) recommended level of care 4, 5, or 6, or

d. Risk of deterioration:

   i. A qualifying diagnosis with probable chronic, relapsing, and remitting course,

   ii. Co-morbidities (e.g., developmental/intellectual disability, Substance Use Disorder (SUD), personality disorders),

   iii. Persistent or chronic factors such as social isolation, poverty, extreme chronic stressors (e.g., life-threatening or debilitating medical illnesses, victimization), or

   iv. Other (e.g., 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).

3. An inability to obtain existing records or information, or lack of a face-to-face psychiatric or psychological evaluation shall not be sufficient in and of themselves for denial of SED eligibility.

Criteria for SMI Eligibility:

1. The final determination of SMI requires both a qualifying SMI diagnosis and functional impairment because of the qualifying diagnosis. Refer to PMMIS screen RF260 and the Medical Coding Page on the AHCCCS website for a list of qualifying diagnoses.

2. To meet the functional criteria for SMI status, an individual shall have, because of a qualifying SMI diagnosis, dysfunction in at least one of the following four domains, as specified below, for most of the past 12 months, or for most of the past six months with an expected continued duration of at least six months:

a. Inability to live in an independent or family setting without supervision – neglect or disruption of ability to attend to basic needs, including but not limited to, hygiene, grooming, nutrition, medical care and/or dental care. Needs assistance in caring for self. Unable to care for self in a safe or sanitary manner. Housing, food, and clothing is or shall be provided or arranged for by others. Unable to attend to the majority of basic needs of hygiene, grooming, nutrition, medical and dental care. Unwilling to seek prenatal care or necessary medical/dental care for serious medical or dental conditions. Refuses treatment for life threatening illnesses because of behavioral health disorder, a risk of serious harm to self or others,

b. 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 is at risk of confinement because of dangerous behavior. Persistently neglectful or abusive towards others. 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 individual's education, livelihood, career, or personal relationships,

c. 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

d. Risk of deterioration.
    i. A qualifying diagnosis with probable chronic, relapsing, and remitting course,
    ii. Co-morbidities (e.g., developmental/intellectual disability, Substance Use Disorder (SUD), personality disorders),
    iii. Persistent or chronic factors such as social isolation, poverty, extreme chronic stressors (e.g., life-threatening or debilitating medical illnesses, victimization), or
    iv. Other (e.g., 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).

3. The following reasons shall not be sufficient in and of themselves for denial of SMI eligibility:
    i. An inability to obtain existing records or information, or
    ii. Lack of a face-to-face psychiatric or psychological evaluation.

Individuals With Co-Occurring Substance Use:

1. For purposes of SED or SMI eligibility determination, presumption of functional impairment is as follows for individuals with co-occurring substance use:
    a. For psychotic diagnoses other than substance-induced psychosis (bipolar I disorder with psychotic features, delusional disorder, major depression, recurrent, severe, with psychotic features, schizophrenia, schizoaffective disorder, and any other diagnosis of persistent psychotic disorder), functional impairment is presumed to be due to the qualifying mental health diagnosis.
    b. For other qualifying psychiatric disorders, functional impairment is presumed to be due to the psychiatric diagnosis, unless:
        i. The severity, frequency, duration, or characteristics of symptoms contributing to the functional impairment cannot be attributed to the qualifying mental health diagnosis, or
        ii. 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. In order to make such determinations, the assessor shall first look at a period of either 30 days or longer of abstinence, or 60 days or longer of reduced use that is less than the threshold expected to produce the resulting symptoms and disability and establish that the symptoms and resulting disability were no longer present after the 30- or 60-day period and/or no longer required mental health treatment to prevent recurrence of symptoms.
    c. A diagnosis of substance-induced psychosis can only be made if both of the following conditions are present:
        i. There is no psychosis present before a period of substance use that is of sufficient type, duration, and intensity to cause psychotic symptoms, and
        ii. The psychosis remits completely (not partially) after a period of abstinence of 30 days or less.
    d. Continuation of new onset psychotic symptoms after a 30-day period of abstinence requires a presumptive diagnosis of a persistent psychotic disorder.
    e. 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 SED or SMI eligibility purposes.
    f. 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 SED or SMI eligibility and determination process. Some individuals will not meet the 30-day period of abstinence. This does not

preclude them from the SED or SMI eligibility assessment and determination process.

Process for Completion of Final SED or SMI Eligibility Determination:

1. The Health Plan shall develop and make available to its providers, policies and procedures that describe the providers' requirements for submitting the evaluation packet and providing additional clinical information for the determining entity to make the final SED or SMI eligibility determination.
2. In the event the determining entity requires additional information to make a final SED or SMI eligibility determination, the evaluating agency shall respond to the determining entity within three business days of request of the information.
3. The licensed psychiatrist, psychologist, or nurse practitioner designated by the determining entity shall make a final determination as to whether the individual meets the eligibility requirements for SED or SMI status based on:
    a. A face-to-face assessment or reviewing a face-to-face assessment by a qualified clinician, and
    b. 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.
4. The following shall 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 (BHP) or Behavioral Health Technician (BHT) that cannot be resolved by oral or written communication:
    a. Disagreement regarding diagnosis: determination that the individual does not meet eligibility requirements for SED or SMI status shall 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 individual's comprehensive clinical record, and
    b. Disagreement regarding functional impairment: determination that the individual does not meet eligibility requirements shall be documented by the psychiatrist, psychologist, or nurse practitioner in the individual's comprehensive clinical record to include the specific reasons for the disagreement and will include a clinical review with the qualified clinician.
5. If there is sufficient information to determine SED or SMI eligibility, the determining entity shall provide the individual with notice, in writing, of the SED or SMI eligibility determination (Notice of Decision) within three business days of the initial meeting with the qualified clinician as specified within this Policy.
6. The determining entity shall provide notification of the eligibility determination result to AHCCCS via the AHCCCS Behavioral Health Web Portal and to the provider who completed the Assessment/Evaluation through an agreed upon medium. For AIHP members, the determining entity shall also provide notification to AHCCCS/DFSM at casemanagers@azahcccs.gov or to the appropriate TRBHA,

when applicable. For Tribal ALTCS members, the determining entity shall also provide notification to the individual's Tribal ALTCS case manager. For DDD THP members, the determining entity shall also provide notification to AHCCCS/DFSM at thp-altcs@azahcccs.gov.

7. Once an SED or SMI eligibility determination decision is made and submitted to AHCCCS, AHCCCS will update the member's behavioral health category to SED or SMI respectively and will provide the eligibility determination documentation to the MCO of enrollment or AIHP, as applicable, via the AHCCCS Secured File Transfer Protocol (SFTP) server.

Issues Preventing Timely Completion of Eligibility Determination – Extending Completion of Eligibility Determination Time Period:

1. The time to initiate or complete the SED or SMI eligibility determination may be extended no more than 20 days if the individual agrees to the extension, and:
    a. There is substantial difficulty in scheduling a meeting at which all necessary participants can attend,
    b. The individual fails to keep an appointment for assessment, evaluation or any other necessary meeting,
    c. The individual is capable of, but temporarily refuses to cooperate in the preparation of the completion of an assessment or evaluation,
    d. The individual or the individual's HCDM requests an extension of time,
    e. Additional documentation has been requested but has not yet been received, or
    f. There is insufficient functional or diagnostic information to determine SED or SMI eligibility within the required time periods.
2. Insufficient diagnostic information shall be 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 SED or 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(s).
3. The determining entity shall:
    a. Document the reasons for the delay in the individual's eligibility determination record when there is an administrative or other emergency that will delay the determination of an SED or SMI status, and
    b. Not use the delay as a waiting period before determining SED or SMI status or as a reason for determining that the individual does not meet the criteria for SMI eligibility (because the determination was not made within the time standards).
4. In situations in which the extension is due to insufficient information:
    a. The determining entity shall request and obtain the additional documentation needed (e.g., current and/or past medical records) and/or perform or obtain any necessary psychiatric or psychological evaluations,

   b. The designated reviewing psychiatrist, psychologist, or nurse practitioner shall communicate with the individual's current treating clinician, or appropriate clinical team member, if any, prior to the determination of SED or SMI, if there is insufficient information to determine the individual's level of functioning, and
   c. Eligibility shall be determined within three days of obtaining sufficient information, but no later than the end date of the extension.
5. If the evaluation or information cannot be obtained within the required time period because of the need for a period of observation or abstinence from substance use in order to establish a qualifying mental health diagnosis, the individual is notified by the Determining Entity that the determination may, with the agreement of the individual, be extended for up to 60 calendar days for an Extended Evaluation Period (EEP). This is a 60-day period of abstinence or reduced use from drug and/or alcohol use in order to help the reviewing psychologist make an informed decision regarding SED or SMI eligibility.

This extension may be considered a technical re-application to ensure compliance with the intent of A.A.C. R9-21-303. However, the individual does not need to actually reapply. Alternatively, the determination process may be suspended, and a new application initiated upon receipt of necessary information.

If the individual refuses to grant an extension, SED or SMI eligibility must be determined based on the available information. If SED or SMI eligibility is denied, the individual will be notified of their appeal rights and the option to reapply in accordance with this Policy.

Notification of SED or SMI Determination

1. If the individual is determined to qualify for an SED or SMI designation, this shall be reported to the individual or their HCDM by the determining entity in writing, including notice of the individual's right to appeal the decision, on the form approved by AHCCCS.
2. If the eligibility determination results in a determination that an individual does not qualify for SED or SMI designation, the determining entity shall provide written notice of the decision and include:
   a. The reason for denial of SED or SMI eligibility
   b. The right to appeal, and
   c. The statement that Title XIX/XXI eligible individuals will continue to receive needed Title XIX/XXI covered services. In such cases, the individual's behavioral health category assignment shall be assigned based on criteria in the AHCCCS technical interface guidelines.

Reenrollment or Transfer

1. If the individual's status is SED or SMI at disenrollment, while incarcerated, or when transitioning to another health plan, AIHP, Tribal ALTCS, TRBHA, or DDD THP, the individual's status shall continue as SED or SMI.
2. An individual will retain their SED or SMI status unless a determination is made by the determining entity that the individual's enrollment remains active and the individual no longer meets criteria.
3. The Health Plan or behavioral health provider shall ensure that the SMI determination process is initiated for adolescents as specified in AMPM Policy 467 and AMPM Policy 520.

Removal of SED or SMI Designation

1. The Health Plan shall make available to their providers the policies and procedures for reviewing an SED or SMI designation.
2. A review of the eligibility determination may not be requested within the first six months from the date an individual has been designated as SED or SMI eligible.
3. The Health Plan, Tribal ALTCS case manager, TRBHA, or behavioral health providers may request a review of an individual's SED or SMI designation from the determining entity:
    a. As part of an instituted, periodic review of all individuals designated to have an SED or SMI,
    b. When there has been a clinical assessment that supports that the individual no longer meets the functional and/or diagnostic criteria, or
    c. As requested by an individual who has been determined to meet SED or SMI eligibility criteria, or their HCDM.
4. Based upon review of the individual's request and clinical data provided, removal of SED or SMI behavioral health category will occur if:
    a. The individual is an enrolled member and has not received any behavioral health service within the previous six months, or
    b. The individual is determined to no longer meet the diagnostic and/or functional requirements for SED or SMI designation.
5. In the event of the Removal of Designation, the determining entity shall:
    a. Inform the individual of changes that may result with the removal of the individual's SED or SMI designation,
    b. Provide written notice of the determination and the right to appeal to the affected individual with an effective date of 30 calendar days after the date the written notice is issued, and
    c. The Health Plan or behavioral health provider shall ensure that services are continued in the event an appeal is timely filed, and that services are appropriately transitioned.

SECTION VII: Behavioral Health Services

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.

SECTION VII: Behavioral Health Services

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.

SECTION VII: Behavioral Health Services

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

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.

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.

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.

SECTION VII: Behavioral Health Services

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.

SECTION VII: Behavioral Health 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.

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.

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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.

SECTION VII: Behavioral Health Services

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.

SECTION VII: Behavioral Health Services

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.

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

SECTION VII: Behavioral Health Services

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.

SECTION VII: Behavioral Health 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

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.

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.

SECTION VII: Behavioral Health Services

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.

SECTION VII: Behavioral Health Services

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	Any needed covered behavioral health service, including admission to a	Pregnant individuals/teenagers referred for substance abuse treatment (includes pregnant

later than 48 hours from the referral/initial request for services.	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.	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 initial request for services/referral. All subsequent services must be provided within timeframes according to the needs of the person.	Includes any needed covered behavioral health services; Admit to a clinically appropriate substance abuse treatment program (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.	All other injection drug users

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.

In collaboration with AHCCCS, ACC, RBHA 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

AZ Workforce Development Alliance – ACC, ACC-RBHA (AWFDA-ACC, ACC-RBHA) is comprised of all the AHCCCS Complete Care (ACC) & Regional Behavioral Health Authority (RBHA) Plans in the state of Arizona. This includes, Arizona Complete Health, Banner University Health Plans, Care 1st, Health Choice Arizona, (Blue Cross-BlueShield, Mercy Care, Molina Complete Care, and United Healthcare Community Plan. Together they act as a single point of contact for reference and direction for the shared provider network. This Alliance is dedicated to working with Relias, the Arizona Health Care Cost Containment System (AHCCCS), health care Providers, Members, and Communities as a whole, to drive long lasting and effective changes in workforce

development and Member outcomes. To achieve this vision, they are working collaboratively as seven separately established Health Plans to assist the Provider network in the transition from a prescriptive and compliance-based system, to a more autonomous, integrated, and competency-based system. Their mission is to evaluate, monitor, and support the development of the capability, capacity, connectivity, culture and commitment of our provider workforce.

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) includes members from AHCCCS, Arizona Complete Health, Banner University Family Care, BCBSAZ Health Choice, Care 1st, Department of Child Safety Comprehensive Health Plan (DCS CHP), Department of Economic Security/Division of Developmental Disabilities (DES/DDD), Mercy Care, Molina Complete Care and UnitedHealthcare Community Plan. This group represents ACC, ACCRBHA, ALTCS, DCS CHP, and DES/DDD lines of business. Together we ensure that initiatives across the state of Arizona align with all lines of business.

AzAHP Workforce Development Alliance (AWFDA) is comprised of all the AHCCCS Complete Care (ACC) & Regional Behavioral Health Authority (RBHA) Plans in the state of Arizona. This includes, Arizona Complete Health, Banner University Health Plans, BCBSAZ Health Choice, Care 1st, Department of Child Safety Comprehensive Health Plan, Mercy Care, Molina Complete Care, and United Healthcare Community Plan. Together they act as a single point of contact for reference and direction for the shared provider network. This Alliance is dedicated to working with Relias, the Arizona Health Care Cost Containment System (AHCCCS), health care Providers, Members, and communities as a whole; to drive long lasting and effective changes in workforce development and Member outcomes. To achieve this vision, they are working collaboratively as eight separately established Health Plans to assist the Provider network in the transition from a prescriptive and compliance-based system, to a more autonomous, integrated, and competency-based system. Their mission is to evaluate, monitor, and support the development of the capability, capacity, connectivity, culture and commitment of the provider workforce.

Definitions

Provider Workforce Development (WFD) is an approach to improving healthcare outcomes of our members by enhancing the training, skills and competency of the Provider workforce. It is an integrative effort between all departments (e.g., leadership, marketing,

finance, quality, clinical, human resources, facilities, etc.) to set goals and initiatives to improve the Provider workforce and provide better member services and care.

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.

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. Abuse & Neglect Prevention

1. Care1st will ensure that providers have access to and are in compliance with all training programs and practices required by the Report of the Abuse & Neglect Prevention Task Force (enacted by Governor Douglas A. Ducey November 1, 2019), as follows:

• Resources and training programs to assist professionals and family caregivers prevent and manage stress and burnout;
• Training for all personnel in the prevention and detection of all forms of abuse and neglect; and
• Routine exercises and drills to test the reactions of staff to simulated conditions where abuse and neglect could potentially occur are incorporated into the providers ongoing workforce/staff training and development plan.

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.
5. **Child and Adolescent Level of Care Utilization System (CALOCUS)**
   a. Employees completing the CALOCUS assessments are required to have training in CALOCUS prior to using the assessment tool with members when assessing for the determination of which children may require high needs case management. Ongoing competency assessments are also required to evaluate a staff member's knowledge and skills.
   b. Any other trained provider (PCP, specialty provider, etc.) working with children and adolescents is also able to conduct the CALOCUS assessment and trained providers can coordinate with the health home to share the assessment results for care coordination purposes.
   c. To ensure the proper identification of children and adolescents with complex needs and appropriate levels of care, AHCCCS has contracted with Deerfield Behavioral Health (Deerfield) to license the Child and Adolescent Level of Care Utilization System (CALOCUS) and Level of Care Utilization System (LOCUS) software, as well as access to online training for those who have familiarity with instruments that measure level of serve acuity. The agreement includes the licensing of both CALOCUS/LOCUS online, though AHCCCES is currently only requiring the use of the CALOCUS. This also includes licensing of the integrated Electronic Health Record (EHR) products, with the intent that providers include the assessment in their data feeds into the Health Information Exchange (HIE).
      a. Providers can implement CALOCUS/LOCUS in one of two was:
         1. Through the web-based version at locus.azahcccs.gov
         2. Through an EHR integration
      b. Regardless of the option chosen, providers must reach out to Deerfield and sign their end user license agreement. There is no cost associated

with this agreement. Key contact at Deerfield is Matthew Monago at mmonago@journeyhealth.org. Be sure to identify that your organization is an AHCCCS provider when outreaching.

d. Individuals who have previously taken the CASII training will also need to complete the CALOCUS training. This will ensure consistent alignment with AHCCCS contractual requirements for CALOCUS training, establish a baseline level of CALOCUS understanding for those that administer the tool, and enhance efforts to maintain fidelity to CALOCUS administration.
    a. For children's providers serving children in the Department of Child Safety Comprehensive Health Plan, Care1st asks to prioritize the completion of the CALOCUS for youth that are either living in a DCS funded Qualified Residential Treatment Program (QRTP) or are being considered to go into a QRTP.
    b. If there are questions regarding CALOCUS training requirements related to the AHCCCS contract, provider agencies can reach out to the Contract Compliance Officer at the Health Plan.
e. Monitoring process
    a. Care1st will monitor the CALOCUS certification process. Relias reports are run to monitor those who have completed it, as well as those who have not completed the requirement in the 30-day timeframe. Reports are compared to the Deerfield completion reports, ensuring fidelity to this AHCCCS requirement. In addition to the 30-day timeframe, provider staff must meet the 2.5-hour minimum time commitment when attending the training through Deerfield.
f. Provider Agency Requirements
    a. All child and adolescent provider agencies who meet the requirements for the CALOCUS training must do the following:
        1. Enroll employees who are required to take the Deerfield CALOCUS training in the "AzAHP-CALOCUS Training Requirement (30 Days)" training plan in Relias.
        2. Once the employee has been enrolled and completes the CALOCUS training through Deerfield, the provider agency's supervisor/administrator must mark them complete in the Relias CALOCUS Training Requirement module.
        3. Once all steps have been completed, the employee will have met the requirements for CALOCUS certification.

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 /RBHA. 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 BH provider types listed on the AzAHP website complete the AZ Healthcare Workforce Goals and Metrics Assessment annually to fulfill the requirements from ACOM 407 & ACOM 407 Attachment A. 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. multiple assessments being disseminated and duplicated). Refer to the website (AZAHP.ORG) for the most up-to-date information, including a list of required Provider Types and a link to the assessment.

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/RBHA Providers:

Training/Compliance Requirements
Relias Learning Management System (LMS)

All AHCCCS Complete Care (ACC)/ Regional Behavioral Health Authority (RBHA) Behavioral Health (BH) Providers must have access to Relias Learning. This is the Learning Management System used by the ACC-RBHA Health Plans and their contracted BH providers through the Arizona Association of Health Plans (AzAHP). Agencies must designate a Relias Administrator (or Supervisor if utilizing the Small Provider Portal) to manage and maintain their Relias Learning portal. This includes activating and deactivating users, enrollment and disenrollment of courses/events, and general reporting and/or oversite of the users in the Relias, to ensure compliance with training requirements.

Per AHCCCS' ACOM 407 and the HP Provider Manuals, it is a contractual requirement that all ACC, ACC-RBHA BH contracted agencies with designated Provider types (listed below) track their staff's course completions of the mandated statewide training requirements through the Statewide Learning Management System, identified as Relias.
• 39 Habilitation Provider
• 77 Behavioral Health Outpatient Clinic
• IC Integrated Clinic
• A3 Community Service Agency
• A6 Rural Substance Abuse Transitional Agency
• B7 Crisis Services Provider
• B8 Behavioral Health Residential Facility
• B1 Level I Residential Treatment Center-Secure (IMD)
• 78 Level I Residential Treatment Center Secure (non IMD)
• B2 Level I Residential Treatment Center-Non-Secure (non-IMD)
• B3 Level I Residential Treatment Center-Non-Secure (IMD)
• C2 Federally Qualified Health Center (FQHC)
29 Community/Rural Health Center (RHC)

SECTION VII: Behavioral Health Services

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
- CEO and/or Key WFD Contact(s):
  - Name
  - Phone Number
  - Email Address
- Contract Type (ACC/RBHA)
- Provider Type / codes (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.

SECTION VII: Behavioral Health Services

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.

Required Training

AzAHP Core Training Plans

AzAHP–Core Training Plan (90 Days)

Care1st requires that Behavioral Health Providers under the ACC, ACC-RBHA lines of business, 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. (This includes, but is not limited to, full time/part time/on-call, direct care, clinical, medical, administrative, leadership, executive and support staff). 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. *AHCCCS – Health Plan Fraud
2. *AHCCCS – NEO – Rehabilitation Employment
3. *AzAHP - Cultural Competency in Health Care
4. *AzAHP – AHCCCS 101
5. *AzAHP – Quality of Care Concern
6. *AzAHP – Client Rights, Grievances and Appeals
7. Basics of Corporate Compliance
8. HIPAA: Basics
9. Integration of Primary and Behavioral Healthcare

AzAHP –Core Training Plan (Annual)

1. *AHCCCS - Health Plan Fraud
2. *AZAHP - Cultural Competency in Health Care
3. *AZAHP - Quality of Care Concern
4. Basics of Corporate Compliance
5. HIPAA: Basics
6. Preventing, Identifying, and Responding to Abuse and Neglect

SECTION VII: Behavioral Health Services

The above Training Plan 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.

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)

Provider - Workforce Development Plan (P-WFDP) Care1st, Mercy Care, Arizona Complete Health, Banner University Family Care, Health Choice Arizona, Molina Complete Care and United Healthcare Community Plan, requires that all Behavioral Health AHCCCS Complete Care (ACC) and Regional Behavioral Health Authority (RBHA) contracted provider agencies, complete an annual Provider - Workforce Development Plan (P-WFDP). Required Provider types can be found at AZAHP.ORG. The purpose of the P-WFDP is to encourage Provider organizations to work together and ensure members receive services from a workforce that is qualified, competent, and sufficiently staffed. The

SECTION VII: Behavioral Health Services

P-WFDP shall include a description of organizational goals, objectives, tasks, and timelines to develop the workforce. The overall approach and philosophy to Workforce Development is to ensure a comprehensive, systematic, and measurable structure that incorporates best practices at all levels of service delivery and utilizes Adult/Children's Guiding Principles, Adult Learning Theories/Methods, Trauma-informed Care, Equitable Services and Culturally Competent practices. All training initiatives, action steps, and monitoring procedures outlined in the P-WFDP are to include targeted efforts for all employees (e.g., direct care Providers, supervisors, administrators, and support staff) who are paid by, partially paid by, or support an agency's Health Plan contract(s).

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

The P-WFDP template is provided for this deliverable by the AWFDA-ACC, ACC-RBHA to providers. P-WFDP's will be submitted between 2/1 – 2/28, annually. Early and late submissions will not be accepted unless an extension was received and granted by the deadline, determined by the AWFDA-ACC, ACC-RBHA (12/31).
• Extension Requests: must be submitted to the workforce@azahp.org email before the date specified by the AWFDA-ACC, ACC-RBHA for each year. Non-submittals are subject to contracted health plan policies as it pertains to the P-WFDP deliverable.
• Exemption Requests: Federally Qualified Healthcare Providers (FQHCs), may request an exemption from their contracted Health Plan(s). Exemptions may be granted on a case-by-case basis and will consider the following: Portion of AHCCCS Members enrolled in the network and served by that Provider, the geographic area serviced, and the number of other service Providers in the surrounding area. Exemption requests must be submitted on/before December 31st and will be reviewed by the Alliance.

Failure, by the contracted Provider agency, to submit the 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), from your contracted Health Plan(s).

Miscellaneous
ACC/RBHA AWFDA Provider Forums

The AZ Workforce Development Alliance (AWFDA-ACC, ACC-RBHA) hosts monthly webinars to provide information, resources and updates for Behavioral Health ACC-RBHA contracted providers. These virtual meetings occur on the second Thursday of each month and registration information for these events will be sent out via email, to all individuals on the Workforce Development email distribution list. It is the Provider agency's responsibility to attend these sessions or review the recorded webinars when they are made available. These recordings can be found by visiting the AWFDA Website.

REQUIRED TRAINING SPECIFIC TO CHILD AND FAMILY TEAM (CFT) INITAITIVES

The statewide Child and Family Team (CFT) Facilitator Course initiative and the two associated Train-the-Trainer (TtT) courses are for Providers who serve children and adolescents in the Children's System of Care (CSOC) **and** have employees who facilitate CFT's.

Initiative 1: CFT Facilitator Course

- The CFT Facilitator Course is 2 days in length, is intended for in-person delivery, and meets all AHCCCS and Health Plan training requirements for individuals who will be leading/facilitating CFT sessions.
- It is expected that provider agencies be prepared to train this course in-house, which enables providing complimentary agency-specific processes, procedures, and protocols, thus creating a robust learner-centric experience for attendees and future CFT facilitators.
- Once an agency has an employee who has become a CFT Champion, by successfully completing the TtT session (noted below), the requirement is for the CFT Champion to train the 2-day CFT Facilitator course to newly hired employees at the provider agency. Employees who already meet the existing CFT Facilitator training requirement need not attend the new course; however, each provider agency may make their own determination otherwise.
- All provider agencies shall utilize the AHCCCS approved training curriculum (ACOM 580, Section F # 2), which is made available to the CFT Champion upon completion of their CFT Facilitator TtT session.

Initiative 2: CFT Facilitator Train the Trainer (TtT)

- The CFT Facilitator TtT session is approximately 6 hours in length and is delivered via virtual instructor-led training. TtT sessions are offered throughout the year. These sessions are intended for employees who will be delivering the 2-day CFT Facilitator course in-house in their own agency. These identified employees will be known as "CFT Champions."
- CFT Champions who participate in the TtT session must be seasoned employees who possess skills equivalent to lead training sessions and must have completed CFT training requirements already in place and must be competent in CFT facilitation. It is left to the discretion of each provider agency to verify trainer competency. Presumption will be that participants have been internally vetted as competent by their provider agency prior to enrollment.

Initiative 3: CFT Supervisor Training

- The CFT Supervisor Training is approximately 5 hours in length, is intended for in-person delivery, and is for leaders who supervise employees who facilitate

CFT's. The CFT Supervisor Training is required for all new and existing leaders. Once the agency has a CFT Champion who successfully completes the CFT Supervisor TtT session (as noted below), this training will provide guidance to leaders related to coaching CFT Facilitators on CFT Practice and the identified competency measurements (ACOM 580, Section G # 1).

Initiative 4: CFT Supervisor Train the Trainer (TtT)

- The CFT Supervisor TtT session is approximately 2.5 hours in length and will be delivered via virtual instructor-led training. CFT Supervisor TtT sessions will be offered throughout the year. These sessions are intended for employees who will be training the CFT Supervisor Training Course in-house within their own agency. These identified staff will be the **same** CFT Champions that took the CFT Facilitator TtT.

AzAHP – CFT Champion Certification Process

- An ****AZAHP- CFT Champion Certification*** training plan has been created in Relias for the identified CFT Champions meeting the above noted requirements.
  - Agency leadership will need to **enroll** the identified CFT Champion(s) in the training plan.
  - Within the training plan there are three module requirements:
  - *AzAHP- CFT Overview (a self-paced course expected to be completed before attending the TtT session),
  - *AZAHP- CFT Facilitator TtT, and
  - *AZAHP- CFT Supervisor TtT.
- If the identified CFT Champion has taken CFT Overview in the last two years, they will not have to take it again and will be given credit automatically in Relias.

Initiative 5: Triannual CFT Collaborative Sessions

- In addition to CFT Champions attending TtT Facilitator Courses, delivering the 2-day CFT Facilitator Training, and CFT Supervisor Training; CFT Champions are required to attend triannual CFT Collaborative Sessions. During these sessions CFT Champions will meet with Health Plan Trainers and leaders to discuss as a group, best practices, challenges, and opportunities for growth and development regarding CFT administration and implementation.

Training and Supervision Expectations

- Provider agencies who have employees that are designated to facilitate/lead CFT's shall be trained in the elements of the CFT Practice Guide, complete an in-person, AHCCCS approved CFT facilitator curricula, and demonstrate competency via the Arizona Child and Family Team Supervision Tool.
- The CFT Supervision Tool must be completed within 90 days, and facilitators must maintain or enhance proficiency within six months as attested to by a supervisor, and annually thereafter (AMPM 580 (F), Attachment C & D).

Monitoring Process

- **CFT Champion Certification**
  - All agencies who are required to have CFT Champions will be tracked in Relias.
  - Workforce Development will maintain a list of all CFT Champions and their provider agencies.

Arizona Child and Family Team Supervisions Tool (AMPM 580 (F), Attachment C & D). The supervision tool requirements will be tracked in Relias via the CFT Competency Evaluation Tool for all employees who facilitate/lead CFT's.

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 can 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.

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.

For providers subcontracted with The Health Plan, the provider notifies The Health Plan of the intent to make a referral for out-of-state placement.

Prior to placing the child or young adult the Behavioral Health Home provider must notify Care1st Behavioral Health Utilization department of the intent to place a member in out-of-state placement. The Health Plan will review the documentation and forward it to the Division of Healthcare Management (DHCM) office with AHCCCS for approval of the out-of-state placement request. The Health Plan will notify the Division of Healthcare Management through the AHCCCS QM portal prior to or upon notification of a member being placed in an Out-of-Home placement. Prior authorization is required for this level of care.

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.

Periodic Updates to AHCCCS

In addition to providing initial notification, the provider is required to submit updates to the Health Plan for review. The updates will be forwarded to the AHCCCS regarding the person's progress in meeting the identified criteria for discharge from the out-of-state placement every 30 days.

Once completed, the Behavioral Health Home must submit updates the Behavioral Health Utilization department every 30 days the person continues to remain in out-of-state placement. The 30 day update timelines will be based upon the date of approval by AHCCCS of the out-

of-state placement. The Health Plan will review the form and forward the information to the DCHM office within AHCCCS.

Required Reporting of an Out-of-State Provider
All out-of-state providers are required to meet the reporting requirements of all incidences of injury/accidents, abuse, neglect, exploitation, healthcare acquired conditions, and/or injuries from seclusion/restraint implementations.

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."

SECTION VII: Behavioral Health Services

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 only contracted with Coconino and Navajo county governments in these GSAs to provide pre-petition screenings and court-ordered evaluation services. The following arrangements for pre-petition screening and court ordered evaluation services exist:

- 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 Care1st who in-turn contracts with ChangePoint Integrated Health, Inc. to provide pre-petition screenings and court-ordered evaluations.
- Coconino County has contract with Care1st. In-turn, Care1st contracts with The Guidance Center to provide pre-petition screening and court ordered evaluation services.
- Yavapai County has contracted with Polara Health to provide pre-petition screenings and court-ordered evaluations.
- Mohave County has contracted with Southwest Behavioral Health to provide pre-petition screening.

Pre-Petition Screening
Unless otherwise indicated in an intergovernmental agreement (IGA), 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 the member's contractor or the FFS program that is responsible for the provision of

behavioral health services. Some counties contract with Regional Behavioral Health Authority/Managed Care Organization/Health Plans to process pre-petition screenings and petitions for court-ordered evaluations.

All applicants calling The Health Plan for court-ordered evaluations are referred to the Crisis Call Center at 866-495-6735 to assist callers in identifying the correct pre-petition screening agency and answering any questions they may have about the process.

When a county does not contract with The Health Plan for pre-petition screening services, the Crisis Call Center will answer any questions the caller may have about the process and warm-transfer the caller to the appropriate county-contracted prepetition screening agency.

When a county contracts with The Health Plan for pre-petition screening and petitioning for court-ordered evaluation, the Crisis Call Center will dispatch a designated pre-petition screening agency.

During the pre-petition screening, the designated agency shall offer assistance to the applicant, if needed, requested by the member, member's representative, or identified as a need by the member's clinical team, in the preparation of the application for involuntary COE. Any behavioral health provider that receives an application for COE shall immediately refer the application for pre-petition screening and petitioning for COE to the Contractor designated pre-petition screening agency or county facility. The pre-petition screening agency must conduct the following procedures:

- Provide pre-petition screening within forty-eight hours of the request excluding weekends and holidays;
- Prepare a report of the clinical assessment, professional 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 members who attempted to conduct the pre-petition screening;
- Request the screening agency's medical director or designee review the report if it indicates that there is no reasonable cause to believe the allegations of the applicant for the court-ordered evaluation;
- Prepare a petition for court-ordered evaluation and file the petition if the screening agency's Medical Director determines that the person, due to a mental disorder, including a primary diagnosis of dementia and other cognitive disorders, is a Danger to Self (DTS), Danger to Others (DTO), Persistently or Acutely Disabled (PAD), or Gravely Disabled (GD). Refer to the Petition for Court-Ordered Evaluation form for pertinent information for court-ordered evaluation;
- If the screening agency determines that there is reasonable cause to believe that the person, without immediate hospitalization, is likely to harm themselves or others, the screening agency will verify completion of the Application for Emergency

Admission for Evaluation form, and take all reasonable steps to procure hospitalization on an emergency basis; and

- Contact the county attorney prior to filing a petition if it alleges that a person is a Danger to Others.

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.

1. Applications indicating DTS, DTO, PAD, and GD can be filed on an emergent basis.
2. The applicant shall have knowledge of the behavior(s) displayed by the individual that is a danger to self or others consistent with requirements as specified in A.R.S. § 36-524.
3. The applicant shall complete application for Emergency Admission for Evaluation, as specified in A.R.S. § 36.524.
4. The applicant and all witnesses identified in the application as direct observers of the dangerous behavior(s) may be called to testify in court if the application results in a petition for COE.
5. Immediately upon receipt of an application for Emergency Admission for Evaluation, as specified in A.R.S. § 36-524, 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 appropriate facility is not currently operating at or above its allowable member capacity, and the individual does not require medical care, then, facility staff will immediately coordinate with local law enforcement or other transportation service contracted by the county for the detention of the individual and transportation to the appropriate facility.
6. If the individual requires a medical facility, or if appropriate placement cannot be arranged within the 48-hour timeframe identified above relating to the application for Emergency Admission for Evaluation, as specified in A.R.S. § 36-524, the Medical Director of the Contractor, or for FFS members, the FFS Provider's Medical Director, shall be consulted to arrange for a review of the case.
7. The application for Emergency Admission for Evaluation, as specified in A.R.S. § 36-524 may be discussed by telephone with the facility admitting physician, the referring physician, and a peace officer to facilitate transportation of the individual to be evaluated.
8. An individual proposed for emergency admission for evaluation may be apprehended and transported to the facility under the authority of law enforcement or other transportation entity contracted by the county using the application for

Emergency Admission for Evaluation, as specified in A.R.S. § 36-524, A.R.S § 36-524(D) and A.R.S § 36-525(A), which outlines criteria for a peace officer or other county contracted transportation provider to apprehend and transport an individual based upon either a telephonic or written application for emergency admission.

9. An emergency admission for evaluation begins at the time the individual is detained involuntarily by the admitting physician who determines if there is reasonable cause to believe that the individual, as a result of a mental disorder, is DTS, DTO, PAD, or GD, and that during the time necessary to complete pre-screening procedures the individual is likely, without immediate hospitalization, to suffer harm or cause harm to others.
10. During the emergency admission period of up to 23 hours the following occurs:
    a. The individual's ability to consent to voluntary treatment is assessed,
    b. The individual shall be offered and receive treatment to which they may consent; otherwise, the only treatment administered involuntarily will be for the safety of the individual or others, i.e., seclusion/restraint or pharmacological restraint as specified in A.R.S. § 36-513, and
    c. When applicable, the psychiatrist will complete the Voluntary Evaluation within 24 hours of determining that the individual no longer requires an involuntary evaluation.

Court-Ordered Evaluation

If, after review of the petition for evaluation, the individual is reasonably believed to be DTS, DTO, PAD, or GD as a result of a mental disorder, the court can issue an order directing the individual to submit to an evaluation at a designated time and place. The order shall specify whether the evaluation will take place on an inpatient or an outpatient basis. The court may also order that, if the individual does not or cannot submit, the individual be taken into custody by a peace officer or other county contracted transportation provider and delivered to an evaluation agency. For further requirements surrounding COEs on an inpatient basis, refer to A.R.S. § 36-529.

If the pre-petition screening indicates that the individual may be DTS, DTO, PAD, or GD, the screening agency will file a petition for COE. When, through an IGA with a county, the Contractor is contracted to provide COE, they shall adhere to the following requirements when conducting COEs:

- An individual who is reasonably believed to be DTS, DTO, PAD, or GD as a result of a mental disorder shall have a petition for COE prepared, signed and filed by the Medical Director of the agency or designee,
- An individual admitted to an evaluation agency shall receive an evaluation as soon as possible, and receive care and treatment as required by their condition for the full period they are hospitalized,
- A clinical record shall be kept for each individual which details all medical and psychiatric evaluations and all care and treatment received by the individual,

- An individual being evaluated on an inpatient basis shall be released within 72 hours (not including weekends and court holidays) if further evaluation is not appropriate, unless the individual makes application for further care and treatment on a voluntary basis, or unless an application for COT has been filed, and
- On a daily basis at minimum, an evaluation shall be conducted throughout the COE process for the purposes of determining if an individual desires to be switched to a voluntary status or qualifies for discharge.

Voluntary Evaluation
Any Health Plan provider that receives an application for voluntary evaluation must immediately refer the person to the facility responsible for voluntary evaluations. Providers are to contact the Crisis Call Center at 1-866-495-6735 for assistance.

The Health Plan providers must follow these procedures:

- The evaluation agency must obtain the individual's informed consent prior to the evaluation (see AHCCCS Section 320-U-7, Application for Voluntary Evaluation) and provide evaluation at a scheduled time and place within five days of the notice that the person will voluntarily receive an evaluation; and
- 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.

If a 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, use AHCCCS AMPM Section 320-U-7 Application for Voluntary Evaluation;
- A completed informed consent form; and
- A written statement of the person'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.

Background
Per Arizona Revised Statutes 36-545.06-County Services: "Each County shall provide directly, or by contract the services of a screening Provider and an evaluation Provider."

Each County must have a process in place for:

- Involuntary mental health treatment requests and evaluations
- Court proceedings to satisfy the statutory requirements under Title 36 for individuals under court-ordered evaluation and court-ordered treatment.

Every County in Arizona manages this responsibility differently based on their interpretation of the state statutes and the resources in that County. The Court Ordered Treatment/Court Ordered Evaluation (COT/COE) Coordinator and Liaison are required to work with the County Attorney's Office to ensure proper execution of its procedures.

The Health Plan is responsible for treatment of an eligible person* once placed under a Title 36 civil commitment or court-ordered treatment (COT). Per Arizona Administrative Code (R9-21-504) the RBHA/MCO/Health Plan "shall provide, either directly or by contract all treatment required by A.R.S. Title 36, Chapter 5, Article 5."

* Populations eligible for RBHA/MCO/Health Plan services per The Health Plan Provider Manual Section 2.1.1-2:

- Title XIX/XXI enrolled individuals;
- Persons determined to have a Serious Mental Illness;
- Special populations, including individuals receiving services through the Substance Abuse Block Grant (SABG)

Overview
Each Behavioral Health Home per the Health Plan contract scope of service is required to designate a staff person to serve as COT/COE Coordinator and Liaison for Title 36 and Court-Ordered services. Each provider should also have a designated back-up staff person to answer inquiries if the designated Coordinator/Liaison is out of the office.

SECTION VII: Behavioral Health Services

A Provider coordinates the provision of clinically appropriate covered services to individuals requiring court ordered treatment and serves as the Supervising Provider for court-ordered outpatient treatment plans.

In all cases, the Provider Medical Director** or physician designee has primary responsibility for oversight of an individual's court-ordered treatment and is responsible for reviewing and signing all documents filed with Court, including the initial court-ordered treatment plan.

** Per ARS 36-501 (24) Definitions - Medical Director of a mental health treatment Provider" means a psychiatrist, or other licensed physician experienced in psychiatric matters, who is designated in writing by the governing body of the Provider as the person in charge of the medical services of the Provider for the purposes of this chapter and includes the chief medical officer of the state hospital."

Individuals on court ordered treatment (COT) are one of the most at-risk populations served. These Individuals will need to receive services with a Behavioral Health Provider who can submit the Outpatient treatment Plan to the Courts.

- Individuals on COT must be seen at least monthly by the Medical Director or designee (must be a Prescriber)
- Outreach and engagement with these individuals should be assertive and follow the re-engagement processes within The Health Plan Provider Manual (Section 3.4). The goal is to avoid re-hospitalization and improve the quality of life for the individual.
- A solid crisis plan must be developed that includes what works and does not work for this individual, support that can help, and types of outreach that should be attempted if the individual has an increase in symptoms or disengages from treatment.
- The Health Plan has developed crisis protocols for every County served that include detailed descriptions about the way the crisis system works in each respective County. There are extensive sections on involuntary treatment that should be referenced for details on how each County facilitates the COT process.
- Providers must closely monitor COT expiration dates. Pursuant to A.R.S 36-540 (D), a court order cannot exceed 365 days, but some counties may order fewer days. Providers must ensure they understand the County's interpretation of the COT expiration date. Providers must monitor expiration dates to schedule annual reviews to determine if the individual's COT should continue for another year. Additionally, it gives Providers enough time to file a Petition for Continued Treatment with Court for individuals who were found Persistently or Acutely Disable or Gravely Disabled.
- The Health Plan will monitor and audit COT requirements and will issue Corrective Action Letters and/or Sanctions for failure to follow the requirements.

SECTION VII: Behavioral Health Services

Requirements
Each Provider is responsible for maintaining a current list of individuals who are receiving court-ordered treatment.

Urgent Engagement, SMI Evaluations and AHCCCS Screening for Member in COE/COT Process
The Health Plan enrolled and State Only (N19/NSMI) individuals who are identified as not engaged with a behavioral health provider must be referred for urgent engagement and "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".

For individuals going through Court Ordered Evaluation to be Court Ordered for Treatment, all avenues are explored to determine eligibility for services offered by The Health Plan. Therefore, when an agency in any county is activated for an Urgent Engagement for an individual who is NT19 and GMH and being evaluated for Court Ordered Treatment, an SMI evaluation/assessment should be completed. In general, the SMI determination should be expedited by checking the 3-day turnaround time frame. The Behavioral Health Home should also conduct financial screenings and assist the individual in applying for Title 19 benefits.

Should the member refuse services during the Court Ordered Evaluation process; the Behavioral Health Home activated due to an urgent engagement shall retain the member until the member is Court Ordered for Treatment and then proceed to engage the member so that eligibility with AHCCCS and an SMI determination can be completed. Please contact the Title 36 Coordinator at The Health Plan for additional Technical Assistance.
Behavioral Health Homes are required to enroll and engage Title XIX members who refuse services during the COE process upon the member being Court Ordered.

Provider Participation in Hearings
The assigned Health Home must ensure a representative with knowledge of the member attend all COT hearings, including the original hearing for court-ordered treatment, judicial reviews, and Petitions for Continued Treatment of Gravely Disabled (GD) or Persistently or Acutely Disabled (PAD). It is expected that the representative will follow courtroom rules of decorum. The representative should be prepared to provide information/clarification to Court regarding facts relevant to the hearing and the proposed outpatient treatment plan. The representative must be present to receive orders set forth by the Judge/Commissioner and specific orders regarding the submitted outpatient treatment plan.

Treatment Plan Development and Filing
Prior to the date of the hearing, the Health Home Agency representative is responsible for coordinating an Adult Recovery Team (ART) meeting for enrolled individual to develop discharge plans and ensure that those plans are included in the individual's Individual

Service Plan (ISP). The ISP must be discussed/reviewed with the Agency Medical Director or physician designee. The individual's inpatient team must be involved in and agree to discharge decisions.

The COT outpatient treatment plan must be signed by the Agency Medical Director or physician designee and appropriate staff that reviewed the plan with the individual and the outpatient team. The individual is not required to sign the COT outpatient treatment plan and individual signature is optional. If the individual does not sign the plan, the individual signature line is to be left blank. Information regarding why the individual did not sign the plan is not to be written on the plan.

The COT outpatient treatment plan should have the individual's correct address/zip code and phone number and the type of residence (home, family, friend, BHRF, jail, etc.). If the individual is to reside with family, friends, etc., Provider staff must confirm this arrangement with family, friends, etc.

If a COT outpatient treatment plan has not been completed, the Agency representative is to inform Court why the plan has not been completed and the projected date of completion.

Overview

The provider can amend/revoke an individual's court order and place the individual in an inpatient setting if the individual is not following the terms of the court order. It is important to note that only the Medical Director or physician designee can request an amendment/revocation of the outpatient treatment plan. Note: Medical Directors are required to be available after hours if needed in order to facilitate the revocation/amendment of a court order.

- It is important the provider track the numbers of days a member has spent in an inpatient setting, because there are a limited amount of inpatient days the court may order pursuant to A.R.S. 36-540:
- DTS up to 90 days
- DTO & PAD up to 180 days
- GD up to 365 days
- If there are no more inpatient days available, the Medical Director must determine if the individual requires continued court-ordered treatment. If the individual is DTO/DTS the provider can follow the process for an Emergency Application for Evaluation for Admission. If the individual is PAD/GD, the provider can initiate the Annual Review process or follow the Pre-Petition Screening process.
- Amended outpatient treatment orders do not increase the total period of commitment originally ordered by Court.

Emergent Amendment/Revocation A.R.S. 36-540 (E)(5)
If the individual is presenting with DTO/DTS behaviors and requires immediate hospitalization, the provider can verbally amend the outpatient treatment plan without an order from Court. The Medical Director or physician designee must contact an inpatient psychiatrist, discuss and agree that the individual requires immediate inpatient treatment. The Medical Director or physician designee may authorize a peace officer to transport the individual to the inpatient treatment facility.

The Medical Director of the outpatient treatment facility must file a motion for an amended court order requesting inpatient treatment no later than the next working day following the individual being taken to the inpatient facility. If this paperwork is not filed in this timeframe, the individual may be detained and treated for no more than 48 hours, excluding weekends and holidays.

When an individual is hospitalized pursuant to an amended order, the provider must inform the individual of the right to judicial review and the right to consult with counsel pursuant to A.R.S. 36-546.

Non-Emergent Amendment/Revocation A.R.S. 36-540 (E)(4)
If the provider determines that the individual is not complying with the terms of the order or that the outpatient treatment plan is no longer appropriate, the Medical Director or physician designee can petition the court to amend/revoke the outpatient treatment plan to inpatient treatment. Court, without a hearing and based on the court record, the patient's medical record, the affidavits, and recommendations of the Medical Director (must be notarized) , and the advice of staff and physicians or the psychiatric and mental health nurse practitioner familiar with the treatment of the patient, may enter an order amending its original order.

If the individual refuses to comply with an amended order for inpatient treatment, the court may authorize and direct a peace officer, on the request of the Medical Director, to take the individual into protective custody and transport the individual for inpatient treatment.

When an individual is hospitalized pursuant to an amended order, the provider must inform the individual of the right to judicial review and the right to consult with counsel pursuant to A.R.S. 36-546.

Quash a Court's Order for Law Enforcement to Transport for a Non-emergent Amendment
If Court has entered an order for law enforcement to transport the individual to an inpatient treatment facility and the provider believes this level of care is no longer required, the Provider can motion the court to quash the order to transport by law enforcement. This ensures the individual is not unnecessarily transported to an inpatient facility.

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:

1. If a member is no longer living in a placement or residence specified by the treatment plan without authorization;
2. Leaving or failing to return to the county or state without authorization;
3. Absent from an inpatient treatment facility without authorization.

The Statute indicates within five (5) days after a patient's unauthorized absence, the Behavioral Health Homes shall file a motion with the Court to request a Toll of the Court Ordered Treatment.

Behavioral Health Home 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 Health Plan Title 36 Coordinators.

Should the member not be re-engaged voluntarily or involuntarily, the Behavioral Health Home 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
Providers must inform the individual of the right to Judicial Review every 60 days and must document this in the clinical record. Judicial Reviews are to be calendared and offered every 60 days from the date of the original court order. The days from the court order are as follows: 60, 120, 180, 240,300, and 360. It is the responsibility of the Provider to track the Judicial Review dates and ensure a Judicial Review is offered to an individual under Court-Ordered Treatment (COT) every 60 days. If an individual is hospitalized pursuant to an amendment to the outpatient treatment plan the Provider must inform the individual of the right to judicial review and the right to consult with counsel pursuant to A.R.S. 36-546. 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 60 days.

A Judicial Review must also be offered to the member should the member be absent for 60 or more days, returns and is re-engaged in treatment. The due dates of the offers may need to be adjusted upon return.

If the individual requests Judicial Review, the Health Care Coordinator completes the Judicial Review-right to Speak to Legal Counsel Form. The form includes the following information:

1. The individual being treated and the treating Provider.
2. The individual to whom the request for release was made.
3. The individual making the request for release, indicating whether the individual is the individual being treated or someone acting on the individual's behalf.

The individual reports the current address and signs the form. The Health Care Coordinator must schedule an appointment for the individual to be evaluated by a Behavioral Health Medical Professional (BHMP) of the Provider. The completed PM form and psychiatric report must be completed and submitted to the County Attorney within 72 hours of the request and by the filing deadline.

The Behavioral Health Medical Provider appointment should be scheduled no later than 48 hours from request, so the Judicial Review form is received by the County Attorney or law firm the next day, to meet the 72-hour timeframe.

If the individual declines a Judicial Review, the Health Care Coordinator completes the same form - Judicial Review-right to Speak to Legal Counsel, and the individual signs this form. The individual provides a current address and location. The Provider maintains this form in the clinical record. If the individual is unavailable at the time the Judicial Review is due, the Health Care Coordinator completes the same form- Judicial Review-right to speak to Legal Counsel. The Health Care Coordinator must provide reasons why the individual was not available for the Judicial Review and include outreach and re-engagement attempts made. The Provider maintains this form in the clinical record. It should match the progress notes regarding outreach.

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 the individual's insight regarding mental illness and information regarding adherence to court-ordered treatment plan. If the individual does not attend the Judicial Review appointment, all attempts should be made to reschedule the appointment. If the member does not attend, the health care coordinator should then confirm with the member that they have changed their mind and are no longer requesting a judicial review hearing. If an individual is hospitalized pursuant to an amended outpatient treatment plan and requests a Judicial Review, merely stating the individual is involuntarily hospitalized is not enough factual information for Court to render a decision. The BHMP should attempt to contact the inpatient Behavioral Health Medical Provider 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. A hearing can be set by the Judge/Commissioner or if requested by the defense attorney.

Status Reports
At the original hearing for court order, the Judge/Commissioner may direct the provider to submit status reports to Court. The Judge/Commissioner will set the dates when the reports are to be submitted.

Annual Review A.R.S. 36-543
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, as determined by the County. 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.

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. The following information must be indicated and written in the BHMP progress notes of the service planning meeting for the annual review that you submit:

- That this appointment is for the face-to-face annual review appointment;
- That the recommendation is either to roll/continue the members COT or to allow the COT to expire;
- That the recommendation was discussed with the member.

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 information changes, provider staff must contact the individual's attorney with this new information.

Annual Review of Incarcerated Members or Missed Annual Review of Appointments
For the Annual Review requirement, please ensure that the Psychiatrist/Behavioral Health Medical Provider does the following within the allotted time frame (45-90 days) of the Annual Review dates:

1. For Incarcerated members:
    a. A note is required in the chart that consists of the following information:
        i. This is an annual review;
        ii. Circumstances as to why the member was not present;
        iii. Indicate the date the member was booked to jail and that the member is still incarcerated;
        iv. If the medical director is willing, indicate whether their recommendation is to roll the order or to allow it to expire. If the recommendation is to roll based on the member's clinical record and a Petition for Continued Treatment with the Court is unable to be filed, indicate that due to lack of coordination from the jail, this is not possible;
        v. Indicate the date when you attempted to reach out to the jail psychiatrist to discuss member's annual review;
        vi. File in the Member's medical Record;
    b. A copy of this note is required to be sent to the Title 36 Coordinator indicating this is an annual review for an incarcerated member.
    c. For members who have missed scheduled annual review appointments within the required time frame, prior to the 45th day of the COT expiring, a chart review may be necessary.
    d. A note is required in the chart that consists of the following information:
        i. This is a chart review for the required annual review;
        ii. Dates of previous annual review appointments scheduled and missed.
        iii. Circumstances as to why the member was not present,

iv. Date a revocation was filed with the Court when appropriate.
v. Indicate whether their recommendation is to roll the order or to allow it to expire. If recommendation would be to roll, indicate that due to lack of contact with the member, this is not possible;
vi. Indicate that re-engagement protocols have been attempted to locate the member (A request for progress notes to review re-engagement attempts may be asked for);
vii. File in the Member's medical record;
viii. Send a copy to the Title 36 Coordinator indicating this is an annual review for a missing member.

If your agency uses a psychiatric annual review examination form, please use that document and include the above information.

NOTE: You should still enter these reviews as the annual review for the member

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.

For individuals whose Court Order is currently being tolled, the annual review will not be required until the member is re-engaged into services.

Progress notes for the annual review can be emailed as soon as the annual review has been completed, but no later than the 2nd business day of the following month the annual review must have been completed.

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.

Suspension of Outpatient Treatment Plan
In some Counties there are certain circumstances where a motion 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. This suspension relieves the Behavioral Health Home of the responsibility of services specifically for the court ordered treatment.

Termination of a Court Order that has been Tolled
Per Revised ARS Title 36 Statute 36-544, if a member's Court Order has been tolled for 180 days, the Behavioral Health Home may petition the court to terminate the member's Court Ordered Treatment. The Court may or may not approve of the request.

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.

Transportation from the sending provider to the receiving provider is the responsibility of the sending behavioral health provider.

ARIZONA STATE HOSPITAL (ASH) Arizona State Hospital (ASH) is a Level I facility currently licensed under applicable State and local law, is accredited by the Joint Commission and certified by the Centers for Medicare and Medicaid Services (CMS). ASH is a long-term inpatient psychiatric hospital that provides the most restrictive setting for care in the state. Coordination between ASH and the Health Plan must occur in a manner that ensures persons being admitted meet medical necessity criteria. Pursuant to A.R.S. § 36-201 through 36-217, ASH provides inpatient care and treatment to patients with mental disorders, personality disorders or emotional conditions. The level of care provided at ASH must be the most appropriate and least restrictive treatment option for the person (A.R.S. § 36-501(21)). The provision of appropriate, medically necessary covered behavioral health services must be consistent with treatment goals outlined on the admission application and individual needs identified in the course of treatment of individuals admitted to ASH.

The goal of all hospitalizations of persons at ASH is to provide comprehensive evaluation, treatment, and rehabilitation services to assist each behavioral health recipient in their own recovery, and to achieve successful placement into a less restrictive community-based treatment option.

1. Admissions

To ensure that individuals are treated in the least restrictive and most appropriate environment that can address their individual treatment and support their needs, the criteria for clinically appropriate admissions to ASH are as follows:

- The Member must not require acute medical care beyond the scope of medical care available at ASH.
- The referral source must make reasonably good-faith efforts to address the individual's target symptoms and behaviors in an inpatient setting(s).
- The referral source must complete Utilization Review of the potential admission referral and it recommend admission to the ASH as necessary and appropriate, and as the least restrictive option available for the person based on clinical status.
- When a community provider agency or other referral source believes that a civilly committed or voluntarily admitted adult is a candidate to be transferred from another inpatient facility for treatment at ASH, the agency will contact the Health Plan ASH Liaison to discuss the recommendation for admission to ASH. The Health Plan must be in agreement with the referral source that a referral for admission to ASH is necessary and appropriate. If the candidate is not Health Plan enrolled, the Member will be referred for SMI determination and the enrollment

process prior to application or at the latest within twenty-four (24) hours of admission pursuant to **Section III Provider Roles and Responsibilities — Appointment and Wait Time Standards** to ASH. The enrollment date is effective the first date of contact by the Health Plan contracted Behavioral Health Home. The Health Plan Behavioral Health Home is required to also complete a Title XIX/XXI application once enrollment is completed. For all non- T/RBHA enrolled Tribal behavioral health recipients, upon admission to ASH, the hospital will enroll the person, if eligible in the AHCCCS Indian Health Program.

- For T/RBHA (Tribal RBHA only) enrolled Members, AHCCCS must also be in agreement with the referring agency that admission to ASH is necessary and appropriate, and AHCCCS must prior authorize the person's admission (see **Section IX Medical Operations – Prior Authorization and Referral Process).**
- The Health Plan ASH Liaison will provide the agency with the ASH Application packet and list of requested documents. Upon completion of the ASH application packet, the Health Plan ASH Liaison will forward the completed packet of information regarding the referral to the ASH Admissions Office, and if determined to be SMI and previously assessed as requiring Special Assistance, then the existing Special Assistance form should be included in the package. If the form has not been completed, please refer to **Section VII Behavioral Health Services - Special Assistance for Members Determined to have a Serious Mental Illness** for further instructions.
- The ASH Admissions Office confirms receipt of the complete packet and notifies the referral source of missing or inadequate documentation within two business days of receipt. ASH cannot accept any person for admission without copies of the necessary legal documents.
- For TXIX enrolled persons, the Health Plan needs to generate a Letter of Authorization (LOA) or issue a denial. Once the member is accepted, the Certification of Need (CON) and Letter of Authorization (LOA) are provided to ASH just prior to admit with other documents as outlined in the ASH Admission Workflow; an ASH document. See **AHCCCS Prior Authorization Forms: Certification of Need at** https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/priorauthorizationforms.html**.**
- The Health Plan is responsible for notifying ASH's Admissions Office of any previous court ordered treatment days utilized by the Member. Members referred for admission must have a minimum of forty-five (45) inpatient court-ordered treatment days remaining to qualify for admission. The Member's AHCCCS eligibility will be submitted by the Health Plan the Health Plan to the ASH Admissions Office with the admission application and verified during the admission review by the ASH Admissions Office. The ASH Admissions Office will notify (AHCCCS) Member Services of the behavioral health recipient's admission to A~~z~~SH and any change in health plan selection, or if any other information is needed.

- The ASH Chief Medical Officer or Acting Designee will review the information within 14 calendar days after receipt of the completed packet and determine whether the information supports admission and whether ASH can meet the Member's treatment and care needs.
- If the ASH Chief Medical Officer or Acting Designee determines that the Member does not meet criteria for admission, the Chief Medical Officer or Acting Designee will provide a denial letter.
- If the admission is approved, the Admissions Office will send the acceptance statement from the Chief Medical Officer or Acting Designee to the referral source.
- A Court Order for transfer is not required by ASH when the proposed Member is already under a Court Order for treatment with forty-five (45) remaining inpatient days. However, in those jurisdictions in which the court requires a court order for transfer be issued, the referring agency will obtain a court order for transfer to ASH.
- If a Court Order for transfer is not required, the ASH Admissions Office will set a date and time for admission. It is the responsibility of the referring agency to make the appropriate arrangements for transportation to ASH.
- When ASH is unable to admit the accepted behavioral health recipient immediately, ASH shall establish a pending list for admission. If the behavioral health recipient's admission is pending for more than 15 days, the referral agency must provide ASH a clinical update in writing, including if any alternative placements have been explored while pending, and if the need for placement at ASH is still necessary.

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.

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.

REPORTING

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.
- It is highly recommended that each Provider designate a backup designee for the COT/COE Coordinator and Liaison to manage report submission and any questions from the Health Plan T-36 Coordinator if the Provider's COT/COE Coordinator and Liaison is not available.
- There can be multiple updates per member per month depending on the number of events occurring in the reporting month.

PERSONS WHO ARE TITLE XIX/XXI ELIGIBLE OR NON-TITLE XIX/XXI AND/OR DETERMINED TO HAVE A SERIOUS MENTAL ILLNESS (SMI)

When a person referred for court-ordered treatment is Title XIX/XXI or non-Title XIX/XXI eligible and/or determined or suspected to have SMI, the provider must:

i. Conduct an evaluation to determine if the person has a Serious Mental Illness and conduct a behavioral health assessment to identify the person's service needs in conjunction with the person's clinical team,
ii. Provide necessary court-ordered treatment and other covered services in accordance with the person's needs, as determined by the person's clinical team, the Member, family Members, and other involved parties and
iii. Perform, either directly or by contract, all treatment required by ARS Title 36, Chapter 5, Article 5 and 9 AAC 21, Article 5.

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.

SECTION VII: Behavioral Health Services

Court ordered DUI Services

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.

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.

ARIZONA STATE HOSPITAL

ASH is a Level I facility currently licensed under applicable State and local law, is accredited by The Joint Commission and certified by the Centers for Medicare and Medicaid Services (CMS). ASH is a long-term inpatient psychiatric hospital that provides the most restrictive setting for care in the state. Coordination between ASH and The Health Plan must occur in a manner that ensures persons being admitted meet medical necessity criteria. Pursuant to A.R.S. § 36-201 through 36-217, ASH provides inpatient care and treatment to patients with mental disorders, personality disorders or emotional conditions. The level of care provided at ASH must be the most appropriate and least restrictive treatment option for the person (A.R.S. § 36-501(21)). The provision of appropriate, medically necessary covered behavioral health services must be consistent with treatment

goals outlined on the admission application and individual needs identified in the course of treatment of individuals admitted to ASH.

The goal of all hospitalizations of persons at ASH is to provide comprehensive evaluation, treatment, and rehabilitation services to assist each behavioral health recipient in their own recovery, and to achieve successful placement into a less restrictive community-based treatment option.

Admissions

To ensure that individuals are treated in the least restrictive and most appropriate environment that can address their individual treatment and support their needs, the criteria for clinically appropriate admissions to ASH are as follows:

i. The Member must not require acute medical care beyond the scope of medical care available at ASH.
ii. The referral source must make reasonable good-faith efforts to address the individual's target symptoms and behaviors in an inpatient setting(s).
iii. The referral source must complete Utilization Review of the potential admission referral and it recommend admission to the ASH as necessary and appropriate, and as the least restrictive option available for the person based on clinical status.
iv. When a community provider agency or other referral source believes that a civilly committed or voluntarily admitted adult is a candidate to be transferred from another inpatient facility for treatment at ASH, the agency will contact The Health Plan to discuss the recommendation for admission to ASH. The Health Plan must be in agreement with the referral source that a referral for admission to ASH is necessary and appropriate. If the candidate is not Health Plan enrolled, the Member will be referred for SMI determination and the enrollment process prior to application or at the latest within twenty-four (24) hours of admission pursuant to Appointment Standards and Timeliness of Service to ASH. The enrollment date is effective the first date of contact by a The Health Plan contracted Behavioral Health Home. The Health Plan Behavioral Health Home is required to also complete a Title XIX/XXI application once enrollment is completed. For all non-T/RBHA enrolled Tribal behavioral health recipients, upon admission to ASH, the hospital will enroll the person, if eligible in the AHCCCS Indian Health Program.
v. For T/RBHA (Tribal RBHA only) enrolled Members, AHCCCS must also be in agreement with the referring agency that admission to ASH is necessary and appropriate, and AHCCCS must prior authorize the person's admission.

vi. The Health Plan and/or other referral sources must contact the ASH Admissions Office and forward a completed packet of information regarding the referral to the Admissions Office, and if determined to be SMI and previously assessed as requiring Special Assistance, then the existing Special Assistance form should be included in the package. If the form has not been completed.

vii. The Admissions Office confirms receipt of the complete packet and notifies the referral source of missing or inadequate documentation within two business days of receipt. ASH cannot accept any person for admission without copies of the necessary legal documents.

viii. For TXIX enrolled persons, The Health Plan needs to generate a Letter of Authorization (LOA) or issue a denial. Once the member is accepted, the Certification of Need (CON) and Letter of Authorization (LOA) are provided to ASH just prior to admit with other documents as outlined in the ASH Admission Workflow; an ASH document. See AHCCCS Prior Authorization Forms: Certification of Need.

ix. The Health Plan is responsible for notifying ASH's Admissions Office of any previous court ordered treatment days utilized by the Member. Members referred for admission must have a minimum of forty-five (45) inpatient court-ordered treatment days remaining to qualify for admission. The Member's AHCCCS eligibility will be submitted by The Health Plan the Health Plan to the ASH Admissions Office with the admission application and verified during the admission review by the ASH Admissions Office. The ASH Admissions Office will notify (AHCCCS) Member Services of the behavioral health recipient's admission to ASH and any change in health plan selection, or if any other information is needed.

x. The Chief Medical Officer or Acting Designee will review the information within 14 calendar days after receipt of the completed packet and determine whether the information supports admission and whether ASH can meet the Member's treatment and care needs.

xi. If the ASH Chief Medical Officer or Acting Designee determines that the Member does not meet criteria for admission, the Chief Medical Officer or Acting Designee will provide a denial letter.

xii. If the admission is approved, the Admissions Office will send the acceptance statement from the Chief Medical Officer or Acting Designee to the referral source.

xiii. A Court Order for transfer is not required by ASH when the proposed Member is already under a Court Order for treatment with forty-five (45) remaining inpatient days. However, in those jurisdictions in which the court requires a court order for transfer be issued, the referring agency will obtain a court order for transfer to ASH.

xiv. If a Court Order for transfer is not required, the ASH Admissions Office will set a date and time for admission. It is the responsibility of the referring agency to make the appropriate arrangements for transportation to ASH.

xv. When ASH is unable to admit the accepted behavioral health recipient immediately, ASH shall establish a pending list for admission. If the behavioral health recipient's admission is pending for more than 15 days, the referral agency must provide ASH a clinical update in writing, including if any alternative placements have been explored while pending, and if the need for placement at ASH is still necessary.

Adult Members Under Civil Commitment

The Member must have a primary diagnosis of Mental Disorder (other than Cognitive Disability, Substance Abuse, Paraphilia-Related Disorder, or Antisocial Personality Disorder) as defined in A.R.S. § 36-501, which correlates with the symptoms and behaviors precipitating the request for admission, and be determined to meet DTO, DTS, GD, or PAD criteria as the result of the mental disorder.

The Member is expected to benefit from proposed treatment at ASH (A.R.S. § 36-202). The Member must have completed 25 days of mandatory treatment in a local mental health treatment agency under T-36 COT, unless waived by the court as per A.R.S. § 36-541 or, if PAD, waived by the Chief Medical Officer of ASH.

ASH must be the least restrictive alternative available for treatment of the person (A.R.S. § 36-501) and the less restrictive long-term level of care available elsewhere in the State of Arizona to meet the identified behavioral health needs of the Member.

The Member must not suffer more serious harm from proposed care and treatment at ASH. (AAC R9-21-507(B)(1) (PDF)).

Hospitalization at ASH must be the most appropriate level of care to meet the person's treatment needs, and the person must be accepted by the Chief Medical Officer for transfer and admission (AAC R9-21-507(B)(2) (PDF)).

Treatment and Community Placement Planning

ASH will begin treatment and community placement planning immediately upon admission, utilizing the Adult Clinical Team model. All treatment is patient-centered and is provided in accordance with AHCCCS-established five principles of person-centered treatment for adult Members determined to have SMI.

Members shall remain assigned to their original clinic/outpatient treatment team throughout their admission, unless the Member initiates a request to transfer to a new clinic site or treatment team.

i. Consideration of comprehensive information regarding previous treatment approaches, outcomes and recommendations/input from The Health Plan and other outpatient community treatment providers is vital.
ii. Representative(s) from the outpatient treatment team are expected to participate in treatment planning throughout the admission in order to facilitate enhanced coordination of care and successful discharge planning.
iii. Treatment goals and recommended assessment/treatment interventions must be carefully developed and coordinated with the outpatient providers (including The Health Plan, ALTCS Health Plan, other providers/other state agencies as appropriate), the Member's legal guardian, family members, significant others as authorized by the Member and advocate/designated representative whenever possible.
iv. The first Inpatient Treatment and Discharge Plan (ITDP) meeting, which is held within 10 days of the Member´s admission, should address specifically what symptoms or skill deficits are preventing the Member from participating in treatment in the community and the specific goals/objectives of treatment at ASH. This information should be used to establish the treatment plan.
v. The first ITDP meeting should also address the discharge plan for reintegration into the community. The Member's specific needs for treatment and placement in the community, including potential barriers to community placement and successful return to the community, should be identified and discussed.
vi. All required medical services for enrolled members residing at ASH that are not provided by ASH will be provided by Valleywise Health Medical Center. The Health Plan will provide payment to MIHS for all medically necessary services provided to enrolled T19/21 persons with a Serious Mental Illness (SMI) as described in the AHCCCS ACOM – Policy 432- Benefit Coordination and Fiscal Responsibility for Behavioral Health Services and Physical Health Services, Section III–B, titled Specific Circumstances Regarding Payment for Behavioral Health Services.

ASH will provide all treatment plans to the responsible agency. The responsible agency should indicate review of an agreement/disagreement with the treatment plan on the document. Any disagreements should be discussed as soon as possible and resolved as outlined in AAC 9R-21 (PDF).

Treatment plans are reviewed and revised collaboratively with the Adult Clinical Team at least monthly.

Any noted difficulties in collaboration with the outpatient provider treatment teams will be brought to the attention of The Health Plan to be addressed. The Health Plan Hospital Liaison will monitor the participation of the outpatient team and assist when necessary.

Through the Adult Clinical Team, ASH will actively address the identified symptoms and behaviors which led to the admission, and link them to the community rehabilitation and recovery goals whenever possible. ASH will actively seek to engage the Member and all involved parties to establish understandable, realistic, achievable and practical treatment, discharge goals and interventions.

While in ASH and depending upon the Member's individualized treatment needs, a comprehensive array of evaluation and treatment services are available and will be utilized as appropriate and as directed by the Member's treatment plan and as ordered by the Member's treating psychiatrist.

Recertification of Need (RON)
The ASH Utilization Manager is responsible for the recertification process, when recertification is required, for all Title XIX/XXI eligible persons and is the contact for ASH for all The Health Plan continued stay reviews.

The ASH Utilization Manager will work directly with the Member's attending physician to complete the Recertification of Need (RON). For members 65 and over, the RONs cover up to a 60 day span, for members under 21 the RONs cover a 30 day span and are submitted accordingly. The RON will be sent to The Health Plan within five (5) days of expiration of the current CON/ RON. If required by The Health Plan, the ASH Utilization Manager will send to The Health Plan Utilization Review staff additional information/documentation needed for review to determine continued stay. The Health Plan pays the first 30 days following admission to the ASH for T19 members; following this period, a 1-day authorization is created for all members regardless of age, and then denies.

All Health Plan decisions regarding to the approval or denial for continued stay will be rendered prior to the expiration date of the previous authorization and upon receipt of the RON for those Members. The Health Plan authorization decisions are based on review of chart documentation supporting the stay and application of the AHCCCS Level Continued Stay criteria. If continued stay is approved, The Health Plan sends a Letter of Approval (LOA) to the ASH Utilization Management Department with the completed RON and updated standard nomenclature diagnosis codes (if applicable). Denials will be issued upon completion of the denial process.

Transition to Community Placement Setting

The Member is considered to be ready for community placement and is placed on the Discharge Pending List when the following criteria are met:

i. The agreed upon discharge goals set at the time of admission with The Health Plan have been met by the Member.
ii. The Member presents no imminent danger to self or others due to psychiatric disorder. Some Members, however, may continue to exhibit occasional problematic behaviors. These behaviors must be considered on a case-by-case basis and do not necessarily prohibit the person from being placed on the Discharge Pending List. If the Member is psychiatrically stable and has met all treatment goals but continues to have medical needs, the Member remains eligible for discharge/community placement.
iii. All legal requirements have been met.

Once a Member is placed on the Discharge Pending List, The Health Plan must immediately take steps necessary to transition the Member into community-based treatment as soon as possible. The Health Plan has up to thirty (30) days to transition the Member out of ASH. The Health Plan outpatient treatment team should identify and plan for community services and supports with the Member's inpatient clinical team 60 – 90 days out from the Member's discharge date. This will allow sufficient time to identify appropriate community covered behavioral health services.

When the Member has not been placed in a community placement setting within 30 days, a quality of care concern will be initiated by the Health Plan or AHCCCS, if an agreement has not been made between ASH and the outpatient treatment team that the discharge will take place after 30 days.

For T19/21 persons with a Serious Mental Illness and insulin-dependent diabetes, Health Plan will provide at discharge the same brand and model glucose monitoring device as used competently at ASH. Care must be coordinated with the ASH prior to discharge to ensure that all supplies are authorized and available to the member upon discharge.

ASH Conditional Release Requirements

The Health Plan has processes in place to provide high touch care management and/or other behavioral health and related services to members on Conditional Release from the Arizona State Hospital (ASH) that are consistent with the Conditional Release Plan (CRP) per AHCCCS AMPM Policy 320Z https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/300/320Z.pdf: Members on Conditional Release. This includes but is not limited to assignment to a

contractor care manager, which may be the assigned Health Plan ASH liaison or another team care manager working in conjunction with the Health Plan ASH liaison. Care management functions may not delegate these functions to a subcontracted provider.

The Health Plan Care Manager or ASH Liaison acts as the single point of contact and is responsible to provide, at a minimum, the following:

- Collaboration with the outpatient treatment team, ASH, and the Superior Court;
- Discharge planning coordination with ASH;
- Participation in developing and implementing Conditional Release Plans;
- Participation in the modification of an existing Individual Service Plan (ISP) or the modification of an existing ISP that complies with the Conditional Release Plan (CRP);
- Member outreach and engagement to help evaluate compliance with CRP;
- Attendance in outpatient staffing at least once per month;
- Coordination of care with member's treatment team, TRBHA, and physical and behavioral health providers to implement the ISP and CRP;
- Routine delivery of comprehensive status reporting to AHCCCS, ASH and Superior Court as specified in A.R.S. § 133991 and A.R.S. §13-3994 – 4000;
- In the event that a member violates any term of their CRP, psychiatric decompensation, or use of alcohol, illegal substances or prescription medications not prescribed to the member, the Health Plan will confirm immediate notification to the Superior Court and ASH was completed by the outpatient provider and provide a copy to AHCCCS;
- The Health Plan agrees and understands that is will follow all obligations, including those stated above, applicable to it as set forth in A.R.S. § 133991 and A.R.S. §13-3994 - 4000.

The Health Plan provides training and technical assistance to outpatient providers serving members on Conditional Release and assures providers demonstrate understanding of A.R.S. § 133991 and A.R.S. §13-3994 – 4000 duties of outpatient providers. The Health plan ensures the monthly Conditional Release Deliverable is received from the outpatient provider team monthly by the 2nd day of the month for the previous months' date and submitted to AHCCCS as required by AMPM 320Z. The Conditional Release Report can be found at https://www.azahcccs.gov/Resources/Downloads/ConditionalReleaseMonthlyMonitoringReport.pdf. The Health Plan will coordinate with the outpatient provider for additional documentation at the request of AHCCCS Medical Management.

In the event that a member's mental status renders them incapable or unwilling to manage their medical condition and the member has a skilled medical need, the Health Plan must arrange ongoing medically necessary nursing services in a timely manner.

SPECIAL ASSISTANCE FOR MEMBERS DETERMINED TO HAVE A SERIOUS MENTAL ILLNESS

Behavioral Health Homes and contracted BH Inpatient Facilities must identify and report to the AHCCCS Office of Human Rights (OHR) on members determined to have a Serious Mental Illness (SMI) who meet the criteria for Special Assistance. If the person's Special Assistance needs appear to be met by an involved family member, friend, designated representative or guardian providers must still submit a notification to the OHR. Behavioral Health Homes, contracted BH Inpatient Facilities and the Behavioral Health Office of Grievances and Appeals (BHOGA) must ensure that the person designated to provide Special Assistance is involved at key stages.

Behavioral Health Homes and contracted BH Inpatient Facilities are expected to follow the policies and procedures outlined in AMPM Policy 320-R, all other applicable AHCCCS policies and state policies outlined in Arizona Revised Statutes and Arizona Administrative Code.

General Requirements

Criteria to deem a member to be in need of Special Assistance:

A member determined to have a Serious Mental Illness (SMI) is in need of Special Assistance if the member is unable to do any of the following:

i. Communicate preferences for services;
ii. Participate effectively in Individual Service Planning (ISP) or Inpatient Treatment Discharge Planning (ITDP);
iii. Participate effectively in the appeal, grievance or investigation processes.

The member's limitations described above must also be due to any of the following:

iv. Cognitive ability/intellectual capacity (i.e. cognitive impairment, borderline intellectual functioning, or diminished intellectual capacity);
v. Language barrier (an inability to communicate, other than a need for an interpreter/translator); and/or
vi. Medical condition (including, but not limited to traumatic brain injury, dementia, or severe psychiatric symptoms).

A member who is subject to general guardianship has been found to be incapacitated under A.R.S. § 14-5304, and therefore automatically satisfies the criteria for Special Assistance.

For a member determined to have a SMI, the existence of any of the following circumstances may warrant the Behavioral Health Home to more closely review whether the member is in need of Special Assistance:

i. Developmental disability involving cognitive ability;
ii. Residence in a 24 hour setting;
iii. Limited guardianship, or The Health Plan or the Behavioral Health Home is recommending the establishment of a limited guardianship; or
iv. Existence of a serious medical condition, that affects intellectual and/or cognitive functioning (such as, dementia or traumatic brain injury).

Persons Qualified to Make a Special Assistance Determination

Specific staff and agencies are qualified to screen for Special Assistance and determine whether a member qualifies for Special Assistance (See AHCCCS AMPM Policy 320-R for specific requirements).

Screening for Special Assistance

Behavioral Health Homes and contracted Behavioral Health (BH) Inpatient Facilities perform screenings to assess whether members determined to have a SMI are in need of Special Assistance, in accordance with the criteria set out in AHCCCS AMPM Policy 320-R.

Documentation

Special Assistance documentation and record keeping policies and procedures are referenced in AMPM Policy 320 Special Assistance for Members Determined to Have a Serious Mental Illness.

If a member is currently identified as a member in need of Special Assistance, a notation of "Special Assistance" and a completed AHCCCS AMPM 320-R, Attachment A, Notification of Member in Need of Special Assistance should already exist in the clinical record. However, if it is unclear, Behavioral Health Homes and contracted Behavioral Health Inpatient Facilities can contact The Health Plan Independent Oversight Committee Liaison to inquire about current status. The Behavioral Health Plan maintains a database on members in need of Special Assistance and shares data with Health Homes and contracted Behavioral Health Inpatient Facilities on a regular basis.

Notification Requirements to the Office of Human Rights

Behavioral Health Homes and contracted Behavioral Health Inpatient Facilities are expected to follow the policies and procedures for notifying the Office of Human Rights as outlined in AMPM Policy 320-R.

SECTION VII: Behavioral Health Services

Behavioral Health Homes and contracted Behavioral Health inpatient Facilities must use the current electronic Special Assistance Notification Form found on the AHCCCS QM Portal.

Members No Longer in Need of Special Assistance
Behavioral Health Homes and contracted Behavioral Health Inpatient Facilities are expected to follow the policies and procedures for notifying the Office of Human Rights when a member no longer meets Special Assistance criteria, as outlined in AHCCCS AMPM Policy 320-R.

Requirement to Help Ensure the Provision of Special Assistance
Behavioral Health Homes and contracted BH Inpatient Facilities collaborate with and involve the member (guardian, family member, friend, Office of Human Rights advocate, etc.) meeting Special Assistance needs in all relevant Behavioral Health planning and processes. Behavioral Health Homes and contracted Behavioral Health Inpatient Facilities are expected to follow the policies and procedures within AHCCCS AMPM Policy 320-R.

Behavioral Health Home Reporting Requirements
Behavioral Health Homes and contracted BH Inpatient Facilities are expected to follow all reporting requirements listed within the AHCCCS AMPM Policy 320-R.

Confidentiality Requirements

Behavioral Health Homes shall grant access to clinical records of members in need of Special Assistance to the Office of Human Rights in accordance with federal and state confidentiality laws (AHCCCS AMPM Policy 550).

Independent Oversight Committees receive confidential information related to Special Assistance members and are expected to safeguard the information in accordance with the requirements set out in AHCCCS ACOM, Policy 447.

Other Procedures
Behavioral Health Homes and contracted Behavioral Health Inpatient Facilities must follow the training requirements related to Special Assistance, as outlined in AHCCCS AMPM, Policy 320-R and AHCCCS AMPM Policy 1060.

Behavioral Health Homes and contracted Behavioral Health Inpatient Facilities must assign one staff member to act as the Special Assistance Single Point of Contact. The Single Point of Contact must be proficient in all Special Assistance policies and procedures as outlined in AHCCCS AMPM, Policy 320-R and all other applicable Special Assistance policy.

The Single Point of Contact verifies AHCCCS Office of Human Rights requests for further information and/or ensures timely submission of documents. The Single Point of Contact is responsible to review all information provided on AHCCCS AMPM 320-R Attachment A, Notification of Member in Need of Special Assistance, prior to submission to AHCCCS Office of Human Rights to ensure member meets criteria.

Behavioral Health Home Single Point of Contact staff are required to attend the Special Assistance Single Point of Contact Monthly Conference Call. Behavioral Health Homes should notify The Health Plan Special Assistance Department (OIFA) to inform of any changes in Single Point of Contact staff.

Transfer of a Special Assistance Member
Notice of a request to transfer, for all Special Assistance members, must be shared with The Health Plan prior to initiating the transfer through the Provider Portal and submitting the transfer packet. All changes and updates to a Special Assistance member's services, including transfers, requires collaboration with the person assigned to meet Special Assistance needs.

ADDITONAL BEHAVIORAL HEALTH HOME REQUIREMENTS

The Health Plan requires contracted Behavioral Health Home providers to meet additional service delivery requirements as outlined below, in addition to all behavioral health requirements outlined in The Health Plan Provider Manual. These include recovery support, access to care, outreach and engagement, enrollment, staffing, and system partner coordination of care. Members can select a Behavioral Health Home to receive their services. Members with chronic behavioral health care conditions are encouraged to receive their coordination of care services through a contracted Behavioral Health Home. The following contracted Behavioral Health Homes are required to meet the requirements identified in this section in addition to all behavioral health requirements identified in the Health Plan Provider Manual.

Screening and Serving Members with Complex Needs
All children must be screened for High Needs at the time of the initial comprehensive assessment and annually thereafter, per the AHCCCS AMPM 320-O, a high needs assessment (using the AHCCCS identified tool when available), for children ages 6-17.

Providers must place a copy of the children's High Needs screening tool in the Member's Electronic Health Record. A progress note is required following each screening, describing the actions taken as a result of the screening.

Providers must develop and implement service plans for Members with High/Complex Needs that include strategies to address a crisis and deliver all appropriate services to help

the Member remain at home, minimize placement disruptions, and avoid the inappropriate use of the police and the criminal justice system.

Declination of Intensive Services

Providers are required to follow evidenced based practices and must ensure Members with High Needs receive appropriate services and take action to address risk management concerns when Members decline against medical advice to receive services. Permitted actions include: 1) notifying Members, guardians and families in writing of the risks associated with declining to accept more intensive treatment, 2) seek a court order for treatment when the adult Member/guardian declines more intensive treatment and the Member is a risk to themselves or others, or 3) with sufficient notice to the Member, decline to continue to provide treatment services which are ineffective in meeting the Member's needs.

High Needs Case Management (HNCM)

Behavioral Health Homes providing services to children are responsible for ensuring that the ratio of HNCM to Children with High Needs does not exceed 1:25. A ratio of 1:15 is preferred.

Behavioral Health Homes providing services to adults are expected to employ an adequate number of Health Care Coordinators to maintain low member to staff ratios and meet the needs of Adult High Needs members.

Appropriate case management intensity is paramount in assisting members in meeting their recovery goals and is based on member need and acuity of symptoms. AMPM Policy 570, Attachment A has identified four levels of case management intensity with different levels of required case manager to member contact:

i. Assertive Community Treatment (ACT) Case Management with a ratio of 12:1
ii. Individuals with Serious Mental Illness (SMI) designation. One component of a comprehensive model of treatment based upon fidelity criteria developed by the Substance Abuse and Mental Health Services Administration. ACT case management focuses upon individuals with severe and persistent mental illness that seriously impairs their functioning in community living, in conjunction with a multidisciplinary team approach to coordinating care across multiple systems (e.g., social services, housing services, health care).
iii. High Needs Case Management for Children with a ratio of 25:1.
iv. Focuses upon providing case management and other support and rehabilitation services to children with complex needs and multiple systems involvements for whom less intensive case management would likely impair their functioning. Children with high service intensity

needs who require to be offered the assignment of a high needs case manager are identified as:

v. Children 0 through five years of age with two or more of the following:
vi. Other agency involvement; specifically: AzEIP, DCS, and/or DDD, and/or;
vii. Out of home placement for behavioral health treatment (within past six months), and/or;
viii. Psychotropic medication utilization (two or more medications), and/or;
ix. Evidence of severe psycho-social stressors (e.g., family member serious illness, disability, death, job loss, eviction), and
x. Children six through 17 years of age: CALOCUS level of 4, 5, or 6.
xi. Supportive Case Management for Children and Adults with a ratio of 30:1
xii. Individuals with an SMI designation, General Mental Health/ Substance Use (GMH/SU), or children. Supportive Case Management: Focuses upon individuals for whom less intensive case management would likely impair their functioning. Supportive case management provides assistance, support, guidance and monitoring in order to achieve maximum benefit from services. Caseloads may include individuals with an SMI designation as well as individuals with a general mental health condition or substance use disorder as clinically indicated.
xiii. Connective Case Management for Children and Adults with a ratio of 70:1
xiv. Individuals with an SMI designation, GMH/SU, or children. Focuses on individuals who have largely achieved recovery and who are maintaining their level of functioning. Connective case management involves careful monitoring of the individual's care and linkage to service. Caseloads may include both individuals with an SMI designation as well as individuals with a general mental health condition or substance use disorder as clinically indicated.

The providers are responsible for ensuring the integrity of the role of the HNCM by empowering the HNCM o facilitate the delivery of behavioral health services; enhance treatment goals and treatment effectiveness; and coordinate services for Members with High Needs.

Requirements for Behavioral Health Homes in Meeting the Needs of Members with High/Complex Needs

Behavioral Health Homes are expected to:

i. Provide 24/7/365 services as clinically appropriate when planned in advance.

ii. Maintain low HNCM to member ratios. The AHCCCS AMPM 570 requires Behavioral Health Homes that serve children with High Needs to ensure that the ratio of HNCM's to Children with High Needs does not exceed 1:25. A ratio of 1:15 is preferred.
iii. Provide support and rehabilitation services that improve member outcomes and reduces the number of members in Out-of-Home placements, reduces Emergency Department visits, and reduces Inpatient stays by providing appropriate support in the member's community and home.
iv. Maintain an adequate number of Direct Support Staff to meet the needs of adult High Needs members.

Transition to Adulthood

Children turning 18 years of age may choose to remain with their current Behavioral Health Home, transfer to another Behavioral Health Home as desired or clinically indicated, or close out of the behavioral health system entirely.

Behavioral Health Home Access to Care Requirements

Screening

Providers must perform various screening and assessment services:

a. Providers must apply for AHCCCS coverage on behalf of Members through Health-e Arizona and assist Members in renewing their AHCCCS enrollment by completing applications on their behalf through Health-e Arizona and not refer persons to DES offices.
b. Offer in-person screenings and assessments for Medicaid, SMI, SABG and MHBG eligibility at no cost to Members or persons requesting the screening/assessment.
c. Provide intake, assessment and coordination services in the community, hospitals, nursing homes, state agency offices, detention, jail and prison facilities, specialty provider offices and Member's homes.
d. Providers must screen all children age 8 to 18, and adults for substance use disorders utilizing a standardized screening tool, at minimum:
    i. At intake;
    ii. Bi-annually for children and annually for adults; and
    iii. Within 7 days of reported or suspected problematic use.

If a screening yields positive results, members must receive a more comprehensive assessment to include substance use history, current use, and trauma.

a. Ensure that all Comprehensive Assessments, Individualized Service Plans, and Assessment Updates are signed by a The Health Plan -Credentialed, Licensed Behavioral Health Professional or Behavioral Health Medical Professional within 72 hours after the member received the assessment.

The Health Plan promotes a network of Trauma Informed Care (TIC)-certified therapists. The Health Plan will analyze the network sufficiency of TIC-certified therapists. Behavioral Health Homes must provide trauma screenings for youth and families. Behavioral Health Providers must ensure the provision of Trauma Informed Care Services, including routine trauma screenings and ensuring sufficient capacity of TIC certified therapists.

Referrals

a. Establish written criteria and procedures for accepting and acting upon referrals, including emergency referrals. The written criteria must include the definition of a referral for health services as described by the State.
b. When a Member requests to access Covered Services, there shall be no wrong door. The Health Plan and Provider are required to respond when a Member requests Covered Services and follow through to ensure the Member receives appropriate services. Provider is required to assist any Member with obtaining Covered Services for which the Member is eligible, from the Participating Health Care Providers best suited to deliver effective services to Member.
c. Behavioral Health Home providers must accept all referrals for intakes and services for populations identified provider's contract with The Health Plan, unless The Health Plan grants a written waiver or suspension of this requirement.
d. Accept all referrals regardless of diagnosis, level of functioning, age, Member's status in family or level of service needs.
e. Providers serving non-Title XIX/XXI must accept and respond to emergency referrals twenty-four (24) hours a day, seven (7) days a week.
f. Make appropriate referrals to and schedule appointments with In-Network Specialty Providers to meet Members' treatment needs and effectively coordinate care.
g. Have a process to verify all Network options have been explored and exhausted before completing a request for out-of-Network services. Provider must notify The Health Plan of all Out-of-Network requests.
h. Provider understands that all community residents, including visitors are eligible to receive crisis services and provider must

assist anyone experiencing a crisis in obtaining crisis services through a The Health Plan contracted crisis provider by calling the Crisis Call Center.

Outpatient Services

Providers must offer outpatient services identified in the provider's agreement with The Health Plan, including intakes, comprehensive assessments, service planning, coordination of care and outpatient services to all populations specified in the provider's agreement with The Health Plan.

Case management services shall be provided by individuals who are qualified BHPs or BHTs/BHPPs supervised by BHPs. Case Management is a provider level supportive service provided to improve treatment outcomes (Reference AHCCCS AMPM 310-B.) Examples of case management activities to meet member's Service Plan goals include:

a. Assistance in maintaining, monitoring and modifying behavioral health services
b. Assistance in finding necessary resources other than behavioral health services
c. Coordination of care with the member's healthcare providers, Family, community resources, and other involved supports including educational, social, judicial, community and other State agencies
d. Coordination of care activities related to continuity of care between levels of care (e.g. inpatient to outpatient care) and across multiple services (e.g. personal assistant, nursing services, and Family counseling)
e. Assisting members in applying for Social Security benefits when using the SSI/SSDI Outreach, Access, and Recovery (SOAR) approach; including,
f. Face-to-face meetings with member
g. Phone contact with member, and
h. Face-to-face and phone contact with records and data sources (e.g. jail staff, hospitals, treatment providers, schools, Disability Determination Services, Social Security Administration, physicians).
i. SOAR services shall only be provided by staff who have been certified in SOAR through SAMHSA SOAR Technical Assistance Center.
j. When using the SOAR approach, billable activities do not include:
1. Completion of SOAR paperwork without member present
2. Copying or faxing paperwork
3. Assisting members with applying for benefits without using the SOAR approach, and
4. Email.
k. For provider case management utilized when assisting members in applying for Social Security benefits (using the SOAR approach) the modifier HK is required.
l. Billing T1016 with an HK modifier indicates the specific usage of the SOAR approach and it cannot be used for any other service.
m. Outreach and follow-up of crisis contacts and missed appointments, and

n. Participation in staffing, case conferences, or other meetings with or without the member or their Family participating.
o. For provider case management used to facilitate a Child and Family Team (CFT), the modifier U1 is required.

Case Management limitations include:

a. Billing for case management is limited to providers who are directly involved with providing services to the member
b. Provider Case Management is not a reimbursable service for ALTCS E/PD, including Tribal ALTCS. Case Management is provided through the ALTCS E/PD Contractors or Tribal ALTCS Program
c. Provider Case management services provided by licensed inpatient, residential (BHRF) or day program providers are included in the rate for these settings and cannot be billed separately. However, providers other than the inpatient, residential (BHRF) facility, or day program can bill case management services provided to the member
d. A single practitioner may not bill case management simultaneously with any other service
e. For assessments, the provider may bill all time spent in direct or indirect contact (e.g. indirect contact may include email or phone communication specific to a member's services) with the member and other involved parties involved in implementing the member's Treatment/Service Plan
f. More than one provider agency may bill for case management at the same time, as long as it is clinically necessary and documented within the member's Treatment/Service Plan
g. More than one individual within the same agency may bill for case management at the same time, as long as it is clinically necessary and documented within the member's Treatment/Service Plan, and
h. When a provider is picking up and dropping off medications for more than one member, the provider shall divide the time spent and bill the appropriate case management code for each involved member.

Answering Service

Providers must maintain an answering service and telephone prompts appropriate to direct Members to verify access to services 24/7. Include language on telephone prompts, voicemail, answering services and advertisements that identifies the provider as Member of The Health Plan's Network of Providers and informs Members what to do in case of an emergency.