Arizona

UNIFORM APPLICATION
FY 2026/2027 Combined MHBGSUPTRS BG ApplicationBehavioral Health Assessment and Plan

SUBSTANCE ABUSE PREVENTION AND TREATMENT
and
COMMUNITY MENTAL HEALTH SERVICES
BLOCK GRANT

OMB - Approved 05/28/2025 - Expires 01/31/2028
(generated on 11/17/2025 3.41.43 PM)

Center for Substance Abuse Prevention
Division of Primary Prevention

Center for Substance Abuse Treatment
Division of State and Community Systems (DSCS)

and

Center for Mental Health Services
Division of State and Community Systems Development

State Information

State Information

Plan Year

Start Year	2026
End Year	2027

State SUPTRS BG Unique Entity Identification

Unique Entity ID	LJGVPF5ULHH3

I. State Agency to be the SUPTRS BG Grantee for the Block Grant

Agency Name	Arizona Health Care Cost Containment System (AHCCCS)
Organizational Unit	Division of Behavioral Health and Housing
Mailing Address	150 N 18th Ave
City	Phoenix
Zip Code	85007

II. Contact Person for the SUPTRS BG Grantee of the Block Grant

First Name	Alisa
Last Name	Randall
Agency Name	Arizona Health Care Cost Containment System
Mailing Address	150 N 18th Ave
City	Phoenix
Zip Code	85007
Telephone	602-417-4794
Fax	
Email Address	alisa.randall@azahcccs.gov

State CMHS Unique Entity Identification

Unique Entity ID	LJGVPF5ULHH3

I. State Agency to be the CMHS Grantee for the Block Grant

Agency Name	Arizona Health Care Cost Containment System
Organizational Unit	Division of Behavioral Health and Housing
Mailing Address	150 N 18th Ave
City	Phoenix
Zip Code	85007

II. Contact Person for the CMHS Grantee of the Block Grant

First Name	Alisa
Last Name	Randall
Agency Name	Arizona Health Care Cost Containment System (AHCCCS)
Mailing Address	150 N 18th Ave
City	Phoenix
Zip Code	85007
Telephone	602-417-4794
Fax	
Email Address	alisa.randall@azahcccs.gov

III. Third Party Administrator of Mental Health Services

Do you have a third party administrator? Yes No

First Name

Last Name

Agency Name

Mailing Address

City

Zip Code

Telephone

Fax

Email Address

IV. State Expenditure Period (Most recent State expenditure period that is closed out)

From

To

V. Date Submitted

Submission Date	8/29/2025 8:01:27 PM
Revision Date	10/31/2025 12:15:03 PM

VI. Contact Person Responsible for Application Submission

First Name	Nereyda
Last Name	Ramirez
Telephone	602-364-4718
Fax	
Email Address	nereyda.ramirez@azahcccs.gov

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [SUPTRS]

Fiscal Year 2026

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Substance Abuse Prevention and Treatment Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
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As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
    a. Checking the Exclusion Extract located on the System for Award Management (SAM) at **http://sam.gov [sam.gov]**
    b. Collecting a certification statement similar to paragraph (a)
    c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work place in accordance with 2 CFR Part 182 by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;

b. Establishing an ongoing drug-free awareness program to inform employees about--
    1. The dangers of drug abuse in the workplace;
    2. The grantee's policy of maintaining a drug-free workplace;
    3. Any available drug counseling, rehabilitation, and employee assistance programs; and
    4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;

d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
    1. Abide by the terms of the statement; and
    2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
    1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
    2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or

attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)

3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-construction Programs and other Certifications summarized above.

State: _____

Name of Chief Executive Officer (CEO) or Designee: _____

Signature of CEO or Designee[1]: _____

Title: _____ Date Signed: _____

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

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13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
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17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
    a. Checking the Exclusion Extract located on the System for Award Management (SAM) at **http://sam.gov [sam.gov]**
    b. Collecting a certification statement similar to paragraph (a)
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2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work place in accordance with 2 CFR Part 182 by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;

b. Establishing an ongoing drug-free awareness program to inform employees about--
    1. The dangers of drug abuse in the workplace;
    2. The grantee's policy of maintaining a drug-free workplace;
    3. Any available drug counseling, rehabilitation, and employee assistance programs; and
    4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;

d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
    1. Abide by the terms of the statement; and
    2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
    1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
    2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or

attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)

3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

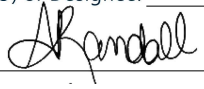
The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-construction Programs and other Certifications summarized above.

State: **Arizona**

Name of Chief Executive Officer (CEO) or Designee: **Alisa Randall**

Signature of CEO or Designee[1]: 

Title: **AHCCCS Mental Health Commissioner and Assistant Deputy Director** Date Signed: 07/24/2025

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Footnotes:

KATIE HOBBS
GOVERNOR

STATE OF ARIZONA
OFFICE OF THE GOVERNOR

EXECUTIVE OFFICE

March 19, 2024

Grants Management Specialist
Division of Grants Management
Substance Abuse and Mental Health Services Administration
5600 Fisher Lane
Rockville, MD 20857

Dear Grants Management Specialist:

Arizona Health Care Cost Containment System (AHCCCS) is Arizona's Medicaid agency that offers health care programs to serve Arizona residents. As the Governor of the State of Arizona, for the duration of my tenure, I delegate all Single State Agency (SSA) for substance abuse authority to the current Assistant Director, Alisa Randall, for administrative transactions required of the Substance Abuse and Mental Health Services Administration's (SAMHSA) Substance Abuse Block Grant (SABG). I delegate all State Mental Health Authority (SMHA) to Alisa Randall for administrative transactions required of the Substance Abuse and Mental Health Services Administration's (SAMHSA) Mental Health Block Grant (MHBG) and Projects to Assistance in Transition to Homelessness (PATH) grant.

If you have any questions, please contact Andrea Lustfiel, Deputy Assistant Director, Division of Grants Administration at Andrea.Lustfield@azahcccs.gov or (602) 417- 7792.

Sincerely,

Katie Hobbs
Governor
State of Arizona

Printed: 10/30/2025 3:46 PM - Arizona OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028 Page 15 of 45

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [MH]

Fiscal Year 2026

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Community Mental Health Services Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1911	Formula Grants to States	**42 USC § 300x**
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	**42 USC § 300x-1**
Section 1913	Certain Agreements	**42 USC § 300x-2**
Section 1914	State Mental Health Planning Council	**42 USC § 300x-3**
Section 1915	Additional Provisions	**42 USC § 300x-4**
Section 1916	Restrictions on Use of Payments	**42 USC § 300x-5**
Section 1917	Application for Grant	**42 USC § 300x-6**
Section 1920	Early Serious Mental Illness	**42 USC § 300x-9**
Section 1920	Crisis Services	**42 USC § 300x-9**

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1941	Opportunity for Public Comment on State Plans	**42 USC § 300x-51**
Section 1942	Requirement of Reports and Audits by States	**42 USC § 300x-52**
Section 1943	Additional Requirements	**42 USC § 300x-53**
Section 1946	Prohibition Regarding Receipt of Funds	**42 USC § 300x-56**
Section 1947	Nondiscrimination	**42 USC § 300x-57**

Section 1953	Continuation of Certain Programs	**42 USC § 300x-63**
Section 1955	Services Provided by Nongovernmental Organizations	**42 USC § 300x-65**
Section 1956	Services for Individuals with Co-Occurring Disorders	**42 USC § 300x-66**

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
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management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

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b. Establishing an ongoing drug-free awareness program to inform employees about--
    1. The dangers of drug abuse in the workplace;
    2. The grantee's policy of maintaining a drug-free workplace;
    3. Any available drug counseling, rehabilitation, and employee assistance programs; and
    4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
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    1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
    2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
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The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Alisa Randall

Signature of CEO or Designee[1]: _____

Title: AHCCCS Mental Health Commissioner and Assistant Deputy Director

Date Signed: _____

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [MH]

Fiscal Year 2026

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Community Mental Health Services Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1911	Formula Grants to States	**42 USC § 300x**
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	**42 USC § 300x-1**
Section 1913	Certain Agreements	**42 USC § 300x-2**
Section 1914	State Mental Health Planning Council	**42 USC § 300x-3**
Section 1915	Additional Provisions	**42 USC § 300x-4**
Section 1916	Restrictions on Use of Payments	**42 USC § 300x-5**
Section 1917	Application for Grant	**42 USC § 300x-6**
Section 1920	Early Serious Mental Illness	**42 USC § 300x-9**
Section 1920	Crisis Services	**42 USC § 300x-9**

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1941	Opportunity for Public Comment on State Plans	**42 USC § 300x-51**
Section 1942	Requirement of Reports and Audits by States	**42 USC § 300x-52**
Section 1943	Additional Requirements	**42 USC § 300x-53**
Section 1946	Prohibition Regarding Receipt of Funds	**42 USC § 300x-56**
Section 1947	Nondiscrimination	**42 USC § 300x-57**

Section 1953	Continuation of Certain Programs	**42 USC § 300x-63**
Section 1955	Services Provided by Nongovernmental Organizations	**42 USC § 300x-65**
Section 1956	Services for Individuals with Co-Occurring Disorders	**42 USC § 300x-66**

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State

management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
    a. Checking the Exclusion Extract located on the System for Award Management (SAM) at **http://sam.gov [sam.gov]**
    b. Collecting a certification statement similar to paragraph (a)
    c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 2 CFR Part 182by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
    1. The dangers of drug abuse in the workplace;
    2. The grantee's policy of maintaining a drug-free workplace;
    3. Any available drug counseling, rehabilitation, and employee assistance programs; and
    4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
    1. Abide by the terms of the statement; and
    2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
    1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
    2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

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Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: **Alisa Randall**

Signature of CEO or Designee[1]: 

Title: **AHCCCS Mental Health Commissioner and Assistant Deputy Director** Date Signed: 07/24/2025

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

State Information

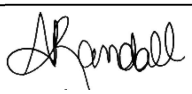
Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL).
Standard Form LLL (click here)

Name
Alisa Randall

Title
Mental Health Commissioner and Assistant Deputy Director

Organization
Arizona Health Care Cost Containment System (AHCCCS)

Signature:  Date: 07/24/2025

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes: **No lobbying activities to disclose.**

BSCA Funding Plan 2026

Arizona Health Care Cost Containment System (AHCCCS)

Block Grant for Community Mental Health Services- BSCA Funding Plan 2026

FAIN# B09SM090572 Award #: 1B09SM090572-01

Project Period: 9/30/2025- 9/29/2027

The Arizona Health Care Cost Containment System (AHCCCS), which serves as the state's Medicaid oversight agency, plays a central role in managing Arizona's behavioral health crisis continuum. Through its contracts with Arizona Complete Care Organizations operating under Regional Behavioral Health Agreements (ACC-RBHAs), AHCCCS ensures that a comprehensive provider network is in place to meet the behavioral health crisis needs of all individuals across the state, regardless of their Medicaid eligibility status.

Arizona's crisis response system is built upon a centralized infrastructure that utilizes a single statewide call center vendor. This vendor functions as the primary hub for dispatching crisis services, enabling streamlined coordination and rapid deployment of resources. The system is designed to provide continuous access to crisis support, operating 24 hours a day, seven days a week, throughout the entire year. Services available through this system include crisis phone support, mobile crisis response teams, and crisis stabilization facilities, all of which are distributed across Arizona to ensure equitable access to both urban and rural communities.

AHCCCS is actively engaged in enhancing and evaluating the use of Bipartisan Safer Communities Act (BSCA) funding to further strengthen the state's crisis response capabilities. These efforts include the provision of specialized training for emergency responders in behavioral and mental health, as well as trauma-informed care training for both providers and first responders. Funding is also being directed toward ensuring immediate access to crisis response services and post-crisis counseling and support through services such as crisis response teams.

Community outreach and education are integral components of AHCCCS's strategic initiatives under BSCA funding. Targeted programs are being implemented in schools, community centers, and other public venues to enhance awareness and preparedness for behavioral health emergencies. These initiatives include the creation and dissemination of user-friendly resource guides, and the organization of public conferences aimed at equipping both community members and professionals with clear guidance on whom to contact and what steps to take during a crisis. Additionally, AHCCCS is exploring the adoption of evidence-based curricula and student-focused presentations on crisis awareness to promote early understanding and build resilience among youth.

To address the growing challenges related to school violence and behavioral health crises involving individuals diagnosed with serious mental illness (SMI) or children identified with serious emotional disturbance (SED), AHCCCS is prioritizing enhanced inter-agency collaboration to ensure timely and effective interventions. Key strategies include organizing statewide conferences, facilitating listening sessions, and delivering targeted training programs in partnership with community stakeholders and behavioral health professionals.

In alignment with its strategic objectives, AHCCCS will utilize the 2025 Bipartisan Safer Communities Act (BSCA) funding to strengthen cross-agency collaboration and expand targeted outreach initiatives. Through partnerships with statewide contractors and community stakeholders, AHCCCS will implement evidence-based programs tailored to identified behavioral health needs. These initiatives will include educational training and

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outreach within schools, coordinated efforts with law enforcement, fire departments, hospitals, and community-based organizations, and the expansion of crisis response infrastructure. Collectively, these measures aim to ensure Arizona remains proactive and well-prepared to address behavioral health emergencies and promote community safety.

A detailed budget outlining the 2025 BSCA funding allocation is provided below.

Category	9/30/2025-9/29/2027	Justification
Personnel	$0	
ERE/Fringe	$0	
Travel	$0	
Contractual	$887,145	AHCCCS will use 10% of the award ($88,715) towards FEP and the remaining will be used as per AHCCCS' plan above
Other	$0	
Total Direct	$887,145	
Indirect	$0	
TOTAL	$887,145	

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State Information

Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL).
Standard Form LLL (click here)

Name

Alisa Randall

Title

AHCCCS Mental Health Commissioner and Assistant Deputy Director

Organization

AHCCCS

Signature: Date:

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

See attachment FY2026 - Disclosure of Lobbying Activities_Signed

State Information

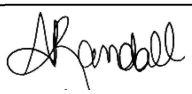
Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL).
Standard Form LLL (click here)

Name
Alisa Randall

Title
Mental Health Commissioner and Assistant Deputy Director

Organization
Arizona Health Care Cost Containment System (AHCCCS)

Signature: 

Date: 07/24/2025

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes: **No lobbying activities to disclose.**

Planning Steps

Step 1: Assess the strengths and organizational capacity of the service system to address the specific populations

Narrative Question

Provide an overview of the state's prevention system (description of the current prevention system's attention to individuals in need of substance use primary prevention), early identification, treatment, and recovery support systems, including the statutory criteria that must be addressed in the state's Application. Describe how the public behavioral health system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of mental health and SUD services. States should also include a description of regional, county, tribal, and local entities that provide mental health and SUD services or contribute resources that assist in providing these services. This narrative must include a discussion of the current service system's attention to the MHBG and SUPTRS BG priority populations listed above under "Populations Served."

1. Please describe how the public mental health and substance use services system is currently organized at the state level, differentiating between child and adult systems.

AHCCCS Overview

Arizona Health Care Cost Containment System (AHCCCS) is the single state Medicaid agency for the State of Arizona. In that capacity, it is responsible for operating the Title XIX and Title XXI programs through the State's 1115 Research and Demonstration Waiver, which allows for the operation of a total managed care model.???

AHCCCS' mission "reaching across Arizona to provide comprehensive, quality health care to those in need" is implemented through the vision of "shaping tomorrow's managed care...from today's experience, quality, and innovation." Built on a system of competition and choice, AHCCCS' $14 billion program operates under an integrated managed care model.???

AHCCCS Complete Care (ACC) Plans

ACC plans and the American Indian Health plan (AIHP) and other Fee For Service (FFS) provide a comprehensive network of providers to deliver all covered physical and behavioral health services to child and adult members without a Serious Mental Illness (SMI) designation and services for members with Children's Rehabilitative Services (CRS) conditions. ACC plans and AIHP address the whole health needs of our state's Medicaid population which is vitally important to improving service delivery for AHCCCS members and reducing the fragmentation that has existed in our healthcare system.??

Children in out-of-home care are eligible for medical and dental care, inpatient, outpatient, behavioral health, and other services through the Mercy Care Department of Child Safety Comprehensive Health Plan (Mercy Care DCS CHP). Children who have been adopted out of foster care may apply for AHCCCS and enroll in a ACC plan. Children adopted from DCS custody follow the same Medicaid enrollment process as other eligible children.

ACC-RBHAs, TRBHAs

Three of the ACC plans hold additional Regional Behavioral Health Agreements with AHCCCS (referred to as ACC-RBHAs) and align the RBHA and ACC contracts under one organization. An ACC-RBHA is a contracted Managed Care Organization (also known as a health plan) responsible for the provision of comprehensive behavioral health services to all eligible individuals assigned by the administration in addition to a provision for comprehensive physical health services to eligible persons with a Serious Mental Illness enrolled by the Administration. The function of the ACC-RBHAs include:??

Providing integrated services for Individuals with Serious Mental Illness.???

Providing behavioral health services for individuals identified with Serious Emotional Disturbance.

Development and support of a regional crisis system.???

Contracting and distributing non-title XIX/XXI funding including Substance Abuse and Mental Health Services Administration (SAMHSA) grants and other sources of funding??to BH providers.

Arizona's three ACC - Regional Behavioral Health Agreements (ACC-RBHAs) are required to maintain comprehensive networks of behavioral health providers to deliver prevention, intervention, treatment, and rehabilitation services to members enrolled in AHCCCS.???

Mercy Care – ACC-RBHA serving central Arizona, including Maricopa, Pinal and Gila Counties????

Arizona Complete Health South – ACC-RBHA serving southern Arizona???

Arizona Complete Health North – ACC-RBHA serving northern Arizona????

Tribal Regional Behavioral Health Authority (TRBHA) is a tribal entity that has an Intergovernmental Agreement (IGA) with AHCCCS, the primary purpose of which is to coordinate the delivery of comprehensive behavioral health to all eligible individuals assigned by the administration to the tribal entity. Tribal governments, through an agreement with the State, may operate a Tribal Regional Behavioral Health Authority for the provision of behavioral health services to American Indian members. Refer to A.R.S. §36-3401 and A.R.S. §36-3407.???

White Mountain Apache – TRBHA serving the White Mountain Apache Nation????

Gila River – TRBHA serving the Gila River Indian Community????

Pascua Yaqui – TRBHA serving the Pascua Yaqui Tribe?????

Navajo Nation – TRBHA serving the Navajo Nation

Comprehensive System

The ACCs, MCOs, ACC-RBHAs, and TRBHAs are required to maintain a comprehensive network of behavioral health providers to deliver prevention, intervention, treatment, and rehabilitative services to members enrolled in the AHCCCS system. This structure allows communities to provide services in a manner appropriate to meet the unique needs of members and families residing within their local areas.???

A map of the geographic service areas for AHCCCS behavioral health services can be found at https://www.azahcccs.gov/Members/BehavioralHealthServices/.?

Through the ACC contracts, Managed Care Organizations (MCOs) are responsible for providing physical, behavioral, and long-term care services. AHCCCS also operates the AIHP, a fee for service program that is responsible for care for American Indian members who select AIHP. AHCCCS also has five unique intergovernmental agreements with Tribes or Tribal Regional Health Authorities (TRBHAs) for the coordination of behavioral health services for American Indian members enrolled with a TRBHA. Contracted health plans coordinate and pay for physical and behavioral health care services delivered by more than 100,000 health care providers.

Continuum of Care (Child and Adult Systems)

As a leader in the public behavioral health field, Arizona's approach to managed care and service delivery is nationally recognized. AHCCCS focuses its efforts and energies toward providing leadership in activities designed to integrate and adapt the behavioral health system to meet the needs of those we serve.???

AHCCCS fosters an environment of person-centered planning that includes the voice and choice of the person being served, their family, identified persons of support, advocates (as designated) and service providers, as identified. The Individual Service Planning (ISP) progress is transparent, fluid and the ISP is a living and breathing document that can change as a persons' choices and treatment needs change.???

AHCCCS has an Adult System of Care (ASOC) that is a continuum of coordinated community and facility-based services and support for adults with, or at risk for, behavioral health challenges. The ASOC is organized into a comprehensive network to create opportunities to foster recovery and improve health outcomes by:??

Building meaningful partnerships with individuals served,??

Addressing the unique the needs and preferences of individuals

Assisting the individual in identifying and achieving personal and recovery goals.??

The ASOC developed the following Nine Guiding Principles to promote recovery in the adult behavioral health system and for engaging with adults who have a serious mental illness. Refer to AHCCCS Medical Policy Manual (AMPM) Exhibit 300-3 AHCCCS Integrated System Of Care Structure, Values, And Principles https://www.azahcccs.gov/shared/MedicalPolicyManual/

AHCCCS has a Children's System of Care (CSOC) that incorporates collaboration with the youth before the age of 18, family, and others to provide services that are tailored to meet the needs of youth, youth with serious emotional disturbances, children with rehabilitative services' conditions (CRS), and their caregivers. The goal is to ensure that services are provided to the youth and

family in the most appropriate setting, in a timely manner, in accordance with the best practices and respecting the child, family, and their unique needs and preferences.????

Arizona/AHCCCS developed?The Twelve (12) Principles?for Children's in the Behavioral Health Service Delivery System. Twelve (12) Guiding Principles. Refer to AMPM 580 – Child And Family Team
https://www.azahcccs.gov/shared/MedicalPolicyManual/Behavioral health service plans identify and appropriately address behavioral symptoms that are reactions to death of a family member, abuse or neglect, learning disorders, and other similar traumatic or frightening circumstances, substance abuse problems, the specialized behavioral health needs of children who are developmentally disabled, maladaptive sexual behavior, including abusive conduct and risky behavior, and the need for stability and the need to promote permanency in class member's lives, especially class members in foster care. Behavioral Health Services are continuously evaluated and modified if ineffective in achieving desired outcomes.???

Overall, the Person-Centered Planning and Service Plan meets the person's unique individual needs and includes individualized goals and desired outcomes. Additionally, the planning process also identifies risk factors (including risks to member rights) and puts measures in place to minimize them with individual back-up plans and other strategies as needed.??

2. Please describe the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of mental health and substance use services.

Single State Authority (SSA) and State Mental Health Authority (SMHA)??

In addition to overseeing the MCOs that provide Medicaid-funded health care services, AHCCCS serves as the SSA on substance use, and as the SMHA responsible for the state public mental health service delivery system administration. AHCCCS is the agency responsible for mental health and substance use and provides oversight, coordination, planning, administration, regulations, and monitoring of all facets of the public behavioral health system in Arizona.???

Service Delivery System

Regardless of the type, amount, duration, scope, service delivery method, and population served, AHCCCS requires all MCOs ensure that their service delivery system:??

Coordinate and provide access to high-quality health care services informed by evidence-based practice guidelines in a cost-effective manner,???

Coordinate and provide access to high-quality and appropriate health care services , family voice and choice, and incorporate a trauma-informed care approach,??

Coordinate and provide access to preventive and health promotion services, including wellness services,??

Coordinate and provide access to comprehensive care coordination and transitional care across settings;?follow-up from inpatient to other settings; participation in discharge planning, and facilitating transfer from the children's system to the adult system of health care,??

Coordinate and provide access to chronic disease management support, including self-management support,??

Conduct behavioral health assessment and service planning following a Health Home model,??

Coordinate and provide access to peer and family delivered support services, based on member's needs, voice, and choice,??

Provide covered services to members in accordance with all applicable Federal and State laws, regulations, and policies,??

Coordinate and integrate clinical and non-clinical health care related needs and services across all systems,??

Implement health information technology to link services, facilitate communication among treating professionals and between the health team and individual and family caregivers, and??

Deliver services by providers that are appropriately licensed or certified, operating within their scope of practice, and registered as an AHCCCS provider.???

AHCCCS further requires that at all MCOS work in partnership to meet, agree upon, and reduce to writing joint collaborative protocols with each county, district, or regional office of:???

Administrative Office of the Courts,???

Juvenile Probation and Adult Probation,???

Arizona Department of Corrections and Arizona Department for Juvenile Corrections,???

Arizona Department of Child Safety (DCS),???

Tribal Nations and Providers (Refer to this section above),???

The Veterans' Administration, and???

The county jails.???

Division of Behavioral Health and Housing (DBHH)??

The Division of Behavioral Health and Housing (DBHH),is the point of contact related to the pursuit, implementation and oversight of grants administered by the agency, including the MHBG and SUPTRS BG.? The Integrated System of Care and Housing Divisions promotes integration and fluidity in the fee-for-service and grant planning and implementation processes.?, The Office of Human Rights and the Justice Administrator are part of the DBHH team and provide enhanced collaboration on the oversight, monitoring and administration of behavioral health programs and initiatives.

DBHH consists of grants-specific, and general behavioral health units. Additionally, the DBHH grants unit employes programmatic, financial, and compliance teams. Together, various DBHH units and teams work closely with each other to ensure effective communication, oversight, and implementation of all grants management for the agency. DBHH grants and behavioral health staff positions include the State Opioid Treatment Authority/Opioid Treatment Network, Women's Treatment Network, National Prevention Network and National Treatment Network representatives, Grant Administrators, and Grant Coordinators as well as Administrators for Housing, Crisis, and Justice initiatives.?

Administration of Non-Title XIX/XXI programs

SUPTRS BG

The SUPTRS BG is used to plan, implement, and evaluate activities to prevent and treat substance use disorders. For treatment and recovery services, DBHH primarily leverages the ACC-RBHA contracts and TRBHA IGAs to provide access to care for substance use disorder. The SUPTRS BG supports primary prevention services through agreements with TRBHAs, state agencies, local and regional non-profits, coalitions. Grant funds are also used to provide early intervention services for HIV and tuberculosis disease in high-risk substance users. Arizona is not an HIV designated state, so there are not specific requirements that need to be met for SAMHSA. However, early intervention efforts remain in place in order to mitigate the high risk of transmission in the SUPTRS BG priority populations. SUPTRS BG funds are used to ensure access to interventions, treatment, and long-term recovery support services for (in order of priority):??

Pregnant women (including teenagers) who use drugs by injection,???

Pregnant women (including teenagers) who use substances,???

Other persons who use drugs by injection,???

Substance using women and teenagers with dependent children and their families, including females who are attempting to regain custody of their children, and???

All other individuals with a substance use disorder, regardless of sex or route of use, (as funding is available).?

As required by federal code, SUBG providers are required to provide specialized, gender-specific treatment and recovery support services for females who are pregnant or have dependent children and their families in outpatient and residential treatment settings. Services are also provided to mothers who are attempting to regain custody of their children, and the family is treated as a unit. Providers must admit both mothers and their dependent children into treatment. The following services are provided or arranged as needed:???

Referral for primary medical care for pregnant females,???

Referral for primary pediatric care for children,???

Gender-specific substance use treatment, and???

Therapeutic interventions for dependent children.???

Contractors must ensure the following issues do not pose barriers to access to obtaining substance use disorder treatment:???

Childcare???

Case management???

Transportation???

The Contractors require any entity receiving funding from the SUPTRS BG for operating a treatment program for substance use disorders to follow procedures which address how the program:??

Will, directly or through arrangements with other public or nonprofit private entities, routinely make available tuberculosis services as defined in [45 CFR 96.121] to?each individual?receiving treatment for such abuse,??

In the case of an individual in need of such treatment who is denied admission to the program?based on?the lack of the capacity of the program to admit the individual, will refer the individual to another provider of tuberculosis services, and???

Will implement infection control procedures designed to prevent the transmission of tuberculosis, including the following:??

Screening of patients,??

Identification of those individuals who are at high risk of becoming infected,???

Meeting all State reporting requirements while adhering to Federal and State confidentiality requirements, including [42 CFR part 2], and??

Will conduct case management activities to ensure that individuals receive such services.???

Interim Services are required for those who meet the priority populations of pregnant women, women with dependent children, or intravenous drug users if there is a waitlist to engage in services. The purpose of interim services is to reduce the adverse health effects of substance use, promote the health of the members, and reduce the risk of transmission of disease. The minimum required interim services include:??

Education that covers prevention of and types of behaviors which increase the risk of contracting HIV, Hepatitis C, and other sexually transmitted diseases,??

Education that covers the 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.??

MHBG

The MHBG is allocated to provide community mental health treatment services to adults with a Serious Mental Illness (SMI) designation, children with Serious Emotional Disturbance (SED), and individuals with an Early Serious Mental Illness (ESMI) including first episode psychosis (FEP). The program makes funding available throughout Arizona to provide community mental health services with the objective to support grantees in carrying out plans for providing comprehensive community mental health services.??

MHBG funds are used to provide treatment services in accordance with AMPM 300-2B and AMPM 320-T1 and to ensure access to an integrated and comprehensive system of care, including employment, housing, case management, rehabilitation, dental, and health services as well as mental health services and supports.??

Adults with a Serious Mental Illness (SMI) designation includes persons aged 18 and older who have a diagnosable behavioral, mental, or emotional condition as defined by the American Psychiatric Association's?Diagnostic and Statistical Manual?(DSM) of? Mental Disorders in addition to functional impairment that substantially interferes with, or limits, their ability to function in the community.??

Serious Emotional Disturbance (SED) includes persons up to age 18 who have diagnosable behavioral, mental, or emotional issues (as defined by the?Diagnostic and Statistical Manual of Mental Disorders (DSM)). Their condition results in a functional impairment that substantially interferes with, or limits, a child's role or functioning in family, school, or community activities.??

Early Serious Mental Illness (ESMI), including First Episode Psychosis (FEP), services are supported by the 10 percent set aside for ESMI/First Episode of Psychosis (FEP) and support evidence-based programs that provide treatment and support services for those

who have experienced a first episode of psychosis within the?past?two?years or individuals recently diagnosed with an SMI qualifying diagnosis.? Psychosis is a brain condition that disrupts a person's thoughts and perceptions, making it difficult to differentiate between what is real and what is not. FEP Program models may include principles or core components identified by National Institute of Mental Health (NIMH) via the Recovery After an Initial Schizophrenia Episode (RAISE) initiative and practice a Coordinated Specialty Care model of early intervention.?

MHBG crisis set aside is used to?support an evidence-based crisis system. Arizona's crisis continuum of care services has gained national recognition for their innovative approach to behavioral health crisis services. The AHCCCS crisis care continuum encompasses a comprehensive range of services, including crisis telephone response, mobile crisis team intervention, facility-based stabilization (including observation and detox), and all other covered services available to any Arizona resident, regardless of insurance coverage. Ensuring recovery-oriented and person-focused care, the crisis services aim to stabilize individuals promptly, enabling them to return to their baseline of functioning.?

AHCCCS is the designated unit of the executive branch that is responsible for administering the MHBG. AHCCCS ensures the following performance requirements are met:??

Subrecipients must submit a plan explaining how they will use MHBG funds to provide comprehensive, community mental health services to adults with serious mental illnesses and children with serious emotional disturbances,??

Subrecipients to provide annual reports on their plans,??

Subrecipients may distribute funds to local government entities and non-governmental organizations,??

Subrecipients must ensure that community mental health centers provide such services as screening, outpatient treatment, emergency mental health services, and day treatment programs,??

Subrecipients must comply with general federal requirements for managing grants. They must also cooperate in efforts by SAMHSA to monitor use of MHBG funds. For example, each year, CMHS conducts investigations (site visits) of at least ten grantees receiving MHBG funds. This is to assess how they are using the funds to benefit the population. These evaluations include careful review of the following:??

How the grantees are tracking use of MHBG funds and their adult and child mental health programs,??

Data and performance management systems,??

Collaboration with consumers and the grantees' mental health planning council, and??

Grantees receiving MHBG funds are required to form and support a state or territory mental health/behavioral health planning council.?? AHCCCS DBHH also administers other non-Title XIX/XXI programs including but not limited to Projects for Assistance in Transition from Homelessness (PATH), State Opioid Response (SOR) Grants, State Pilot Grant Program for Treatment for Pregnant and Postpartum Women (PPW-PLT), and other State Funds

As the SSA, AHCCCS DBHH convenes the Arizona Behavioral Health Planning Council (BHPC)??

AHCCCS utilizes the Arizona BHPC to advise the state in planning and implementing a comprehensive community-based system of behavioral health and mental health Services.??

AHCCCS also houses an Office of Individual and Family Affairs (OIFA)?

The AHCCCS Office of Individual and Family Affairs (OIFA) is staffed by individuals and family members whose lives have been affected by substance use and/or mental health disorders.? As a part of the Behavioral Health Planning Council (BHPC), OIFA is in a unique position to bring more voices of the community into the oversight process.? In addition to the AHCCCS OIFA, each AHCCCS health plan is contractually required to have its own OIFA.? The health plan OIFAs extend the reach of the BHPC to increase prospects for more responsive and accountable substance abuse and behavioral health services.???

Although AHCCCS is the agency responsible for public behavioral health services, other state agencies are important partners in behavioral health prevention, treatment and recovery:

The Arizona Department of Health Services (ADHS) licensed behavioral health facilities, collects and reports opioid overdose data, purchases and distributes naloxone, and is responsible for many intersecting health issues for block grant priority populations (e.g. HIV, TB).

The Attorney General's Office (AGO) is an integral partner is AHCCCS's adherence to the Synar Amendment (tobacco retail compliance). The AGO also administers the opioid settlement funds so the AHCCCS State Opioid Treatment Authority (SOTA) engages with the AGO to reduce silos and duplication.

The Arizona Board of Behavioral Health Examiners establishes and maintains standard of qualifications and performance for licensed behavioral health professionals.

The Arizona Department of Economic Security (DES) and Division of Developmental Disabilities (DDD) administer programs that intersect with the priority populations of the MHBG and SUPTRS BG.

The Arizona Department of Liquor Licenses and Control (DLLC) is a strong substance use prevention partner, as they conduct statewide alcohol retail compliance checks, retailer education, community/school/student alcohol prevention education, and more.

The Governor's Office of Youth, Faith and Family (GOYFF) are a strong substance use prevention partner, as they administer a large portion of the SUPTRS primary prevention set aside.

The Arizona Department of Corrections Rehabilitation and Reentry (ADCRR)

Arizona Department of Education (ADE)

Department of Child Safety (DCS)

3. Please describe how the public mental health and substance use services system is organized at the regional, county, tribal, and local levels. In the description, identify entities that provide mental health and substance use services, or contribute resources that assist in providing these services. This narrative must include a description of the current service system's attention to the MHBG and SUPTRS BG priority populations listed above under "Populations Served."

Arizona's public mental health and substance use services system is organized through a statewide framework administered by the Arizona Health Care Cost Containment System (AHCCCS), with regional, county, tribal, and local implementation supported by a network of Managed Care Organizations (MCOs). These entities deliver integrated services to individuals with Early Serious Mental Illness (ESMI), Serious Mental Illness (SMI), Serious Emotional Disturbance (SED), Substance Use Disorders (SUD), and those in recovery.

At the regional level, AHCCCS contracts with three ACC-RBHAs—Arizona Complete Health North, Mercy Care (Central Arizona), and Arizona Complete Health South. Each serves a distinct Geographic Service Area (GSA) and is responsible for behavioral health services for non-Title XIX/XXI members, including those with SMI, SED, and SUD. These entities also manage regional crisis systems and allocate federal block grant funding to support priority populations.

AHCCCS partners with Tribal Regional Behavioral Health Authorities (TRBHAs) through Intergovernmental Agreements to provide culturally responsive behavioral health services to American Indian members. Current TRBHAs include the White Mountain Apache, Gila River, Pascua Yaqui, Navajo Nation, and Colorado River Indian Tribe. Tribal governments may operate their own behavioral health units or subcontract with providers to deliver prevention, treatment, and recovery services both on and off tribal lands.

At the county and local levels, services are delivered through a diverse network of providers, including subacute detox facilities, outpatient clinics, integrated care centers, Federally Qualified Health Centers (FQHCs), Medication-Assisted Treatment (MAT) and Medications for Opioid Use Disorder (MOUD) providers, and behavioral health residential facilitiesRecovery services are supported by peer-led organizations and programs such as Oxford House, Barbell Saves, and employment support initiatives. For persons who inject drugs (PWID), Arizona operates 67 opioid treatment programs, including four that offer 24/7 access. Office-Based Opioid Treatment (OBOT) programs and harm reduction services are also available. Sonoran Prevention Works (SPW) provides statewide outreach, HIV and Hepatitis C testing, naloxone distribution, and peer supportArizona's system is deeply aligned with the priority populations identified under the Mental Health Block Grant (MHBG) and the Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUPTRS BG):

Adults with SMI and Children with SED receive community-based treatment supported by MHBG funding.

Individuals with ESMI, including those with First Episode Psychosis (FEP), benefit from a 10% MHBG set-aside supporting evidence-based Coordinated Specialty Care.

Crisis services are supported by a 5% MHBG set-aside and include telephone response, mobile crisis teams, and facility-based stabilization accessible to all Arizona residents.

Pregnant and parenting women with SUD, PWID, and individuals at risk for HIV, TB, overdose, or suicide are served through targeted SUPTRS BG-funded programs and outreach.

Justice-involved individuals receive coordinated care through pre- and post-release services, navigation, and court liaison programs.

Primary prevention efforts under SUPTRS BG are implemented through partnerships with TRBHAs, state agencies, and community

coalitions. Key partners include the Governor's Office of Youth, Faith and Family (GOYFF), which administers the Trauma Informed Substance Abuse Prevention Program (TISAPP), and Matforce/SACLAz, which coordinate outreach and education through 25 community-based coalitions.

Together, AHCCCS and its contracted partners ensure that MHBG and SUPTRS BG resources are used effectively to support a responsive, integrated behavioral health system across Arizona's regional, county, tribal, and local levels.

As outlined in the previous section, Arizona's public mental health and substance use service systems are administered statewide through contracts with Managed Care Organizations (ACC Plans). These organizations partner with integrated and specialty behavioral health providers to deliver services to members with ESMI, SMI, SED, SUD, including those in recovery. Regionally, three ACC-RBHAs—Arizona Complete Health North (Northern AZ), Mercy Care (Central AZ), and Arizona Complete Health South (Southern AZ)—each serve a distinct Geographic Service Area (GSA), providing behavioral health services for non-Title XIX/XXI members affected by ESMI, SMI, SED, and SUD. Additionally, AHCCCS collaborates with Tribes and Tribal Regional Behavioral Health Authorities (TRBHAs) through Intergovernmental Agreements (IGAs) to facilitate comprehensive behavioral health care for all eligible individuals assigned to tribal entities. Tribal governments may operate their own TRBHA by agreement with the State to support American Indian members. Current TRBHAs include the White Mountain Apache, Gila River, Pascua Yaqui, Navajo Nation, and Colorado River Indian Tribe. Our system offering a wide array of mental health and substance use services, encompassing various provider types, specialties, and populations served. For substance use treatment services and certain recovery services under the SUPTRS BG, the majority of providers fall under: subacute facilities to administer detox services, outpatient, integrated care, FQHCs, MAT/MOUD providers, and behavioral health residential facilities. Some examples of some unique or specialty programs for pregnant women and women with dependent children include Hushabye Nursery, Arizona Women's Recovery Center, West Valley OBGYN, The Guidance Center, CODAC and their transitional living casitas and their Connie Hillman House. Recovery services and programs include peer support, employment support, Oxford House and Barbell Saves recovery program. The PWID population is served by 67 opioid treatment programs. There are 4 OTP programs that provide 24/7 access to care to provide immediate access to opioid treatment and connect to ongoing services. MOUD services may also be offered through Office Based Opioid Treatment (OBOT) programs. Another program option for PWID who are not yet ready for treatment is Sonoran Prevention Works (SPW) who operates the statewide program that focuses on overdose prevention and infectious disease prevention among people who use drugs. SPW provides access to stigma-free services including street-based outreach, HIV and Hepatitis C testing and referrals, naloxone distribution and other overdose prevention resources and training, peer support, and syringe services programming (hypodermic syringes or any items used in the act of injection drug use are NOT funded by federal dollars). SPW is a partner that is uniquely posed to engaged positively and effectively with the PWID population and provide referrals to substance use and mental health treatment.

For substance use primary prevention, The SUPTRS BG supports programs and activities through agreements with TRBHAs, state agencies, local and regional non-profits, and coalitions. The majority of prevention efforts are administered through either 1) GOYFF with their Trauma Informed Substance Abuse Prevention Program (TISAPP), where they contract with over 25 local, county, or regional organizations that offer outreach, information dissemination, and education primarily to communities and individuals across the state, or 2) Matforce and the Substance Awareness Coalitions Leaders of Arizona (SACLAz) who contracts with approximately 25 community-based prevention coalitions across the state. AHCCCS works closely with these two entities, as well as the TRBHAs, DLLC, and other subrecipients to monitor the planning, implementation, and evaluation of prevention services.

The Mental Health Block Grant (MHBG) plays a critical role in supporting this system by funding community-based mental health treatment for specific priority populations. These include:

Adults with Serious Mental Illness (SMI): Individuals aged 18 and older who have a diagnosable behavioral, mental, or emotional condition that significantly impairs their ability to function in the community.

Children with Serious Emotional Disturbance (SED): Individuals under the age of 18 who experience behavioral, mental, or emotional challenges that interfere with their functioning in family, school, or community settings.

Individuals with Early Serious Mental Illness (ESMI), including those experiencing First Episode Psychosis (FEP): These services are supported by a 10% set-aside of MHBG funds and follow evidence-based models such as Coordinated Specialty Care, incorporating principles from the National Institute of Mental Health's RAISE initiative.

In addition to these targeted services, 5% of MHBG funds are reserved for crisis services. Arizona's crisis care continuum includes a robust and nationally recognized system of support, offering:

Crisis telephone response

Mobile crisis team interventions

Facility-based stabilization services, including observation and detox

Access to all other covered services for any Arizona resident, regardless of insurance status

This crisis system is designed to be recovery-oriented and person-focused, aiming to stabilize individuals quickly and help them return to their baseline level of functioning.

Together, AHCCCS and its contracted ACC-RBHAs ensure that MHBG resources are used effectively to support a responsive and integrated behavioral health system across Arizona's regional, county, tribal, and local levels.

AHCCCS TRBHA partners tend to be tribal government organizations who have their own behavioral health services units from which to provide direct behavioral health prevention, treatment and recovery services. They may also have subcontracted or partnered behavioral health facilities within their tribal lands and jurisdiction as well as off-reservation placement options as indicated.

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Footnotes:

Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system, including state plans for addressing identified needs and gaps with MHBG/SUPTRS BG award(s)

Narrative Question

This narrative should describe your states needs assessment process to identify needs and service gaps for its population with mental or substance use disorders as well as gaps in the prevention system. A needs assessment is a systematic approach to identifying state needs and determining service capacity to address the needs of the population being served. A needs assessment can identify the strengths and the challenges faced in meeting the service needs of those served. A needs assessment should be objective and include input from people using the services, program staff, and other key community stakeholders. Needs assessment results should be integrated as a part of the state's ongoing commitment to quality services and outcomes. The findings can support the ongoing strategic planning and ensure that its program designs and services are well suited to the populations it serves. Several tools and approaches are available for gathering input and data for a needs assessment. These include use of demographic and publicly available data, interviews, and focus groups to collect stakeholder input, as well as targeted and focused data collection using surveys and other measurement tools.

Please describe how your state conducts needs assessments to identify behavioral health needs, determine adequacy of current services, and identify key gaps and challenges in the delivery of quality care and prevention services.

Grantees must describe the unmet service needs and critical gaps in the state's current systems identified during the needs assessment described above. The unmet needs and critical gaps of required populations relevant to each Block Grant within the state's behavioral health system, including for other populations identified by the state as a priority should be discussed. Grantees should take a data-driven approach in identifying and describing these unmet needs and gaps.

Data driven approaches may include utilizing data that is available through a number of different sources such as the **National Survey on Drug Use and Health (NSDUH)**, **Treatment Episode Data Set (TEDS)**, **National Substance Use and Mental Health Services Survey (N-SUMHSS)**, the **Behavioral Health Barometer**, **Behavioral Risk Factor Surveillance System (BRFSS)**, **Youth Risk Behavior Surveillance System (YRBSS)**, the CDC mortality data, and state data. Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention, treatment, and recovery support services planning. States with current Strategic Prevention Framework - Partnerships for Success discretionary grants are required to have an active SEOW.

This step must also describe how the state plans to address the unmet service needs and gaps identified in the needs assessment. These plans should reflect specific services and activities allowable under the respective Block Grants. In describing services and activities, grantees must also discuss their plan for implementation of these services and activities. Special attention should be made in ensuring each of the required priority populations listed above, and any other populations, prioritized by the state as part of their Block Grant services and activities are addressed in these implementation plans.

1. Please describe how your state conducts statewide needs assessments to identify needs for mental and substance use disorders, determine adequacy of current services, and identify key gaps and challenges in the delivery of quality care and prevention services.

The Arizona Health Care Cost Containment System (AHCCCS) utilizes several data feeds, surveys, systemic evaluations, as well as stakeholder forums to determine statewide need for services.? AHCCCS works in tandem with the ACC Plans with Regional Behavioral Health Agreements (ACC-RBHAs) and Tribal Regional Behavioral Health Authorities (TRBHAs) to ensure efficient resource allocation that correlates system capacity with service demand. AHCCCS utilizes and continually works to enhance data driven decision-making processes when assessing prevention, intervention, treatment, and recovery needs for behavioral health disorders.?

ACC Plan and ACC-RBHA Assessment Efforts

AHCCCS maintains active policies that allow for the assessment and monitoring of unmet needs at the contract level, in communities, and within specified populations either accessing or in need of behavioral health services statewide. The AHCCCS Contractor Operations Manual (ACOM) Policy 415 Provider Network Development and Management Plan - Periodic Network Reporting Requirements ensure that regular assessments of need are occurring. This policy applies to AHCCCS Complete Care (ACC) and ACC-RBHAs. The policy states that provider networks shall provide a foundation that supports an individual's needs as well as the membership in general. This policy establishes Contractor requirements for the submission of the Network Development and Management Plan and other periodic network reporting requirements allowing AHCCCS to assess and monitor both programmatic and financial activities. Specific requirements of activities contractors are required to manage and report on include, but are not limited to:?

Contractor's Workforce Development Plan?

Contractor's Value Based Purchasing/24/7 Access Points Report?

Evaluation of the prior year's Network Plan including:?Actions proposed in the prior year's plan, network issues over the past year that required intervention,?interventions taken to resolve network issues,?barriers to the interventions, and?evaluation of the effectiveness of the interventions.?

Contractor's current network gaps?

Contractor's network development steps for the coming year based upon its review of the prior year's Network Plan, current identified gaps, and any other priorities identified in the current plan?

Contractor's analysis demonstrating it has the capacity and the appropriate range of services adequate for the anticipated enrollment in its assigned service area?

Description of the integrated network design by GSA for the following populations: members undergoing substance use disorder treatment:?Pregnant Women and/or Pregnant Women with Dependent Children,?Persons who use drug by injection,?Adults, and??Children.?

General membership requiring access to the following types of substance use disorder treatment:?Medication Assisted Treatment,?Outpatient,?Intensive Outpatient, Partial Hospitalization, and??Residential Inpatient.?

A description of subcontracts for substance use treatment and recovery through the Substance Use Prevention, Treatment and Recovery Services (SUPTRS) Block Grant utilizing capacity data including wait list management methods for SUPTRS Block Grant Priority populations.?

Some specific examples of needs assessments processes implemented by the ACC-RHBAs relating to the SUBG include:

AzCH North and South- The health plan monitors access through monthly gap analyses and tracks both existing and expanding SUD programming, including Medication for Opioid Use Disorder (MOUD) programs and State Opioid Response (SOR) initiatives.

Mercy Care – The health plan uses a multi-method approach which includes data analysis and trends of current SUBG network, stakeholder & provider engagement, provider pre-award risk assessment, and outcomes of the Independent Case Review. Provider pre-award risk assessment involves several evaluation criteria that contributes to the health plan ensuring providers that are selected to receive SUBG funding have the operational, financial, and programmatic/clinical experience with priority populations, which ensures funding decisions are data informed and responsive to community needs. The health plan also conducts stakeholder and provider meetings where regional and local need and gaps are identified. Mercy Care analyzes data on current SUBG subrecipient demographics and most used services. Quarterly, data analysis and trends are reviewed through a quarterly report of claims data that identifies how many individuals were served, demographics including pregnancy status, top 10 clinical services provided, and specific services received by age group. This type of data helps to inform trends of what is currently being provided within the SUBG network and what gaps still exist.

The National Survey on Drug Use and Health (NSDUH)

Prepared by the Substance Abuse and Mental Health Services Administration (SAMHSA), the NDSUH provides the underlying methodology used by AHCCCS to quantify the need for substance abuse treatment in Arizona. On an annual basis, prevalence information from the NSDUH compares census data, both actual and estimated, for the State of Arizona. The results outlined treatment needs based on demographic groups by state, county and/or sub-state planning area.??

The Arizona Department of Health Services (ADHS) Data Dashboard

ADHS maintains an interactive data dashboard to provide timely data about the opioid epidemic in Arizona. The dashboard is a tool that ADHS, the Governor's Office of Youth, Faith, and Families (GOYFF), AHCCCS and others use to assess statewide impacts of opioid and other drugs. Data is displayed at multiple levels, across demographics, and over time, including tables, graphs, maps, and downloadable data files covering a variety of reporting and visualization needs.?

AHCCCS Office of Data Analytics (AODA)

AHCCCS also relies on the results of data management and numerous qualitative surveys to determine need and direct resources accordingly. Data management on process-related performance measures occurs with contracted providers and partners reporting independent numbers no less than quarterly. The reports are then aggregated by the AODA within the Division of Managed Care (DMC). Data management and analysis on impact and outcome measures occur across the partner agencies. Sending this information to AHCCCS ensures a central location for consistent packaging and reporting to SAMHSA and for public

dissemination. Qualitative surveys are critical to identifying potential service gaps, as they capture the human component and the effect a lack of services can have on a community which quantitative analysis cannot adequately determine.?

Independent Case Review (ICR)

AHCCCS contracts annually with a professional consulting agency to conduct the Independent Case Review (ICR) to meet the independent peer review federal requirement of the SUBG grant. Each year member treatment case files from SUBG treatment providers under each ACC-RBHA are provided to AHCCCS and then to the consulting agency. Files are reviewed systematically by the consulting agency to assess the quality, appropriateness, and efficacy of SUBG-funded treatment services. The files that are reviewed by the contractor include intake documents, assessments, treatment plans, treatment services or referrals (HIV screening, peer support, case management, employment services, therapy, MAT services, etc.) and discharge paperwork. The contractor uses a validated case file review tool, which is reviewed annually, to assess if members were referred to appropriate services, provided knowledge of available services and whether the members utilized the services offered. Some specific examples of evaluation measures within the tool include: the timeliness of the assessment (within 45 days), presence of an individual service plan (ISP), timeliness of the ISP (within 90 days), use of certified peer support services and that the peer support specialist is "credentialed", whether telehealth was offered as a treatment option, if non-medical determinants of health were assessed and when/how/if services were offered to the member throughout their time enrolled with the provider.

Additionally, the consulting agencies reviews for how many specific services (e.g. family therapy) were utilized throughout treatment and categorizes services offered/received for specific high-risk populations (e.g. pregnant/parenting women).

Additionally, focus groups are facilitated to allow members and providers to voice supplementary feedback including whether certain services were provided/available, the members experience while in treatment services and additional services that could have been beneficial to their treatment and recovery process.

Several other processes are implemented to continually assess needs and gaps for behavioral health services in Arizona. This includes professional needs assessments conducted by outside vendors (2021 Pregnant and Parenting Women Needs Assessment, 2022 Arizona Behavioral Health Needs for the Uninsured and Underinsured), reviews of data that AHCCCS compiles for required SAMHSA reporting (e.g. Table 10a, 10b, 5a, 5b), and monthly meetings with the Arizona Behavioral Health planning Council. AHCCCS is currently considering and planning how best to conduct an updated comprehensive statewide substance use and mental health services needs assessment to assist in future and continued strategic planning of the SUBG and MHBG.

LMA NEEDS ASSESSMENT

AHCCCS finalized a statewide substance abuse prevention needs assessment in May 2025 that highlighted areas of needs in the current statewide primary prevention system structure. The assessment generated a community prevention inventory, conducted focus groups throughout AZ, conducted key informant interviews throughout AZ, conducted an online Substance Use Prevention Workforce survey, and synthesized secondary data analysis for a multitude of data sources.

To comprehensively assess Arizona's substance use prevention landscape, LeCroy & Milligan Associates (LMA) employed a mixed-methods approach grounded in SAMHSA's Strategic Prevention Framework (SPF). This framework emphasizes data-driven decision-making, stakeholder engagement, and contextual understanding of community needs. The methodology was designed to capture both quantitative and qualitative insights across all Arizona populations and regions.

The assessment was structured around four major themes:

Substance Use Trends – What is the prevalence and pattern of substance use across Arizona's demographic and geographic groups?

Current Prevention Efforts – What programs are in place, who do they serve, and where are the gaps?

Risk and Protective Factors – What influences substance use at individual, community, and systemic levels?

Prevention Needs – What strategies and resources are needed to strengthen Arizona's prevention infrastructure?

LMA analyzed state and national datasets to identify substance use prevalence, trends, and areas of high need. Sources included:

Arizona Youth Survey (AYS)

Arizona Department of Health Services (ADHS)

Arizona Institutes for Higher Education (AZIHE)

National Survey on Drug Use and Health (NSDUH)

Youth Risk Behavior Survey (YRBS)

Centers for Disease Control and Prevention (CDC)

Arizona Department of Public Safety (DPS)

These datasets provided insights into substance use by demographic groups, geography, and socioeconomic status.

LMA conducted a targeted literature review of best practices in prevention from 2019–2024 focused on:

Trauma-informed care

Youth engagement strategies

Locally responsive programming

Technology-based interventions

Policy and environmental approaches

A statewide workforce survey was distributed to Substance use prevention coalitions and organizations and school mental health professionals and nurses. The sample size was 314 respondents. LMA analyzed the data using descriptive statistics and thematic coding. Focus areas included workforce demographics, training history, service areas, preparedness, and perceived gaps. Ten listening sessions were held across Arizona, with a focus on rural and college populations. Participants included youth and college students, parents and educators, tribal community members, coalition leaders. There were 91 total participants. These were in-person, 1.5-hour sessions, and $25 gift cards were offered as incentives. LMA analyzed the survey using thematic analysis of qualitative feedback.

Eight in-depth stakeholder interviews were conducted with coalition directors (including tribal-focused), college prevention leaders, tribal health program directors, and state education prevention specialists. These were 45–60 minute Zoom interviews and $25 gift card incentives were offered. LMA analyzed the interviews using thematic synthesis of expert perspectives.

Efforts were made to include all regions of the state, as well as high-risk populations , which often times are not reflected in generic data collection efforts and thus is a common limitation. AHCCCS provided a stakeholder list and LMA supplemented recruitment through strategic outreach to coalitions, schools, and community organizations.

Overall, quantitative data were analyzed using descriptive statistics to identify patterns and areas of high need. Qualitative data from sessions and interviews were coded thematically to extract insights on lived experiences, barriers, and recommendations. Triangulation of data sources ensured validity and depth of findings.

The needs assessment will be included within this application as an attachment and will be posted on the AHCCCS SUBG webpage.

Arizona Youth Survey

The Arizona Youth Survey (AYS) is administered every two years to a statewide sample of 8th, 10th, and 12th grade youth under the direction of the Arizona Criminal Justice Commission Statistical Analysis Center and in partnership with the Arizona State University School of Criminology & Criminal Justice. Based on the nationally recognized Risk and Protective Factor model and the Communities That Care survey (Hawkins et al., 1992), the AYS assesses the prevalence and frequency of youth substance use, gang involvement, and other risky behaviors, and helps stakeholders to better understand the risk and protective factors that are correlated with these behaviors. The survey sample encompasses students in schools in all 15 Arizona counties. From the collected data, individual county results are published in separate reports. AHCCCS utilizes the AYS data on a state level, as well as promotes its use in local community planning. At the state level, at minimum, the AYS data is integrated throughout our statewide needs assessment, identifying salient risk factors across the state such as 30-day use, perceived risk, and family and peer attitudes, as well as protective factors such as sense of belonging, peer and parental disapproval of substance use, etc. At the local level, communities can receive reports at the county level or school district level, to identify the unique local conditions that influence substance use trends and issues in their community.

State Epidemiology Outcomes Workgroup (SEOW)

The Arizona Substance Abuse Partnership (ASAP) State Epidemiology Outcomes Workgroup (SEOW) was created in 2004 as a requirement of the Strategic Prevention Framework State Incentive Grant (SPF SIG) and continues to serve as an invaluable resource. The membership roster includes statisticians, data analysts, academics, holders of key datasets, other stakeholders from various state and federal agencies, tribal entities, private and non-profit substance abuse-related organizations, and universities. This group provides data management and analytics related to substance use and impacts within Arizona. The objective is data-driven analytics to inform decision-making to prevent, assess risks, evaluate treatments, and develop priorities. The analysis integrates, links, and associates data from multiple sources in Arizona for a comprehensive view of status and trends. AHCCCS membership and attendance at this group is necessary to ensure data reports and trends are incorporated into the planning of all substance abuse prevention, treatment, and recovery efforts. The Epidemiology Workgroup has been an integral part to AHCCCS' substance abuse prevention planning efforts, including the development and implementation of statewide needs assessments, strategic plans, and evaluation efforts.??

As the designated unit of the executive branch that is responsible for administering the Community Mental Health Services Block Grant (MHBG), AHCCCS ensures the following performance requirements are met:?

Subrecipients must submit a plan explaining how they will use MHBG funds to provide comprehensive, community mental health services to adults with serious mental illness (SMI) designation, children with serious emotional disturbances (SED), and Early Serious Mental Illness (ESMI) including First Episode Psychosis (FEP)?

Subrecipients to provide annual reports on their plans.?

Subrecipients may distribute funds to local government entities and non-governmental organizations.?

Subrecipients must ensure that community mental health centers provide such services as screening, outpatient treatment, emergency mental health services, and day treatment programs.?

Subrecipients must comply with general federal requirements for managing grants. They must also cooperate in efforts by SAMHSA to monitor use of MHBG funds. For example, each year, CMHS conducts investigations (site visits) of at least ten grantees receiving MHBG funds. This is to evaluate how they are using the funds to benefit the population. These evaluations include careful review of the following:?

How the grantees are tracking use of MHBG funds and their adult and child mental health programs,?

Data and performance management systems,?

Collaboration with consumers and the grantees' mental health planning council, and?

Grantees receiving MHBG funds are required to form and support a state or territory mental health/behavioral health planning council.?

Grantees receiving MHBG funds are required to form and support a state or territory mental health/behavioral health planning council.??

2. Please describe the unmet service needs and critical gaps in the state's current mental and substance use systems identified in the needs assessment described above. The description should include the unmet needs and critical gaps for the required populations specified under the MHBG and SUPTRS BG "Populations Served" above. The state may also include the unmet needs and gaps for other populations identified by the state as a priority.

Treatment - ICR

According to the SFY 2024 ICR report, only 3% of the chart reviews showed that members included family therapy in their treatment plan. Since we know that a support system is crucial for the members in the recovery process, integrating family therapy into the members treatment plan is an opportunity to better meet member's treatment and recovery needs. Although many members in treatment may choose not to involve family in their process for various reasons, there may be great opportunity, for those who are willing, to have facilitated support through family therapy or identify and engage a helpful family member to participate in the treatment and recovery process as a natural support.

Additionally, only 16% of charts had evidence of gender-specific treatment services, which is a requirement of the grant. Increasing gender-specific treatment is valuable to address at-risk members including pregnant and parenting mothers. Many providers offer at least one program that can fall under women's programming or gender-specific treatment such as the Seeking Safety program, but not all women elect into such program offering. While some programs are specialized in treating SUD among

pregnant and parenting mothers and provide a wide array of treatment services specific to women (e.g. prenatal and postnatal care, women's groups, child welfare systems navigation, parenting classes, etc.) other programs that are not women-specific, may have opportunity to explore how to better address gender-specific needs.

According to member and provider focus groups captured in the ICR report, transportation was a barrier for members to get to their treatment service appointments. Although there are strategies in place to support member's transportation needs (e.g. telehealth, bus passes, transportation as a covered service), challenges remain. For example, there are many rural and remote areas in Arizona where transportation options are more limited (no public transportation, no transportation provider available), or challenges that providers and members experience in arranging the covered transportation service. AHCCCS continues to research and address transportation issues to support improvements but it continues to be reported as a challenge.

Other Data Sources

Through discussions with ACC-RBHA and provider agencies, AHCCCS is also aware of the following unmet needs and service gaps that we hope to better address in the future as funding and capacity allows: access to recovery housing matched with employment support to address barriers to employment such as having a criminal record. Additional barriers include child sitting and childcare, stigma that hinders our highest priority populations from seeking care such as people who use drugs by injection, pregnant women, and parenting women, residential care, limited resources for outreach, care coordination for TB screening, addressing medical needs of uninsured individuals with SUD. Finally, ACC-RBHAs and providers have identified that the demand for MAT/MOUD services can surpass funding availability.

Prevention - Needs assessment data

The 2025 AHCCCS Prevention Needs Assessment, conducted by LeCroy & Milligan Associates, Inc., provides a comprehensive evaluation of Arizona's substance use prevention landscape. While the state has made notable progress in expanding coalitions and school-based programming, the assessment identifies unmet service needs and critical gaps which are highlighted below.

Access to prevention services remains highly uneven across Arizona. Rural, tribal, and border communities face significant barriers due to limited infrastructure, staffing shortages, and inconsistent program availability. Counties such as Mohave, Santa Cruz, and La Paz report thinly spread resources and a lack of structured activities for youth. Tribal communities, in particular, encounter challenges related to sovereignty, space constraints, and competing priorities, which limit their ability to host or sustain prevention programming.

The prevention workforce, particularly in rural and tribal regions, is under-resourced and undertrained. Many professionals report a lack of preparedness in key areas such as trauma-informed care, addressing the unique needs of the local community, and emerging drug trends like fentanyl and cannabis concentrates. According to the workforce survey, only 37% of respondents felt adequately equipped to address new challenges such as youth vaping and the influence of social media on substance use behaviors.

According to the needs assessment current prevention efforts often fail to effectively reach all Arizonans. There is a pressing need for prevention that meets the unique needs of local communities and populations, addressing elevated stress levels in local communities and populations, and reaching youth outside of traditional school settings. Overall, results point to the need for community-driven models that resonate with local conditions. Without addressing the specific needs of local communities, prevention efforts risk being ineffective for populations with unmet or higher needs. While the assessment found many communities unreached by prevention efforts, reasons for this may include funding limitations, lack of capacity and/or training, and need for increased strategic outreach and partnerships).

Many communities lack the physical and social infrastructure necessary to support effective prevention. This includes safe spaces for youth, reliable transportation, and recreational opportunities. Funding instability and staffing shortages further limit the sustainability of programming. Schools and coalitions in these areas struggle with limited training, misaligned messaging between home and school environments, and insufficient programmatic support.

Youth perceptions of substance use are shaped by legalization, normalization within households, and peer influence. Substances such as marijuana and vaping are often viewed as low-risk, undermining prevention messaging. Conflicting messages from family members and school personnel contribute to confusion and reduce the impact of educational efforts.

In relation to MHBG, the following areas were identified as needed enhancement: Standardized Process for SED Identification, Enhanced Capacity and Accessibility of Behavioral Health Services, Expanding Primary Care Workforce Capacity, Expanding Evidence-Based Practices for Adults with SMI and ESMI/FEP, and Crisis Intervention and Coordination.

3. Please describe how the state plans to address the unmet service needs and gaps identified in the needs assessment. These plans should reflect specific services and activities allowable under the respective Block Grants. In describing services and activities, grantees must also discuss plans for the implementation of these services and activities. Special attention should be made in

ensuring each of the required priority populations and any other populations prioritized by the state as part of the Block Grant services and activities are addressed in the implementation plan.

Treatment and recovery

Continue to allocate funds to the ACC-RBHAs based on regional factors identified in the data drive allocation methodology.

Continue to review SOR vs SUBG service array and utilization to identify gaps and reduce duplication. Monitor the adherence to SUBG priority populations to ensure they are served first.

Prioritize funding to SPW for the specific purpose of addressing the needs of the SUBG priority populations through outreach, support, referral, and engagement into services. This includes funding the SSP program to prioritize PWID, which involves reducing overdose death, reducing spread of infectious disease such as HIV and Hep C, and connecting to treatment services. Another specific focus of SPW under the SUBG will be to outreach, identify, and connect PWID and pregnant and parenting women with SUD into treatment and related services.

Continue to monitor and address access to treatment for individuals in rural and tribal communities through outreach, care coordination, and other support services.

RECOVERY

Continue to promote the ACC-RBHAs and SUBG providers to address barriers to care for priority populations such as increasing utilization of the billable child sitting service, addressing transportation barriers,

Continue to promote and utilize the Oxford House model for recovery housing.

Add allowability of the ACC-RBHA SUBG networks to use SUBG to childcare (more formal/comprehensive than currently allowable on-site child sitting service) for women with dependent children engaging in SUD treatment.

Continue to promote the certification, employment and utilization of certified Peer and Recovery Support Service (PRSS) professionals and their services as well as family engagement in treatment services.

Continue and increase the implementation of programmatic site visits to subrecipients to identify unmet service needs and gaps that can be addressed with the SUBG, as well as strengths and limitations of the grant that we may draw upon or address as needed.

Prevention

GOYFF TISAPP program

Matforce/SACLAz coalition-based prevention cohort.

DLLC – AHCCCS will sustain funding to DLLC to continue a focus on underage alcohol use and its negative impacts.

TRBHAs – AHCCCS will continue to fund three TRBHAs with primary prevention funds: Gila River Indian Community, Pascua Yaqui Tribe, and the White Mountain Apache Tribe.

Sustain funding to Institutes of Higher Education (IHEs)

Promote addressing prevention at a younger age, such as elementary age children 11 and younger.

SACLAz media campaign and toolkit was developed and implemented under SUBG funding from the American Rescue Plan Act (ARPA). The SACLAz media campaign and toolkit initiative provided statewide dissemination of varied media messages educating youth and adults on the harmful impacts of underage alcohol, vaping, and marijuana. This included a message specifically targeted at parent-child conversations about substances. An educational toolkit on alcohol, vaping, and marijuana prevention was developed and implemented in schools. If funding is available, AHCCCS would plan to sustain the school-based educational toolkit component of this initiative.

Promote parent prevention strategies, building prevention toolkits for parents, and promoting parent-child conversations about substances,

In relation to MHBG, The Arizona Health Care Cost Containment System (AHCCCS), has developed comprehensive plans to address the unmet service needs and gaps identified in the needs assessment. These plans include specific services and activities allowable

under the respective Block Grants.

Standardized Process for SED Identification: AHCCCS has undertaken a thorough initiative to establish a statewide standardized procedure for the identification, referral, and assessment of children with Serious Emotional Disturbance (SED) over the past several years. The objective is to provide accessible interfaces for educational institutions and primary care providers, facilitating timely referrals for SED assessments and promoting early detection and service initiation for children identified as experiencing SED. To advance this initiative, AHCCCS has introduced the use of an electronic portal known as DUGless, which enables providers to submit member information for either SED identification or removal requests. Effective October 1, 2025, usage of the DUGless portal will be mandatory.

To submit an SED identification request within DUGless, providers are required to:

Locate the member in the Supplemental Data section of the portal;

Specify whether they are requesting SED identification (Yes) or removal (No);

Provide detailed member information including AHCCCS ID, first and last name, date of birth, effective date of SED identification, CALOCUS Level of Care Score (ranging from 1 to 6; use 99 for members under age 6 or for FFS members, specifically AIHP/TRBHA/FES, when CALOCUS is unavailable), and SED qualifying diagnosis.

The implementation of this SED identification process is designed to enhance the evaluation of member needs and support improved service delivery.

Enhanced Capacity and Accessibility of Behavioral Health Services: To address the increased need for behavioral health services, especially since the COVID-19 pandemic, AHCCCS has expanded the use of telehealth services. This expansion aims to increase access to behavioral health services in rural areas and for populations with limited transportation. Additionally, AHCCCS is developing crisis stabilization services for children and adolescents with an SED Identification in Northern Arizona, reducing the need for children to leave their geographic service area for treatment. The state is also contracting with National Wraparound Innovation Services to develop an Arizona Center of Excellence for serving children with an SED designation and their families.

Expanding Primary Care Workforce Capacity: Arizona faces a shortage of psychiatrists and other licensed mental health professionals, particularly in rural communities. To address this, AHCCCS is supporting the Arizona Pediatric Psychiatry Access Line (A-PPAL) in partnership with the University of Arizona. This initiative provides primary care providers with direct access to child and adolescent psychiatrists, enhancing the capacity to serve children designated with SED or symptoms of a first episode of psychosis.

Expanding Evidence-Based Practices for Adults with SMI and ESMI/FEP: AHCCCS is expanding evidence-based practices such as Assertive Community Treatment (ACT), Permanent Supportive Housing (PSH) , and Peer Support for adults with Serious Mental Illness (SMI) and Early Serious Mental Illness/First Episode Psychosis (ESMI/FEP). The state is conducting a balance of state analysis to develop infrastructure and provide services that meet fidelity criteria established by SAMHSA. Additionally, AHCCCS is partnering with ACC-RBHA's in Northern and Southern Arizona to expand development and monitor fidelity of Permanent Supportive Housing.

Crisis Intervention and Coordination: AHCCCS is committed to ensuring that the crisis continuum of care meets demand. The state is partnering with first responders, law enforcement, and healthcare professionals to provide crisis intervention training. Additionally, AHCCCS is working to improve integration and coordination between crisis services, mental health facilities, law enforcement, and social support programs for a more comprehensive crisis response approach.

These initiatives reflect Arizona's commitment to addressing the behavioral health needs of its residents, ensuring that all priority populations and other prioritized groups have access to necessary services and support.

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Footnotes:

Planning Tables

Table 1: Priority Area and Annual Performance Indicators

Priority #: 1

Priority Area: Enhanced Capacity and Accessibility of Behavioral Health Services- Access to Crisis Services

Priority Type: BHCS

Population(s): SMI, SED, ESMI, BHCS

Goal of the priority area:

Maintaining the number of individuals receiving crisis services.

Strategies to attain the goal:

Maintain statewide coverage through regional behavioral health authorities (RBHAs) and contracted providers, ensuring that mobile crisis teams, walk-in centers, and hotlines remain available 24/7 across all counties.
Use Arizona's data systems to monitor utilization trends, enabling proactive resource deployment and showcasing how data-driven planning can support national replication.
Promote Arizona's model through technical assistance and peer learning networks, positioning the state as a mentor to other jurisdictions seeking to build comprehensive crisis systems.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Maintaining the number of individuals receiving crisis services

Baseline measurement (Initial data collected prior to and during 2026): 728,221 individuals

First-year target/outcome measurement (Progress to the end of 2026): 728,221 individuals

Second-year target/outcome measurement (Final to the end of 2027): 728,221 individuals

Data Source:

Crisis integrated data systems

Description of Data:

As outlined in AMPM Policy 590, ACC-RBHA Contractors are required to submit a Crisis Services Report as specified in contract. All reported data is separated out and reported based upon the region in which the crisis calls originated, including call metrics. The report additional requires detailing unmet metrics and notable trends when compared to previous reporting periods and interventions implemented based on the trends identified. This data is aggregated and analyzing by AHCCCS.

Data issues/caveats that affect outcome measures:

Data issues are not identified at this time.

Priority #: 2

Priority Area: Reduction in Arizona Suicide

Priority Type: SUP, SUT, SUR, MHS, ESMI, BHCS

Population(s): SMI, SED, ESMI, BHCS, PWWDC, PP, PWID

Goal of the priority area:

Reduce the Arizona Suicide Rate

Strategies to attain the goal:

AHCCCS will continue to work collaboratively with other state agencies and stakeholders to implement suicide prevention strategies for all Arizonans. Strategies will include but are not limited to community and conference presentations, social media messaging, social marketing/public awareness campaigns, youth leadership programs, gatekeeper (including teachers, healthcare providers, and first responders) trainings, reduction of stigma, promotion of early intervention, increased capacity of the suicide prevention helpline, encouragement of help-seeking behavior.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Reduce the Arizona Suicide Rate to 19% per 100,000 by the end of end of calendar year (CY) 2027

Baseline measurement (Initial data collected prior to and during 2026): 19.7% per 100,000

First-year target/outcome measurement (Progress to the end of 2026): 19.4% per 100,000

Second-year target/outcome measurement (Final to the end of 2027): 19% per 100,000

Data Source:

Arizona Department of Health Services https://www.azdhs.gov/prevention/tobacco-chronic-disease/suicide-prevention/index.php

Description of Data:

Information on death by suicide is compiled from the original documents filed with the ADHS, Bureau of Vital Records and from transcripts of original death certificates filed in other states but affecting Arizona residents. Rate is calculated by dividing the count of suicide deaths by the population for the given time period and multiplying by 100,000.

Data issues/caveats that affect outcome measures:

Not applicable at this time.

Priority #: 3

Priority Area: Expanding Evidence-Based Practices for Adults with SMI and ESMI/FEP

Priority Type: MHS, ESMI

Population(s): SMI, ESMI

Goal of the priority area:

Ensure SMI member will receive EBP, including ACT services that meet state fidelity in rural areas.

Strategies to attain the goal:

Reviewing fidelity review data provided by 3rd party reviewers and contractors, collaborating with ACC-RBHA's on how they are enhancing oversight measures with results provided.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Arizona will work to meet 80% fidelity of EBOP/ACT in rural areas.

Baseline measurement (Initial data collected prior to and during 2026): 70% fidelity of EBOP/ACT in rural areas.

First-year target/outcome measurement (Progress to the end of 2026): 75% fidelity of EBOP/ACT in rural areas

Second-year target/outcome measurement (Final to the end of 2027): 80% fidelity of EBOP/ACT in rural areas

Data Source:

3rd party fidelity reviewers

Description of Data:

The contractor collects and reports the following data as part of fidelity reviews for targeted behavioral health services provided to individuals with Serious Mental Illness (SMI) residing outside Maricopa County. Aggregated fidelity scores for all providers reviewed during the year. Analysis of year-over-year trends, and System-level recommendations for improving fidelity and service quality.

Data issues/caveats that affect outcome measures:

No data issues identified at this time.

Priority #: 4

Priority Area: Crisis Intervention and Coordination

Priority Type: BHCS

Population(s): SMI, SED, ESMI, BHCS, PWWDC

Goal of the priority area:

Maintaining percentage of crisis episodes resolved without hospitalization

Strategies to attain the goal:

Maintain and Lead Through Integrated Follow-Up Care
Expand post-crisis care coordination by embedding peer support specialists into mobile crisis teams to ensure warm handoffs to outpatient services.
Implement statewide tracking of 7-day follow-up rates after crisis episodes, using health information exchanges (HIEs) to monitor continuity of care.
Leverage Arizona's leadership in behavioral health integration by showcasing how AHCCCS and RBHAs collaborate to reduce repeat crisis episodes through data-driven interventions.
Promote Arizona's model nationally by publishing outcomes and presenting at conferences.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Maintaining 73% of crisis episodes resolved without hospitalization

Baseline measurement (Initial data collected prior to and during 2026): 73%

First-year target/outcome measurement (Progress to the end of 2026): 73%

Second-year target/outcome measurement (Final to the end of 2027): 73%

Data Source:

AHCCCS contractors, including ACC-RBHA contractors providing crisis services.

Description of Data:

As outlined in AMPM Policy 590, ACC-RBHA Contractors are required to submit a Crisis Services Report as specified in contract. All reported data is separated out and reported based upon the region in which the crisis calls originated, including call metrics. The report additional requires detailing unmet metrics and notable trends when compared to previous reporting periods and interventions implemented based on the trends identified. This data is aggregated and analyzing by AHCCCS.

Data issues/caveats that affect outcome measures:

No data issues identified at this time.

Priority #: 5

Priority Area: Substance Use Primary Prevention - early childhood

Priority Type: SUP

Population(s): PP

Goal of the priority area:

Fund programs that provide prevention in early childhood to build protective factors early in life.

Strategies to attain the goal:

To increase the number of younger children served with prevention services, AHCCCS will seek to expanding school-based programming in elementary and middle schools, expand services in areas of high-need regions such as Apache, Navajo, and Santa Cruz counties. Evidence-based programs like Lions Quest, Catch My Breath, and Too Good for Drugs will be implemented as appropriate for younger age groups. AHCCCS also plans to support prevention efforts in community-based settings like libraries, youth centers, and afterschool programs to reach children outside traditional school environments.

In addition, AHCCCS is investing in workforce development to improve service delivery for younger populations. This includes training prevention professionals in trauma-informed care and early childhood engagement. Outreach efforts will target high need or unmet need communities, and parent engagement will be supported through toolkits and workshops to strengthen early prevention messaging. These strategies aim to build protective factors early in life and ensure broader access to prevention services for children aged 12 and younger.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	number of children (aged 12 and younger) served by SUBG primary prevention programming (direct and indirect services).
Baseline measurement (Initial data collected prior to and during 2026):	27,906
First-year target/outcome measurement (Progress to the end of 2026):	28,604
Second-year target/outcome measurement (Final to the end of 2027):	29,302

Data Source:

Coalition Reporting - SUBG Web Portal

Description of Data:

This includes only those coalitions contracted under AHCCCS contract with Matforce/SACLAz.

Data issues/caveats that affect outcome measures:

GOYFF also implemented SUBG primary prevention activities that may reach young children that are not captured in this reporting. Therefore, the services are under-represented in this data.

Priority #: 6

Priority Area: Substance Use Recovery - Oxford House

Priority Type: SUR

Population(s): PWWDC, PWID, PRSUD

Goal of the priority area:

Increase the availability of affordable recovery housing for members seeking/in recovery from SUD.

Strategies to attain the goal:

To expand access to recovery housing in Arizona, AHCCCS continues to support the Oxford House model across all regions through its ACC-RBHA contracts. In the Central GSA, Mercy Care contracts with Oxford House, Inc. to operate 64 peer-run sober living homes, including specific options for parents with children. In FY25, Oxford House expanded into Gila County and plans further growth in Pinal and Gila counties, including reentry programming. Mercy Care also promotes the model through strategic outreach and coordination events to build referral networks.

In the Southern GSA, Arizona Complete Health (AzCH) supports Oxford House outreach through presentations to providers and participation in community events such as the Southern Arizona Opioid Symposium. Between April and June 2025, four new homes were opened, three of which were funded through the Revolving Loan Fund (RLF), which covers essential startup costs.

AzCH-North in the Northern GSA continues to collaborate with Oxford House to expand housing, with current efforts focused on establishing a

women-with-children home in Flagstaff. Outreach workers regularly present updates at provider meetings and engage with community coalitions and law enforcement to assess housing needs and promote referrals. These coordinated efforts across regions aim to increase recovery housing availability and support sustained recovery for individuals with SUD.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: the number of Oxford Houses in Arizona that are supported by the ACC-RBHAs

Baseline measurement (Initial data collected prior to and during 2026): 131

First-year target/outcome measurement (Progress to the end of 2026): 137

Second-year target/outcome measurement (Final to the end of 2027): 143

Data Source:

ACC-RBHA Deliverable: Oxford House Model Report

Description of Data:

Data issues/caveats that affect outcome measures:

Priority #: 7

Priority Area: Women's Services and PPWDC - Service utilization

Priority Type: SUT

Population(s): PWWDC

Goal of the priority area:

Improve access to care for PPW with SUD

Strategies to attain the goal:

AHCCCS and SUBG partners have implemented initiatives across the state to improve access to obstetric, prenatal, and postnatal care for pregnant and parenting women with substance use disorders (SUD), following findings from a statewide needs assessment.

In the Central region, Mercy Care and West Valley Health Equity have expanded services through supported housing, integrated care, and childcare resources. West Valley OBGYN's program demonstrated strong outcomes, including high abstinence and relapse prevention rates, and successful custody retention. Mercy Care also funds Hushabye Nursery, which provides subacute detox for infants, prenatal/postpartum support groups, and therapeutic services for families.

In the South region, AzCH-CCP supports outreach positions and Maternal Health Coordinators to connect pregnant women to behavioral health and SUD treatment. CODAC outreach staff operate in jails and hospitals to ensure continuity of care, including referrals and intake coordination. CODAC's Connie Hillman House offers transitional housing for mothers and infants, while AzCH-South plans to collaborate with The Haven to expand access through assessments and admissions support.

In the North, AzCH-North launched the PPW-PLT pilot program in Coconino County through The Guidance Center, offering wraparound services including OB/postpartum care, case management, transportation, and housing. The program provides a safe, DCS-approved living environment that supports recovery and family reunification. These coordinated efforts across regions aim to reduce barriers and improve maternal and infant health outcomes for women with SUD.

Finally, AHCCCS intends to use technical assistance funding to continue the implementation of Hope Horizons Regional Institutes, a conference and training opportunity focused on promoting recovery for Arizona families, and specifically addresses issues relating to access to care for pregnant women and women with dependent children.

Through these women-specific and pregnant and postpartum service efforts, we hope to see an increase in the number and percent of women with SUD and pregnant/postpartum women with SUD enter SUD treatment services as well as those necessary services to support the holistic health of her and her baby or children.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: the number and % of pregnant and postpartum females with an SUD diagnosis who received an OB, prenatal care, or postnatal care service

Baseline measurement (Initial data collected prior to and during 2026): 27.06% (SFY2024)

First-year target/outcome measurement (Progress to the end of 2026): 27.74% (SFY2025)

Second-year target/outcome measurement (Final to the end of 2027): 28.43% (SFY2026)

Data Source:

AHCCCS Claims and Encounters

Description of Data:

Data issues/caveats that affect outcome measures:

Historical data includes all AHCCCS claims. AHCCCS is working to build a report of SUBG only members that may impact the data description/expression. Additionally, access to care may be impacted by future changes to the Medicaid program that will impact SUBG services.

Priority #: 8

Priority Area: Women's Services and PPWDC - Childsitting

Priority Type: SUT, SUR

Population(s): PWWDC, PRSUD

Goal of the priority area:

Improve access to care for PPW with SUD

Strategies to attain the goal:

AHCCCS has taken several steps to improve access to childcare and child-sitting services for individuals receiving substance use disorder (SUD) treatment, recognizing that lack of childcare is a significant barrier. A child-sitting billing code (T1009) allows eligible treatment providers to bill for staff time spent supervising a member's dependent child during treatment. In 2025, AHCCCS worked with ACC-RBHAs and providers to promote the use of this code by updating reimbursement guidance, reviewing provider eligibility, and offering education on proper use of the code. Mercy Care in the Central region led efforts by meeting with 26 providers to offer technical assistance, conducting a child-sitting screening questionnaire, and supporting implementation through audits and site visits. In SFY25, 55 child-sitting services were billed in the Central GSA, with 28 paid, and Mercy Care also developed NTXIX training materials available statewide via Relias.

In the Southern and Northern regions, Arizona Complete Health (AzCH) South and North have supported awareness and implementation of the child-sitting code through quarterly provider meetings and technical assistance. AHCCCS is actively working to identify and address barriers to the use of the child-sitting code, such as ensuring appropriate listing of provider types/place of services allowed to bill the code. Some SUBG providers have created dedicated child-sitting spaces equipped with age-appropriate toys and equipment to support safe and developmentally appropriate care. These efforts reflect a coordinated statewide approach to reducing childcare-related barriers and improving treatment access for families.

We seek to continue these efforts to increase access to care for priority populations such as pregnant women and women with dependent children (PWWDC).

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: the number of claims submitted to AHCCCS that include the T1009 child sitting code

Baseline measurement (Initial data collected prior to and during 2026): TBD

First-year target/outcome measurement (Progress to the end of 2026): TBD

Second-year target/outcome measurement (Final to the end of 2027): TBD

Data Source:

AHCCCS Claims and Encounters

Description of Data:

Data issues/caveats that affect outcome measures:

RBHAs report that childsitting claims are very low and childcare remains a barrier to care reported to AHCCCS. AHCCCS needs more time to pull the baseline report in order to develop up to date targets.

Priority #: 9

Priority Area: Tuberculosis

Priority Type: SUT

Population(s): TB

Goal of the priority area:

Increase TB early intervention services for members with SUD

Strategies to attain the goal:

AHCCCS will ensure grant subrecipients are aware of and adhere to the requirement to routinely make available tuberculosis (TB) services to each individual receiving treatment for Substance Use Disorder (SUD), as well as consistently implement infection control strategies such as providing TB screenings to patients entering SUD treatment.

According to the most recent ICR report, in the review of the SFY 2024 statewide aggregate data, there were several areas of strength identified that have demonstrated improvement each year over the periods of SFY 2022, SFY 2023, and SFY 2024. Of note, there was an increase in cases in which there was documentation of testing for tuberculosis, which occurred in 61% of cases in SFY 2024, a significant increase from SFY 2023 and SFY 2022, which were 44% and 46%, respectively.

Each ACC-RBHA has procedures and protocols in place to provide TB services to members with SUD. The ACC-RBHAs submit these documents to AHCCCS for review and approval. This must include offering interim services, including TB services, to any member awaiting placement into SUD treatment services.

Mercy Care ACC-RBHA educates the community and providers on accessing services, including but not limited to screenings and treatment of infectious diseases associated with substance use, such as HIV, Hep C, and TB services.

Mercy Care requires residential providers to conduct TB screenings to members in residential services. They refer positive screenings to the appropriate medical providers as necessary. Screenings include Purified protein derivative (PPD) skin testing and chest x-rays. Testing and Education on HIV, TB, and Hep C is provided on a regular basis made possible through partnerships with Terros Health. Over the last two years when conducting site visits, Mercy Care has incorporated and emphasized the importance of providing TB screenings and referrals as part of not only interim services but including this as part of their regular service delivery. As a result, the percent of Mercy Care provider case files reviewed under the Independent Case Review (ICR) documenting evidence of TB screening there was a 41% in the documentation of tuberculosis screening and Mercy Care intends continue to grow in this area of service delivery.

Additional infection control procedures designed to prevent the transmission of TB are fulfilled by functions executed by Mercy Care's Quality Management Department. Quality Management fulfills annual review of treatment providers through the Residential Treatment Center Review Tool. This annual component includes a site observation of the treatment environment which includes auditing of staff and member records for current TB screenings. Insufficient provider scoring results in corrective action plans for providers demonstrating noncompliance.

AzCH-CCP-South works with SUD partners to track incidences of member Hep C and TB. CODAC, La Frontera, The Haven, Community Medical Services and COPE offer hepatitis C assessment and treatment. If a system is not in place, AzCH-CCP-South will guide agencies to appropriate screening and referral processes for this information. All other providers have TB screening as a part of member intake.

AzCH-South provider COPE, has implemented a mobile unit Wellness on Wheel (WOW) that operates 3 days a week to provide PCP services including TB testing. COPE plans to expand these services to 5 days per week as new staff members are currently being hired.

AzCH-CCP-South continues to remind providers about the overall trends identified in the audits. A positive finding of note is a significant increase in the number of assessments, reflecting a screening for tuberculosis, increasing from 33% in the previous year to 73% in SFY 2024, according to the most recent ICR Report. TB documentation has been identified as an area of growth and the ACC-RBHA works to support providers in improving this initiative.

AzCH-South plans to provide information about TB and testing by document conversation in member chart by educating and providing updates in SUD and Non-title Provider Meetings. Additionally, AzCH-North will ensure that provider network staff will participate in a Relias Learning session on TB Basics by requiring new staff within 90 days of hire and existing staff will take the course on a one-time basis

AzCH-South-CCP continues to partner and meet with each contracted provider's site directors, to ensure their understanding of SUBG funds and ICR Peer Review needs, and to better serve the Non-Title XIX/XXI-eligible community. ICR Reviews, Substance Use Provider Meetings, Non-Title Provider meetings have been great venues to share with providers some of the gaps in treatment and documentation. Technical Assistance is offered to partners as needed to clarify grant parameters and answer questions.

AzCH-North, previously Care 1st has adopted the same protocol and procedures as AZCH-South. According to the SFY2024 ICR report, a positive finding of note is a significant increase in the number of assessments reflecting a screening for tuberculosis, increasing from 20% in SFY 2023 to 51% in SFY 2024 for the Northern GSA.

AzCH-North plans to increase provider awareness and education of Tuberculosis that will result in an increase in documented education and referral to screening in the medical record with the targeted utilization of Relias Learning Modules.

AHCCCS also holds an interagency service agreement (ISA) with the Arizona Department of Health Services (ADHS) to consult and collaborate on the issue of TB among the SUD population. AHCCCS and ADHS collaborate to review federal and state regulations, updated policies and procedures relating to the prevention, identification, and treatment of TB, and strategies to be used to identify and address federal and state regulation, or contract compliance. ADHS establishes linkages with other health care providers to ensure that TB services are routinely made available. ADHS supports education and referral needs, advises on service gaps, and prevalence and incidence of TB. ADHS is an important partner to AHCCCS for the administration of the SUBG as it relates to TB rules and regulations.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: the % of SUBG member case files that include documentation of TB screenings

Baseline measurement (Initial data collected prior to and during 2026): 61

First-year target/outcome measurement (Progress to the end of 2026): 64

Second-year target/outcome measurement (Final to the end of 2027):

Data Source:

Annual Independent Case Review (ICR) Report

Description of Data:

Data issues/caveats that affect outcome measures:

Priority #: 10

Priority Area: Recovery - Peer Support Services

Priority Type: SUT, SUR

Population(s): PWWDC, PWID, PRSUD

Goal of the priority area:

Increase the use of peer support services in treatment and recovery.

Strategies to attain the goal:

Finally, AHCCCS intends to support additional training and workforce development of peers through an agreement with the Peer and Family Career Academy which specializes in such trainings.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: % of members that received peer support services as evidenced by documentation of PS service provision in the ICR

Baseline measurement (Initial data collected prior to and during 2026): 59%

First-year target/outcome measurement (Progress to the end of 2026): 62%

Second-year target/outcome measurement (Final to the end of 2027): 65%

Data Source:

Annual ICR Report

Description of Data:

Data issues/caveats that affect outcome measures:

Priority #: 11

Priority Area: Substance Use Primary Prevention - Coalition Functioning

Priority Type: SUP

Population(s): PP

Goal of the priority area:

Increase the coalitions' administration of the Wilder Collaboration Factors Inventory survey and enhance prevention coalition effectiveness and functioning throughout the state

Strategies to attain the goal:

To increase the implementation and use of the Wilder Collaboration Factors Inventory (WCFI) survey, AHCCCS is focused on building coalition capacity and integrating the survey into planning and funding cycles. Technical assistance, training webinars, and toolkits will be provided to help coalitions administer and interpret both pre- and post-surveys. Outreach will prioritize coalitions with limited evaluation capacity, especially in rural and tribal regions, and materials will be translated into additional languages as needed. Peer learning networks and regional collaboratives will also be established to share best practices and success stories.

AHCCCS plans to embed WCFI survey completion into coalition work plans and align it with strategic planning milestones such as annual goal setting. Coalitions will be encouraged to use survey results to inform logic models, SPF implementation, and action planning. To incentivize participation, AHCCCS may consider recognizing coalitions with strong survey engagement through, and will provide statewide feedback reports to benchmark performance and highlight improvements in coalition functioning.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: the number of Wilder Collaboration Factors Inventory surveys (total, pre-and post) reported

in the AZ SUBG prevention data portal by contracted prevention coalitions

Baseline measurement (Initial data collected prior to and during 2026): 385

First-year target/outcome measurement (Progress to the end of 2026): 404

Second-year target/outcome measurement (Final to the end of 2027): 424

Data Source:

Coalition Reporting - SUBG Web Portal

Description of Data:

Data issues/caveats that affect outcome measures:

Priority #: 12

Priority Area: PWID and Overdose Prevention and Infectious Disease Prevention

Priority Type: SUT, SUR

Population(s): PWWDC, PWID, EIS/HIV, PRSUD

Goal of the priority area:

Increase peer-based and street-based connections to care for priority populations

Strategies to attain the goal:

Sonoran Prevention Works (SPW) leads Arizona's efforts to provide risk reduction and connection to care for the population of people who use drugs, with a special emphasis on people who use drugs by injection. Therefore, they also are a key player in our goals to expand outreach and care coordination for women who use drugs, with a focus on pregnant and parenting women. Through its statewide syringe services program (SSP), SPW identifies and engages priority populations, offering tailored services such as pediatric care, child welfare coordination, legal assistance, and family counseling. SPW aims to serve at least 30 women per region and has dedicated staff specializing in supporting women, including a Women's Health Peer Support Specialist who provides education, hygiene kits, family planning resources, and perinatal support at key outreach sites.

SPW also facilitates referrals to treatment for substance use, mental health, and medical care, and collaborates with behavioral health, public health, and social service providers. Partnerships with organizations like Hushabye Nursery and Jacob's Hope enhance support for substance-exposed infants and their families. SPW's outreach efforts reached over 7,300 women in 2024, and its Community Engagement Manager maintains a vetted network of over 200 organizations to ensure reliable referrals. SPW continues to expand mobile SSP services across seven counties and participates in statewide coalitions to reduce stigma and promote evidence-based care for women who use drugs.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: number of women reached by SPW for outreach and care coordination

Baseline measurement (Initial data collected prior to and during 2026): 3000

First-year target/outcome measurement (Progress to the end of 2026): 3150

Second-year target/outcome measurement (Final to the end of 2027): 3307

Data Source:

Sonoran Prevention Works (SPW) deliverable

Description of Data:

Data issues/caveats that affect outcome measures:

Indicator #:	2
Indicator:	number of women who use drugs referred to SUD treatment services
Baseline measurement (Initial data collected prior to and during 2026):	46
First-year target/outcome measurement (Progress to the end of 2026):	48
Second-year target/outcome measurement (Final to the end of 2027):	

Data Source:

Sonoran Prevention Works (SPW) deliverable

Description of Data:

Data issues/caveats that affect outcome measures:

Number only includes referrals to individuals willing to seek treatment. Of note, the population served by SPW is people who use drugs, and the goal of the program is overdose prevention and infectious disease prevention, as well as connections to care. A large portion of the participants are not ready to seek treatment, so this number may seem low, it is reasonable in the context of the program.

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Footnotes:

Planning Tables

Table 2: SUPTRS BG Planned State Agency Budget for Two State Fiscal Years (SFY)

ONLY include funds budgeted by the executive branch agency (SSA) administering the SUPTRS BG. This includes only those activities that pass through the SSA to administer substance use primary prevention, substance use disorder treatment, and recovery support services for substance use disorder.

Planning Period Start Date: 7/1/2025 Planning Period End Date: 6/30/2027

Activity	Source of Funds							
	A. SUPTRS BG	B. Mental Health Block Grant	C. Medicaid (Federal State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare), etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. Bipartisan Safer Communities ACT Funds
1. Substance Use Disorder Prevention[a] and Treatment	$61,665,037.00		$1,004,148,200.00	$29,639,309.00	$16,893,498.00	$145,100.00	$0.00	
a. Pregnant Women and Women with Dependent Children (PWWDC)[b]	$7,001,554.00			$377,268.00				
b. All Other	$54,663,483.00		$1,004,148,200.00	$29,262,041.00	$16,893,498.00	$145,100.00		
2. Recovery Support Services[c]	$6,473,765.00							
3. Primary Prevention[d]	$19,130,347.00							
4. Early Intervention Services for HIV[e]								
5. Tuberculosis								
6. Evidence-Based Practices For Early Serious Mental Illness including First Episode Psychosis (10 percent of total MHBG award)								
7. State Hospital								
8. Other Psychiatric Inpatient Care								
9. Other 24-Hour Care (Residential Care)								
10. Ambulatory/Community Non-24 Hour Care								
11. Crisis Services (5 percent Set-Aside)								
12. Other Capacity Building/Systems Development[f]	$3,600,000.00							
13. Administration[g]	$4,782,587.00			$893,064.00				
14. Total	**$95,651,736.00**		**$1,004,148,200.00**	**$30,532,373.00**	**$16,893,498.00**	**$145,100.00**	**$0.00**	

[a] Prevention other than primary prevention.

[b] Grantees must plan expenditures for Pregnant Women and Women with Dependent Children in compliance with Women's Maintenance of Effort (MOE) over the two-year planning period.

[c] This budget category is mandated by Section 1243 of the Consolidated Appropriations Act, 2023 and includes an aggregate of planned expenditures allowable under the 2023 guidance, "Allowable Recovery Support Services (RSS) Expenditures through the SUBG and the MHBG." Only plan RSS for those in need of RSS from substance use disorder.

[d] Row 3 should account for the 20 percent minimum primary prevention set-aside of SUPTRS BG funds to be used for universal, selective, and indicated substance use prevention activities.

[e] The most recent AtlasPlus HIV data report published on or before October 1 of the federal fiscal year for which a state is applying for a grant is used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective SUPTRS BG allotments to establish one or more projects to provide early intervention services regarding the human immunodeficiency virus (EIS/HIV) at the sites at which individuals are receiving SUD treatment.

[f] Other Capacity Building/Systems development include those activities relating to substance use per **45 CFR §96.122 (f)(1)(v)**

[g] Per **45 CFR § 96.135** Restrictions on expenditure of the SUPTRS BG, the state involved will not expend more than 5 percent of the BG to pay the costs of administering the SUPTRS BG.

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Footnotes:

SUPTRS BG planned budget for recovery support services is currently planned as a simple percentage. Arizona's system is not currently set up to capture all RSS expenditures under one system, which creates a system challenge in planning this budget with precision. However, efforts are underway to more strategically plan SUPTRS BG dollars for the recovery category and to develop a methodology to best delineate planned RSS expenditures. This is also subject to change based on upcoming changes to the Medicaid program that are likely to impact the use of the SUPTRS BG.

Planning Tables

Table 2: MHBG Planned State Agency Budget for Two State Fiscal Years (SFY)

States are asked to present their projected two-year budget at the State Agency level, including all levels of state and applicable federal funds to be expended on mental health and substance use services allowable under each Block Grant. When planning their budgets, states should keep in mind all statutory requirements outlined in the application Funding Agreement/Certifications and Assurances.

Table 2 addresses funds budgeted to be expended during State Fiscal Years (SFY) 2026 and 2027 (for most states, the 24-month period is July 1, 2025, through June 30, 2027).Table 2 includes columns to capture state planned budget of BSCA funds (MHBG only)

Include public mental health services provided by mental health providers or funded by the state mental health agency by source of funding.

Planning Period Start Date: 7/1/2025 Planning Period End Date: 6/30/2027

Activity	Source of Funds							
	A. SUPTRS BG	B. Mental Health Block Grant	C. Medicaid (Federal State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare), etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. Bipartisan Safer Communities ACT Funds[a]
1. Substance Use Disorder Prevention and Treatment								
a. Pregnant Women and Women with Dependent Children (PWWDC)								
b. All Other								
2. Recovery Support Services								
3. Primary Prevention								
4. Early Intervention Services for HIV								
5. Tuberculosis								
6. Evidence-Based Practices For Early Serious Mental Illness including First Episode Psychosis (10 percent of total MHBG award)[b]		$4,609,770.00						$798,430.00
7. State Hospital								
8. Other Psychiatric Inpatient Care								
9. Other 24-Hour Care (Residential Care)		$1,096,867.00	$751,353,643.00		$47,596,170.00			
10. Ambulatory/Community Non-24 Hour Care		$35,465,353.00	$3,376,402,357.00		$213,885,727.00			
11. Crisis Services (5 percent Set-Aside)[c]		$2,620,824.00		$3,143,209.26				$88,715.00
12. Other Capacity Building/Systems Development								
13. Administration		$2,304,884.00		$367,383.00				
14. Total		**$46,097,698.00**	**$4,127,756,000.00**	**$3,510,592.26**	**$261,481,897.00**	**$0.00**	**$0.00**	**$887,145.00**

[a]The expenditure period for the 3rd and 4th allocations of Bipartisan Safer Communities Act (BSCA) supplemental funding will be from **September 30, 2024 through September 29, 2026** (3rd increment), **September 30, 2025 through September 29, 2027** (4th increment). Column H should reflect the state planned expenditure for this planning period (FY2026 and FY2027) [July 1, 2025 through June 30, 2027, for most states].

[b]Row 6 in Columns B and H: per statute, states are required to set-aside 10 percent of the total MHBG and BSCA awards for evidence-based practices for Early Serious Mental Illness (ESMI), including Psychotic Disorders.

[c]Row 11 in Columns B and H: per statute, states are required to set-aside 5 percent of the total MHBG and BSCA awards for Behavioral Health Crisis Services (BHCS) programs.

[d]Per statute, administrative expenditures for the MHBG and BSCA funds cannot exceed 5 percent of the fiscal year award.

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Footnotes:

Planning Tables

Table 3: Persons in Need of/Receiving SUD Treatment – Required for SUPTRS BG Only

This table allows states to present their estimated current need and baseline reach of the priority populations laid out in the SUPTRS BG statute. This information is intended to assist the state in demonstrating the unmet need of these populations that informs their plans for FY2026 - 2027. The estimates provided should represent the unmet need at the time of the application.

To complete the Aggregate Number Estimated in Need (Column A), please refer to the most recent edition of the **National Survey on Drug Use and Health** (NSDUH) or other federal/state data that describes the populations of focus in rows 1-5.

To complete the Aggregate Number in Treatment (Column B), please refer to the most recent edition of the **Treatment Episode Data Set** (TEDS) data prepared and submitted to the Behavioral Health Services Information System (BHSIS).

States should contact their federal points of contact for assistance in drawing these estimates from national and state survey data.

Estimates should utilize the most recent data from NSDUH, TEDS, and other data sources.

	A. Aggregate Number Estimated in Need of SUD Treatment	B. Aggregate Number in SUD Treatment
Pregnant Women	0	5599
Women with Dependent Children	0	0
Individuals with a co-occurring M/SUD	0	49740
Persons who inject drugs	0	4153
Persons experiencing homelessness	0	0

Please provide an outline of how the state made these estimates, including data sources and values used for each row. For any cell which the state is

unable to estimate the need or number in treatment, please provide an explanation for why these estimates could not be drawn.
8/27/2025 EH: AHCCCS followed instructions utilizing NSDUH data source for Column A and TEDS data source for Column B and completed what was located within those respective data sources. Our SAMHSA GPO provided ideas of alternate data sources on 8/25/2025 but we will need more time to locate any missing fields. 8/29/2025 AA: There are some differences from the last time this table was completed. The service/procedures codes were reviewed and updated. This more noticeable in the pregnant women category, as we added a few more codes than were used before.
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Footnotes:

Planning Tables

Table 4: SUPTRS BG Planned Award Budget by Federal Fiscal Year

In addition to projecting planned budget by State Fiscal Year (Table 2b), states must project how they will use SUPTRS BG funds to provide authorized services as required by the SUPTRS BG regulations and expenditure categories. Therefore, Plan Table 4b must be completed for the SUPTRS BG awarded for Federal Fiscal Year (FFY) 2026 and FFY 2027. The totals for each FFY planning year should match the SUPTRS BG Final Allotments for the state in that award year.

Note: The FFY presented in the table is that of the award year, however states have up to two years to expend the award received. For example, the FFY 2026 award may be expended from October 1, 2025 through September 30, 2027.

Planning Period Start Date: 10/1/2025 Planning Period End Date: 9/30/2026

Expenditure Category	FFY 2026 SUPTRS BG Award
1 . Substance Use Disorder Prevention[a] and Treatment	$30,832,518.00
2 . Recovery Support Services[b]	$3,236,883.00
3 . Substance Use Primary Prevention[c]	$9,565,174.00
4 . Early Intervention Services for HIV[d]	$0.00
5 . Tuberculosis Services	$0.00
6 . Other Capacity Building/Systems Development[e]	$1,800,000.00
7 . Administration[f]	$2,391,293.00
8. Total	$47,825,868.00

[a]Prevention other than primary prevention. The amount in this row should reflect the planned budget for direct services during the planning period. Do not include budgeted funds for other capacity building/systems development, those are required to be presented in Row 6 of this table.

[b]This expenditure category is mandated by Section 1243 of the Consolidated Appropriations Act, 2023 and includes an aggregate of budget allowable under the 2023 guidance, "Allowable Recovery Support Services (RSS) Expenditures through the SUBG and the MHBG." Only present the estimated budget for RSS for those in need of RSS from substance use disorder. Do not include budgeted funds for other capacity building/systems development, those are required to be presented in Row 6 of this table.

[c]This row should reflect the state's planned budget of direct primary prevention activities that are intended to meet the SUPTRS BG 20 percent set aside. Activities include those used for universal, selective, and indicated substance use prevention activities. The budget for direct activities in this row should match the total budget planned in Table(s) 5a and 5b. Do not include budgeted funds for other capacity building/systems development, those are required to be presented in Row 6 of this table.

[d]The most recent AtlasPlus HIV data report published on or before October 1 of the federal fiscal year for which a state is applying for a grant is used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective SUPTRS BG allotments to establish one or more projects to provide early intervention services regarding the human immunodeficiency virus (EIS/HIV) at the sites at which individuals are receiving SUD treatment.

[e]Other Capacity Building/System Development include those activities relating to substance use per **45 CFR §96.122 (f)(1)(v)**. The amount presented here should reflect the total found in Planning Table 6 across treatment, recovery, and primary prevention.

[f]Per **45 CFR §96.135** Restrictions on expenditure of grant, the State involved will not expend more than 5 percent of the BG to pay the costs of administering the SUPTRS BG.

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Footnotes:

Planning Tables

Table 4: MHBG State Agency Planned Budget

Table 4 addresses the planned budget for MHBG. Please use this table to capture your estimated budget for MHBG-funded services and programs over a 24-month period (for most states, it is July 1, 2025 - June 30, 2027).

Planning Period Start Date: 7/1/2025 Planning Period End Date: 6/30/2027

MHBG-Funded Services	MHBG Funds Budgeted for This Item
1. Services for Adults	
1a. EBPs for Adults	0.00
1b. Crisis Services for Adults	1310412.00
1c. CSC/ESMI program for Adults	2304885.00
1d. Other outpatient/ambulatory services for Adults	16911110.00
1e. *Other Direct Services for Adults	0.00
2. Subtotal of Services for Adults	20526407.00
3. Services for Children	
3a. EBPs for Children	0.00
3b. Crisis Services for Children	1310412.00
3c. CSC/ESMI program for Children	2304885.00
3d. Other outpatient/ambulatory services for Children	16911110.00
3e. *Other Direct Services for Children	0.00
4. Subtotal of Services for Children	20526407.00
5. Other Capacity Building/Systems Development[a]	2740000.00
6. Administrative Costs[b]	2304884.00
7. *Any Other Cost	0.00
8. Total MHBG Allocation[c]	**46097698.00**

Please provide brief explanation for services with an asterisk* below:
Includes

[a] This row for Other Capacity Building/Systems Development should be equal to the total of your planned budget in Table 6

[b] Administrative Costs should not exceed 5 percent of total MHBG allocation

[c] The total budget should be equal to your MHBG allocation for the next two years.

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Footnotes:

Planning Tables

Table 5a: SUPTRS BG Primary Prevention Planned Budget by Strategy and Institutes of Medicine (IOM) Categories

Planning Period Start Date: 10/1/2025 Planning Period End Date: 9/30/2026

Strategy	IOM Classification	FFY 2026 SUPTRS BG Award
1. Information Dissemination	Universal	$1,763,424
	Selective	$133,852
	Indicated	$0
	Unspecified	$0
	Total	**$1,897,276**
2. Education	Universal	$3,174,748
	Selective	$625,853
	Indicated	$144,726
	Unspecified	$0
	Total	**$3,945,327**
3. Alternatives	Universal	$401,444
	Selective	$67,312
	Indicated	$0
	Unspecified	$0
	Total	**$468,756**
4. Problem Identification and Referral	Universal	$114,093
	Selective	$7,037
	Indicated	$268
	Unspecified	$0
	Total	**$121,398**
	Universal	$2,531,207
	Selective	$374,099

5. Community-Based Processes	Indicated	$8,386
	Unspecified	$0
	Total	**$2,913,692**
6. Environmental	Universal	$218,725
	Selective	$0
	Indicated	$0
	Unspecified	$0
	Total	**$218,725**
7. Section 1926 (Synar)-Tobacco	Universal	$0
	Selective	$0
	Indicated	$0
	Unspecified	$0
	Total	**$0**
8. Other	Universal	$0
	Selective	$0
	Indicated	$0
	Unspecified	$0
	Total	**$0**
Total Prevention Budget		**$9,565,174**
Total Award [a]		**$47,825,868**
Planned Primary Prevention Percentage		**20.00%**

[a] Total SUPTRS BG Award is populated from Plan Table 4 SUPTRS BG Planned Award Budget by Federal Fiscal Year

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Footnotes:

8/14/25 EH: Table includes full 20% primary prevention set aside to align with Table 4, Row 3, Primary Prevention per the instructions. Some planned expenditures reported in Table 5a will be also reported in Table 6 Capacity Building/Systems Development Activities due to the subrecipient indirect/admin costs that falls under the 20% set aside.

Planning Tables

Table 5b: SUPTRS BG Planned Primary Prevention Budget by Institutes of Medicine (IOM) Categories

States should identify the planned budget for primary prevention disaggregated by IOM Categories the state plans to prioritize with primary prevention set-aside dollars from the FFY 2026 and FFY 2027 SUPTRS BG allotments.

Planning Period Start Date: 10/1/2025 Planning Period End Date: 9/30/2026

Strategy	FFY 2026 SUPTRS BG Award
1. Universal Direct	$8,203,641
2. Universal Indirect	
3. Selective	$1,208,153
4. Indicated	$153,380
5. Column Total	**$9,565,174**
6. Total SUPTRS Award[a]	**$47,825,868**
7. Primary Prevention Percentage	**20.00%**

[a] Total SUPTRS BG Award is populated from Plan Table 4 SUPTRS BG Planned Award Budget by Federal Fiscal Year

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Footnotes:

Planning Tables

Table 5c: SUPTRS BG Planned Primary Prevention Priorities

States should identify the categories of substances the state plans to prioritize with primary prevention set-aside dollars from the FFY 2026 SUPTRS BG award.

Planning Period Start Date: 10/1/2025 Planning Period End Date: 9/30/2026

Priority Substances	FFY 2026 SUPTRS BG Award
Alcohol	☑
Tobacco/Nicotine-Containing Products	☑
Cannabis/Cannabinoids	☑
Prescription Medications	☑
Cocaine	☑
Heroin	☑
Inhalants	☑
Methamphetamine	☑
Fentanyl or Other Synthetic Opioids	☑
Other	☐
Priority Populations	
Students in College	☑
Military Families	☑
American Indian/Alaska Native	☑
African American	☑
Hispanic	☑
Persons Experiencing Homelessness	☐
Native Hawaiian/Pacific Islander	☑
Asian	☑
Rural	☑

Footnotes:

Planning Tables

Table 6: SUPTRS BG Other Capacity Building/Systems Development Activities

Please enter the total amount of the SUPTRS BG budgeted for each activity described above, by treatment, recovery support services and primary prevention. In budgeting for each activity, states should break down the row budget by funds planned for SSA activities and those planned to be contracted out under other subrecipient contracts. States should plan their budgets on a single Federal Fiscal Year (FFY), specified in the table below.

Planning Period Start Date: 10/1/2025 Planning Period End Date: 9/30/2026

	FFY 2026		
Activity	A. SUPTRS Treatment	B. SUPTRS Recovery Support Services	C. SUPTRS Primary Prevention
1. Information Systems	$107,000.00	$107,000.00	$36,000.00
a. Single State Agency (SSA)	$107,000.00	$107,000.00	$36,000.00
b. All other subrecipient contracts	$0.00	$0.00	$0.00
2. Infrastructure Support	$100,000.00	$100,000.00	$0.00
a. Single State Agency (SSA)	$100,000.00	$100,000.00	$0.00
b. All other subrecipient contracts	$0.00	$0.00	$0.00
3. Partnerships, community outreach, and needs assessment	$75,000.00	$75,000.00	$0.00
a. Single State Agency (SSA)	$75,000.00	$75,000.00	$0.00
b. All other subrecipient contracts	$0.00	$0.00	$0.00
4. Planning Council Activities	$0.00	$0.00	$0.00
a. Single State Agency (SSA)	$0.00	$0.00	$0.00
b. All other subrecipient contracts	$0.00	$0.00	$0.00
5. Quality Assurance and Improvement	$150,000.00	$150,000.00	$0.00
a. Single State Agency (SSA)	$150,000.00	$150,000.00	$0.00
b. All other subrecipient contracts	$0.00	$0.00	$0.00
6. Research and Evaluation	$0.00	$0.00	$300,000.00

a. Single State Agency (SSA)	$0.00	$0.00	$300,000.00
b. All other subrecipient contracts	$0.00	$0.00	$0.00
7. Training and Education	$200,000.00	$200,000.00	$200,000.00
a. Single State Agency (SSA)	$200,000.00	$200,000.00	$200,000.00
b. All other subrecipient contracts	$0.00	$0.00	$0.00
8. Total	**$632,000.00**	**$632,000.00**	**$536,000.00**

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Footnotes:

AHCCCS is reporting the planned Other Capacity Building/System Development Activities that will be contracted by a competitive statewide Procurement processes. The "All other subrecipient contract" activities will be reported by the subrecipients under their respective programmatic allocations. (Primary prevention, Recovery Services, and SUPTRS Recovery Support Services

Planning Tables

Table 6: MHBG Other Capacity Building/Systems Development Activities

MHBG Plan 6 address MHBG funds to be expended on other capacity building /systems development during State Fiscal Year (SFY) 2026 and 2027 (for most states, the 24-month period is July 1, 2025, through June 30, 2027). This table includes columns to capture planned state budget for BSCA supplemental funds. Please use these columns to capture how much the state plans to expend over a 24-month period. Please document the planned uses of BSCA funds in the footnotes section.

MHBG Planning Period Start Date: 07/01/2025 MHBG Planning Period End Date: 06/30/2027

Activity	A. MHBG[1]	B. BSCA Funds[2]
1. Information Systems	$500,000.00	
2. Infrastructure Support	$800,000.00	$88,715.00
3. Partnerships, Community Outreach, and Needs Assessment	$300,000.00	$266,144.00
4. Planning Council Activities	$10,000.00	
5. Quality Assurance and Improvement	$1,060,000.00	
6. Research and Evaluation		
7. Training and Education	$70,000.00	$532,286.00
8. Total	**$2,740,000.00**	**$887,145.00**

[1] The standard MHBG planned expenditures captured in column A should reflect the state planned budget for this planning period (SFYs 2026 and 2027) [**July 1, 2025 – June 30, 2027**, for most states].

[2] The expenditure period for the 3rd and 4th allocations of the Bipartisan Safer Communities Act (BSCA) funding is **September 30, 2024 – September 29, 2026** (3rd increment) and **September 30, 2025 – September 29, 2027** (4th increment). Column B should reflect the state planned budget for this planning period (SFYs 2026 and 2027) [**July 1, 2025, through June 30, 2027** for most states].

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Footnotes:

Environmental Factors and Plan

1. Access to Care, Integration, and Care Coordination – Required for MHBG & SUPTRS BG

Narrative Question

Across the United States, significant proportions of adults with serious mental illness, children and youth with serious emotional disturbances, and people with substance use disorders do not have access to or do not otherwise access needed behavioral healthcare. **States should focus on improving the range and quality of available services and on improving the rate at which individuals who need care access it**. States have a number of opportunities to improve access, including improving capacity to identify and address behavioral health needs in primary care, increasing outreach and screening in a variety of community settings, building behavioral health workforce and service system capacity, and efforts to improve public awareness around the importance of behavioral health. When considering access to care, states should examine whether people are connected to services, and whether they are receiving the range of needed treatment and supports.

A venue for states to advance access to care is by **ensuring that protections afforded by MHPAEA are being adhered to in private and public sector health plans, and that providers and people receiving services are aware of parity protections**. SSAs and SMHAs can partner with their state departments of insurance and Medicaid agencies to support parity enforcement efforts and to boost awareness around parity protections within the behavioral health field. The following resources may be helpful: **The Essential Aspects of Parity: A Training Tool for Policymakers**; **Approaches in Implementing the Mental Health Parity and Addiction Equity Act: Best Practices from the States**.

The integration of primary and behavioral health care remains a priority across the country to ensure that people receive care that addresses their mental health, substance use, and physical health problems. People with mental illness and/or substance use disorders are likely to die earlier than those who do not have these conditions.[1] Ensuring access to physical and behavioral health care is important to address the physical health disparities they experience and to ensure that they receive needed behavioral health care. **States should support integrated care delivery in specialty behavioral health care settings as well as primary care settings**. States have a number of options to finance the integration of primary and behavioral health care, including programs supported through Medicaid managed care, Medicaid health homes, specialized plans for individuals who are dually eligible for Medicaid and Medicare, and prioritized initiatives through the mental health and substance use block grants or general funds. States may also work to advance specific models shown to improve care in primary care settings, including Primary Care Medical Homes; the Coordinated Care Model; and Screening, Brief Intervention, and Referral to Treatment.

Navigating behavioral health, physical health, and other support systems is complicated and many individuals and families require care coordination to ensure that they receive necessary supports in and efficient and effective manner. **States should develop systems that vary the intensity of care coordination support based on the severity and complexity of individual need**. States also need to consider different models of care coordination for different groups, such as High-Fidelity Wraparound and Systems of Care when working with children, youth, and families; providing Assertive Community Treatment to people with serious mental illness who are at a high risk of institutional placement; and connecting people in recovery from substance use disorders with a range of recovery supports. States should also provide the care coordination necessary to connect people with mental and substance use disorders to needed supports in areas like education, employment, and housing.

[1]Druss, B. G., Zhao, L., Von Esenwein, S., Morrato, E. H., & Marcus, S. C. (2011). Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. Medical care, 599-604.Avaiable at: **https://journals.lww.com/lww-medicalcare/Fulltext/2011/06000/Understanding_Excess_Mortality_in_Persons_With.11.aspx**

1. Describe your state's efforts to improve **access to care for mental disorders, substance use disorders, and co-occurring disorders**, including details on efforts to increase access to services for:

a) Adults with serious mental illness (SMI)

b) Adults with SMI and a co-occurring intellectual and developmental disabilities (I/DD)

c) Pregnant women with substance use disorders

d) Women with substance use disorders who have dependent children

e) Persons who inject drugs

f) Persons with substance use disorders who have, or are at risk for, HIV or TB

g) Persons with substance use disorders in the justice system

h) Persons using substances who are at risk for overdose or suicide

i) Other adults with substance use disorders

j) Children and youth with serious emotional disturbances (SED) or substance use disorders

k) Children and youth with SED and a co-occurring I/DD

l) Individuals with co-occurring mental and substance use disorders

Arizona has a comprehensive, integrated approach to improving access to care for individuals with mental disorders, substance use disorders (SUD), and co-occurring conditions. Arizona Health Care Cost Containment System (AHCCCS), who serves as the State Mental Health Agency, delivers services via Managed Care Organizations (MCOs), including AHCCCS Complete Care (ACC) plans, ACC Contractors with Regional Behavioral Health Agreements (ACC-RBHAs), the Arizona Long Term Care System (ALTCS), and Tribal Regional Behavioral Health Authorities (TRBHAs). These entities provide a full continuum of care that includes primary health services, behavioral health treatment, peer and family support, medication-assisted treatment, and crisis intervention. AHCCCS ensures that services are accessible to a wide range of populations, including adults with serious mental illness (SMI), individuals with co-occurring intellectual and developmental disabilities (I/DD), pregnant and parenting women with SUD, persons who inject drugs, individuals at risk for HIV or TB, justice-involved individuals, and those at risk for overdose or suicide. Children and youth with serious emotional disturbance (SED), including those with co-occurring I/DD, are also a priority. Services are delivered in integrated settings that address both physical and behavioral health needs, with a focus on recovery, person-centered care, and community integration.

Peer-Run Organizations also play a vital role in ensuring that individuals with mental health and substance use conditions can connect to the services they need. Staff, through their shared lived experiences, have a unique ability to engage with individuals and act as a bridge to services. They also provide ongoing support assisting in individuals staying connected to services to achieve their wellness goals.

The majority of AHCCCS members receive integrated health services through their chosen acute care program, one of seven AHCCCS Complete Care (ACC) plans throughout the state. Services include, but are not limited to, primary health care, mental health individual and group counseling, case management, psychiatric and psychologist services, peer support services, family support services, individual and group skills training, vocational training, substance use disorder treatment, medication for opioid use disorder (MOUD), and medication for the treatment of alcohol use disorder. The ACC Contractors with a Regional Behavioral Health Agreement (ACC-RBHAs) specifically serve individuals with a Serious Mental Illness (SMI) designation, Serious Emotional Disturbance (SED) and Early Serious Mental Illness (ESMI) including First Episode Psychosis (FEP) while also providing crisis, other grant-funded, and state-only funded services. Additionally, the Arizona Long Term Care System (ALTCS) program provides health insurance for individuals who are age 65 or older or who have a disability. American Indians and Alaska Natives (AI/AN) enrolled in AHCCCS or CHIP (KidsCare) may choose to receive their coverage through the American Indian Health Program (AIHP), Tribal ALTCS, or Tribal RBHAs (TRBHAs enter into Intergovernmental Agreements with AHCCCS for behavioral health care management) or one of the AHCCCS-contracted managed health plans. The core principles of AHCCCS' system of care are based on the concepts of recovery, member input, family involvement, person-centered care, communication, and commitment. AHCCCS MCOs are expected to demonstrate an unwavering commitment to these principles, while demonstrating creativity and innovation in their oversight and management of an integrated service delivery system. MCOs are required to develop and promote care integration activities, such as establishing integrated settings which serve members' primary care and behavioral health needs and encouraging member utilization of these settings. MCOs are also required to consider the entirety of the member population's health needs during network development and provider contracting to ensure member access to care, care coordination, and management, and to reduce duplication of services.

Arizona's model is based upon the premise that people want and deserve dignity, respect, integration, and safety. Based on four elements:
Affording people dignity, compassion and respect
Offering coordinated care, support or treatment
Offering personalized care, support or treatment
Supporting people to recognize, as well as develop, their strengths and abilities enables them to live a fulfilling and independent life.

To ensure that individuals with lived experience have a voice in system design, AHCCCS mandates that all contracted health plans maintain an Office of Individual and Family Affairs (OIFA). These offices mirror the AHCCCS OIFA and ensure that peer and family perspectives are represented in decision-making at every level—from the state agency to health plans and providers. In addition, OIFAs at each contracted health plan facilitate Member Advisory Councils to gather input, identify challenges and barriers, and strategize on ways to strengthen the service delivery system.

To support these efforts, AHCCCS leverages federal funding through the Mental Health Block Grant (MHBG) and Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUPTRS BG). Collaborative block grant funding and respective supplemental allocations have facilitated the expansion of innovative initiatives, such as the Arizona Peer and Family Career Academy. To address the growing demand for behavioral health services and workforce accessibility, the Academy provides comprehensive professional development and advanced training for Peer Recovery Support Specialists and Family Support Partners. This ensures that these specialized providers receive targeted instruction to support individuals affected by mental

health disorders, substance use disorders, and co-occurring conditions. Additionally, the Arizona Peer and Family Career Academy developed and implemented a training program for clinical supervisors, as required by AHCCCS, for those overseeing these unique service providers. This initiative not only reinforces the behavioral health workforce but also enhances the quality and effectiveness of services for individuals with complex needs. In addition, enhanced support for justice- involved individuals with mental disorders, substance use disorders, and co-occurring disorders have been provided through the services of justice navigation providers, court liaisons, and coordinated care before and after release. AHCCCS also supports the expansion of Permanent Supported Housing programs in rural Northern and Southern Arizona geographic service areas increasing access to evidence-based Permanent Supportive Housing (PSH) models for serving persons experiencing homelessness, persons with behavioral health needs including mental illness or substance use disorders (SUD) and co-occurring disorders premised on: 1) access to and availability of both affordable housing subsidies and capacity, and, 2) individualized wrap around housing focused supportive services to support housing placement, stability and coordination with member's other service goals and resources.

Through SUPTRS BG Arizona has shifted the culture in the treatment of pregnant and postpartum parents by raising awareness, providing training to providers serving this population, improving referral pathways to local and culturally responsive programming, and coordinating with other state and local agencies to create a multi-systemic collaborative approach necessary to serve this population. Projects such as the Arizona Women's Recovery Center Childcare Initiative support retention in SUD treatment for women/families with childcare needs by connecting families with meaningful age-appropriate childcare or activities and specialty residential programs for maternal health, pregnancy care, SUD treatment and recovery support services to pregnant and parenting women.
SUPTRS BG also leverages funding to reach underserved populations through mobile outreach efforts such as the Intensive Treatment Systems Mobile Methadone Van, which delivers services directly to high-risk individuals in jails, shelters, and syringe distribution sites.

Additional efforts include covering child sitting and childcare for women with dependent children seeking SUD treatment services, covering transportation, and telehealth. The use of certified peer support specialists in the AZ behavioral health also improves access to care and retention in care by offering support by someone who has been in their shoes and can help them navigate their treatment and recovery journey.
Both AHCCCS and the ACC-RBHAs conduct secret shopper calls to SUBG providers to assess how providers respond when a priority population member seeking care, assess compliance to block grant requirements and address any access to care issues.

MHBG has strategically leveraged funding to strengthen delivery systems and service provision through effective implementation across the state of Arizona, with a particular focus on rural communities.
In relation to children identified with serious emotional disturbance (SED), improvements have been made to the AHCCCS SED identification process. The state recognized that the previous approach, which required lengthy and complex documentation, imposed unnecessary administrative burdens and could result in delayed access to care due to avoidable errors or incomplete submissions. Consequently, the process was streamlined to facilitate easier submission of SED identification requests by providers. This revision not only reduced paperwork but also improved the accuracy and timeliness of assessments, enabling children to receive essential services more promptly. These enhancements aim to improve access to care for children and youth with SED and co-occurring intellectual and developmental disabilities (I/DD).
Furthermore, children and adolescents with SED benefit from the Arizona Pediatric Psychiatry Access Line, which provides psychiatric consultation services in rural regions. The establishment of child and adolescent crisis stabilization units in Northern Arizona has further mitigated notable deficiencies within the rural behavioral health infrastructure.

Supplemental grant funding has also been leveraged for developing additional First Episode Psychosis (FEP) treatment programs, including a unit dedicated to providing mobile FEP services in two rural Arizona counties, as well as expanded outreach and training initiatives for ESMI/FEP service providers in these areas. To reduce barriers to care, AHCCCS has recently issued clarifications and technical assistance to contractors regarding ESMI identification and utilization of ESMI funds, with the objective of minimizing obstacles during this clinically critical intervention period.

Arizona's behavioral health system is grounded in the belief that all individuals deserve dignity, respect, and the opportunity to live fulfilling lives. The state's model emphasizes coordinated, personalized care that builds on individual strengths and promotes long-term recovery and independence. Through these targeted efforts and systemic innovations, Arizona continues to reduce barriers and expand access to care for all residents affected by mental health and substance use challenges.

2. Describe your efforts, alone or in partnership with your state's department of insurance and/or Medicaid system, to advance **parity enforcement and increase awareness of parity protections** among the public and across the behavioral and general health care fields.

AHCCCS functions as both the Single State Agency (SSA) and the official State Medicaid Agency for Arizona. In response to the Centers for Medicare & Medicaid Services (CMS) Medicaid Mental Health Parity Final Rule issued on March 30, 2016, AHCCCS has implemented key initiatives to enhance access to mental health and substance use disorder (MH/SUD) services for Medicaid enrollees. This federal rule mandates that MH/SUD services be provided on par with physical health services.

To ensure compliance, AHCCCS released Policy 110 on Mental Health Parity within the AHCCCS Contractor Operations Manual (ACOM), available at the following webpage www.azahcccs.gov/Shared/Downloads/ACOM/PolicyFiles/100/110.pdf. These parity standards apply whenever any portion of a benefit is administered through a managed care organization (MCO).

Further guidance is outlined in the 2022–2023 AHCCCS Delivery System Integration Key, which emphasizes parity coverage for physical health, behavioral health, children's rehabilitative services, and long-term care. Available at the following webpage https://www.azahcccs.gov/shared/Downloads/2022_Delivery_SystemIntegration_10012022.pdf
Additionally, AHCCCS provides detailed information on covered behavioral health services through the Covered Behavioral Health Services Guide (CBHSG). Available at the following webpage https://www.azahcccs.gov/PlansProviders/Downloads/MedicalCodingResources/AHCCCSCoveredBHServicesManual.pdf)

AHCCCS also monitors contractor compliance through regular reporting, technical reviews, and corrective action plans when necessary. These oversight mechanisms ensure that parity is not only a policy but a practice embedded in service delivery.

In terms of public and provider awareness, AHCCCS promotes parity protections through educational materials, provider training, community outreach, member-facing resources, and provider toolkits to increase understanding of parity rights and responsibilities.

For individuals dually eligible for Medicare and Medicaid, AHCCCS contracts with Medicare Advantage Dual Special Needs Plans (D-SNPs) that are affiliated with AHCCCS Complete Care (ACC) Medicaid health plans. This alignment promotes enrollment in a single, integrated plan, simplifying access to services and improving care coordination for over 180,000 Arizonans.

To advance its ongoing initiatives, AHCCCS partners with the Arizona Department of Health Services and additional stakeholders through the Arizona Health Improvement Plan (AzHIP) 2021–2025, which identifies health parity as one of its five strategic priorities.
AHCCCS remains actively engaged in parity enforcement and increase awareness.

3. Describe how the state supports the provision of **integrated services and supports for individuals with co-occurring mental and substance use disorders**, including screening and assessment for co-occurring disorders and integrated treatment that addresses substance use disorders as well as mental disorders.

AHCCCS, which is also the State Mental Health Agency, delivers services through Managed Care Organizations (MCOs). These organizations offer a comprehensive continuum of care that includes primary health services, behavioral health treatment, peer and family support, medication-assisted treatment, and crisis intervention.
Arizona has a deep-rooted commitment to integrated care that addresses both mental health and substance use challenges. This approach includes thorough screening and assessment for co-occurring disorders, along with coordinated treatment plans that address both substance use and mental health conditions.

To uphold service parity, the AHCCCS Medical Policy Manual (AMPM) and the AHCCCS Contractor Operations Manual (ACOM) outline specific mandates ensuring pard access to medical and behavioral health services. These policies are applicable to all AHCCCS members, irrespective of diagnosis, including mental illness, serious emotional disturbance in youth, substance use disorder, or co-occurring conditions. You can access the AHCCCS AMPM and ACOM manuals at the following webpages: https://www.azahcccs.gov/shared/MedicalPolicyManual/ and https://www.azahcccs.gov/shared/ACOM/.

AMPM Exhibit 300-3—The AHCCCS Integrated System of Care Structure—outlines the foundational values, principles, and goals applicable to both youth and adult populations. Key components include service accessibility, care coordination, health management, prevention, efficiency, engagement, operational excellence, technology, and communication. The exhibit further delineates best practices for service delivery: for youth, Arizona's Child and Family Team (CFT) model integrates elements from both the 12 Arizona Principles and the 10 Principles of Wraparound; for adults, the state utilizes the 12 Arizona Principles in conjunction with nine guiding principles to address member needs.

To enhance service provision and provider oversight, AMPM Policy 580—Child and Family Team—details the universal CFT practice within the AHCCCS System of Care. It includes indicators for assessing a child's and family's complexity of needs, describes the implementation of core CFT activities on an individualized continuum, and explains the utilization of CALOCUS within the system. Additionally, AMPM Behavioral Health Practice Tool 580, Attachment B, provides a matrix illustrating how CFT practice is tailored for children and families based on varying needs and intensity levels.

AMPM Chapter 500—Behavioral Health Practice Tools—comprises policies dedicated to quality assessment and the adoption of best practices, thereby strengthening Arizona's Behavioral Health System to meet the needs of children, adolescents, and young adults. AMPM Policy 320-O—Behavioral Health Assessments, Service, and Treatment Planning—establishes requirements for conducting behavioral health assessments, service provision, and treatment planning. It mandates that contractors ensure compliance with the Adult Behavioral Health Services Delivery System by having qualified professionals perform these tasks, incorporating an integrated team approach for each member, and documenting agreement or disagreement with the service plan, as well as informing members of their right to appeal. Specialized provisions for individuals designated as SMI are also detailed within this policy.

AHCCCS Managed Care Organizations (MCOs) are mandated to establish processes for identifying Health Homes within their network and assigning members who have a Serious Mental Illness (SMI) designation—including individuals with co-occurring SMI and substance use disorders—to a Health Home within five days of enrollment. Each assigned Health Home is accountable for

directly providing, or coordinating the provision of, all medically necessary healthcare services. Furthermore, the Health Home must deliver or facilitate an array of integrated, recovery-oriented services, including medication management, counseling for mental health and/or substance use disorder treatment, medical oversight, case management, transportation, peer and family support, as well as health and wellness group activities. To promote continuity of care and ensure effective coordination across systems, Health Homes are also required to guarantee prompt follow-up and ongoing care following crisis intervention.

In addition, AHCCCS MCOs must maintain and implement comprehensive policies and procedures that describe the coordinated delivery of integrated physical and behavioral health services, encompassing both administrative and clinical integration. Integration efforts are expected to center on improving individual health outcomes, enhancing care coordination—including coordination for Medication Assisted Treatment (MAT)—and increasing member satisfaction. Due to Arizona's model of integrated care coordination, fixed teams are not designated, as integration is assumed to be standard practice. MCOs are directed to apply evidence-based practices for all members, including those with co-occurring diagnoses, and fidelity reviews are conducted for Adult Care Team (ACT), Consumer Operated Services (COS), Permanent Supported Housing (PSH), and Supported Employment (SE) programs.

a. Please describe how this system differs for youth and adults.

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b. Does your state provide evidence-based integrated treatment for co-occurring disorders (IT-COD), formerly known as IDDT? Please explain.

Yes, AHCCCS provides evidence-based integrated treatment for co-occurring disorders (IT-COD), formerly known as IDDT. The Arizona Health Care Cost Containment System (AHCCCS) offers comprehensive integrated health care services for individuals with co-occurring mental and substance use disorders through Managed Care Organizations (MCOs). These services include primary health care, mental health counseling, case management, psychiatric and psychologist services, peer support services, family support services, skills training, vocational training, substance use disorder treatment, and

medication for opioid and alcohol use disorders.

AHCCCS MCOs are expected to demonstrate creativity and innovation in their oversight and management of an integrated service delivery system. They are required to develop and promote care integration activities, such as establishing integrated settings that serve members' primary care and behavioral health needs and encouraging member utilization of these settings . Additionally, AHCCCS supports integrated systems of care for individuals and families with co-occurring mental and substance use disorders, including management, funding, and payment strategies that foster co-occurring capability.

c. How many IT-COD teams do you have? Please explain.

Arizona does not have a specific number of teams classified solely as IT-COD teams. Instead, the state uses a comprehensive, integrated approach to deliver care for individuals with co-occurring mental health and substance use disorders. AHCCCS, which serves as the State Mental Health Agency, provides these services through Managed Care Organizations (MCOs), including AHCCCS Complete Care (ACC) plans, ACC-RBHAs, ALTCS, and TRBHAs. These entities offer a full continuum of care—including behavioral health treatment, primary care, peer support, and crisis services—ensuring that integrated treatment is available system-wide rather than through isolated teams.

d. Do you monitor fidelity for IT-COD? Please explain.

AHCCCS mandates that Managed Care Organizations (MCOs) comply with fidelity standards for Integrated Treatment for Co-Occurring Disorders (IT-COD). This compliance is ensured through multiple mechanisms, such as the implementation of evidence-based practices and the use of fidelity monitoring tools. For example, the Assertive Community Treatment (ACT) model—applied for individuals with severe and persistent mental illness—adheres to fidelity criteria established by the Substance Abuse and Mental Health Services Administration (SAMHSA).
Furthermore, the Targeted Investment (TI) Program provides support to providers in delivering integrated and coordinated care at the provider level. As part of this program, participating providers are required to complete the Integrated Practice Assessment Tool (IPAT) annually, which evaluates their integration level according to the SAMHSA Levels of Integrated Care continuum.

Additionally, AHCCCS requires MCOs to submit an annual Provider Case Management Plan, detailing how the contractor intends to implement and monitor provider case management standards and caseload ratios for both adult and pediatric populations.

These quality assurance measures are designed to ensure ongoing fidelity monitoring and maintenance for IT-COD, thereby promoting the delivery of high-quality, integrated care to individuals with co-occurring disorders.

Under AHCCCS guidelines, MCOs must also provide an annual Provider Case Management Plan. This plan describes the strategies for implementing and monitoring provider case management standards and managing caseload ratios for both adults and children. It encompasses performance outcomes, lessons learned, and targeted improvement strategies.

Moreover, AHCCCS Targeted Investment (TI) Program supports providers in the delivery of integrated and coordinated care. As part of TI Program requirements, providers are obligated to complete the IPAT assessment annually to determine their integration level along the SAMHSA Levels of Integrated Care continuum. The TI Program incentivizes providers to implement and sustain various protocols, policies, and systems that facilitate person-centered integrated care.

The establishment of co-located, integrated clinics—where primary care and behavioral health services are delivered jointly to justice-involved individuals—has been another significant outcome supported by the TI Program. Providers participating in the TI Program have reported improvements in service quality and coordination stemming from enhanced communication protocols between primary care and behavioral health teams.
Collectively, these initiatives ensure that fidelity data is systematically reported and monitored, advancing the provision of high-quality, integrated care for persons with co-occurring disorders.

e. Do you have a statewide COD coordinator? ○ Yes ◉ No

4. Describe how the state **supports integrated behavioral health and primary health care**, including services for individuals with mental disorders, substance use disorders, co-occurring M/SUD, and co-occurring SMI/SED and I/DD. Include detail about:

a) Access to behavioral health care facilitated through primary care providers

b) Efforts to improve behavioral health care provided by primary care providers

c) Efforts to integrate primary care into behavioral health settings

d) How the state provides integrated treatment for individuals with co-occurring disorders

AHCCCS has established a robust and comprehensive framework for integrating behavioral health and primary care. This framework promotes coordinated care across diverse systems and populations, including individuals with mental health conditions, substance use disorders (SUD), co-occurring mental and substance use disorders (M/SUD), and those with serious mental illness (SMI), serious emotional disturbance (SED), and intellectual or developmental disabilities (I/DD).

Under AMPM Policy 510, primary care providers (PCPs) are responsible for coordinating ongoing treatment, including behavioral health services. This includes ensuring timely referrals to behavioral health providers, transferring medical records, maintaining medication continuity, and supporting transitions for members with SMI designations.
AMPM Policy 541 emphasizes collaboration with various government agencies to ensure integrated service delivery. This includes coordination with the Arizona Department of Child Safety (DCS) for behavioral risk assessments and services for children and families; expedited, family-centered SUD treatment through the Arizona Families FIRST program; behavioral health support in educational settings via the Arizona Department of Education; employment and early intervention services through the Arizona Department of Economic Security; and transition planning for justice-involved individuals through partnerships with courts and correctional systems.

AMPM Policy 570 outlines multiple levels of provider case management to meet the needs of individuals across the behavioral health spectrum. These include Assertive Community Treatment (ACT) for adults with severe mental illness, High Needs Case Management for children and adolescents with complex needs, and Medium and Low Intensity Case Management for adults based on their recovery status. Specialized teams such as Forensic ACT (FACT) in Maricopa County serve justice-involved individuals with SMI, while Medical ACT (MACT) teams provide integrated care for individuals with both SMI and significant medical conditions.

AMPM Policy 590 ensures that all Arizona residents, regardless of Medicaid eligibility, have access to behavioral health crisis services. These services include crisis hotlines, mobile crisis response, and stabilization facilities. The policy also mandates post-crisis care planning, coordination with health plans, and timely notifications to ensure continuity of care for enrolled members.

AHCCCS also supports tribal health system integration through its Division of Fee for Service Management (DFSM). This includes the American Indian Medical Home (AIMH) program, which enhances primary care case management, diabetes education, and care coordination for American Indian Health Program (AIHP) members. DFSM also promotes Care Coordination Agreements between IHS/638 and non-IHS/638 facilities to improve access and continuity of care for tribal members.

To ensure quality and accountability, Managed Care Organizations (MCOs) are required to submit annual Provider Case Management Plans. These plans detail implementation strategies, caseload ratios, performance outcomes, and mechanisms for member and family involvement in service improvement and decision-making.

5. Describe how the state **provides care coordination**, including detail about how care coordination is funded and how care coordination models provided by the state vary based on the seriousness and complexity of individual behavioral health needs. Describe care coordination available to:

a) Adults with serious mental illness (SMI)

b) Adults with substance use disorders

c) Adults with SMI and I/DD

d) Children and youth with serious emotional disturbances (SED) or substance use disorders

e) Children and youth with SED and I/DD

Arizona provides care coordination through a fully integrated system managed by the Arizona Health Care Cost Containment System (AHCCCS), which administers Medicaid services statewide. This system ensures that behavioral and physical health services are coordinated across the lifespan, guided by detailed policies in the AHCCCS Medical Policy Manual (AMPM) and Contractor Operations Manual (ACOM). Funding for care coordination is supported through Medicaid capitation payments, federal block grants—including the Mental Health Block Grant (MHBG) and Substance Abuse Prevention and Treatment Block Grant (SUPTRS BG)—as well as state general funds.

Care coordination models in Arizona are tailored to the seriousness and complexity of an individual's behavioral health needs. These models include Health Homes, Child and Family Teams (CFTs), Assertive Community Treatment (ACT) teams, and collaborative efforts with the Division of Developmental Disabilities (DDD). Each model is designed to ensure that individuals receive the right level of support and services based on their unique circumstances.

For adults with Serious Mental Illness (SMI), AHCCCS mandates assignment to a Health Home within five days of enrollment. These Health Homes are responsible for coordinating all medically necessary services, including behavioral and physical health care, as well as social supports. Services provided include medication management, counseling, case management, peer and family support, transportation, and wellness programs. For individuals with high complexity—such as those with frequent hospitalizations, co-occurring disorders, or housing instability—ACT teams offer intensive, multidisciplinary, community-based services. These services are funded through Medicaid, MHBG, and state general funds.

Adults with substance use disorders (SUD) receive care coordination based on the American Society of Addiction Medicine (ASAM) Criteria, which helps determine the appropriate level of care. AHCCCS provides a crosswalk aligning ASAM levels with Arizona-specific facility types and services. Managed Care Organizations (MCOs) ensure that assessments and treatment planning are

conducted by qualified professionals and coordinated across providers. For individuals with mild to moderate SUD, outpatient services with case management are typically provided. Those with severe or co-occurring conditions may receive residential treatment or support from integrated care teams. SABG funds are used to support services for non-Medicaid eligible individuals and to fund critical overdose prevention and response initiatives, such as mobile methadone vans and peer outreach.

For adults with both SMI and Intellectual/Developmental Disabilities (I/DD), Arizona employs enhanced care coordination strategies. Health Homes work in close collaboration with DDD to coordinate services across behavioral health and developmental systems. These services include individualized service planning, crisis response, permanent supportive housing, employment services, adaptive communication supports, and legal guardianship coordination. Funding for this population is braided across Medicaid Title XIX, MHBG, and state general funds, and service delivery is highly specialized and cross-agency in nature.

Children and youth with Serious Emotional Disturbances (SED) or SUD are supported through the Child and Family Team (CFT) model, which is central to care coordination. The Child and Adolescent Level of Care Utilization System (CALOCUS) is used to assess the intensity of services needed. CFTs engage in nine core activities, including crisis stabilization, service planning, and transition planning. For youth with SUD, treatment planning is guided by the ASAM Criteria. Funding sources include Medicaid, MHBG, SUBG, and state appropriations. Care coordination is especially critical during transitions such as entry into or exit from foster care or involvement with the juvenile justice system.

For children and youth with both SED and I/DD, care coordination involves close collaboration between AHCCCS, DDD, and behavioral health providers. The CFT process is adapted to include developmental specialists and address the unique needs of this population. CALOCUS continues to guide service intensity, while care plans incorporate behavioral interventions, habilitation services, educational supports, and transition planning beginning at age 16. Funding for these services is provided through Medicaid, MHBG, and state general funds.

6. Describe how the state supports the provision of **integrated services and supports for individuals with co-occurring mental and substance use disorders**, including screening and assessment for co-occurring disorders and integrated treatment that addresses substance use disorders as well as mental disorders. Please describe how this system differs for youth and adults.

Arizona supports individuals with co-occurring mental health and substance use disorders through a robust, integrated system led by the Arizona Health Care Cost Containment System (AHCCCS), the state's Medicaid agency and Mental Health Authority. Services are delivered through Managed Care Organizations (MCOs), which provide a full continuum of care—including primary care, behavioral health treatment, medication-assisted treatment, peer and family support, and crisis services.

The state emphasizes comprehensive screening and assessment for co-occurring disorders, ensuring that treatment plans address both mental health and substance use conditions in a coordinated, person-centered manner. This integrated approach is reinforced by policies in the AHCCCS Medical Policy Manual (AMPM) and the AHCCCS Contractor Operations Manual (ACOM), which mandate equitable access to care for all members, regardless of diagnosis.

Arizona's system of care is tailored to meet the distinct needs of youth and adults. For youth, the Child and Family Team (CFT) model is central, blending the 12 Arizona Principles with the 10 Principles of Wraparound to guide individualized, family-driven care. Tools like the CALOCUS and AMPM Behavioral Health Practice Tool 580 help assess and match services to the complexity of each child's needs.
For adults, the state applies the 12 Arizona Principles alongside nine guiding principles to ensure holistic, recovery-oriented care. Behavioral health assessments and treatment planning are conducted by qualified professionals using a team-based approach, with special provisions for individuals designated as having a Serious Mental Illness (SMI).

To further support integration, MCOs must assign individuals with SMI—including those with co-occurring disorders—to a Health Home within five days of enrollment. These Health Homes coordinate all medically necessary services and provide a wide range of supports, from medication management and counseling to peer support and wellness activities. They also ensure timely follow-up after crises, promoting continuity and stability in care.

7. Describe how the state supports the provision of **integrated services and supports for individuals with co-occurring mental and intellectual/developmental disorders (I/DD)**, including screening and assessment for co-occurring disorders and integrated treatment that addresses I/DD as well as mental disorders. Please describe how this system differs for youth and adults.

Arizona supports the provision of integrated services for individuals with co-occurring mental health and intellectual or developmental disabilities (I/DD) through a multi-layered system of care led by AHCCCS in partnership with the Division of Developmental Disabilities (DDD). This system is grounded in person-centered planning and integration, designed to meet the complex needs of both youth and adults.

The state's approach begins with early identification and comprehensive assessment. Behavioral health providers statewide have access to a specialized I/DD Course Library via the Relias training platform, which includes over 100 CEU-eligible courses. These resources build provider competency in recognizing and treating co-occurring conditions. A structured training plan—"Intellectual & Developmental Disabilities Essential Knowledge for Behavioral Health Providers"—covers trauma-informed care, cognitive behavioral therapy for individuals with I/DD, and integrated care strategies.

From November 2023 to September 2024, AHCCCS collaborated with the National Center for START Services® (NCSS) at the

University of New Hampshire to enhance the capacity of Arizona professionals working with individuals with co-occurring I/DD and mental health needs. The initiative focused on training Care Coordinators and Case Managers to better support both youth and adults.

For youth, Arizona uses the Child and Adolescent Level of Care Utilization System (CALOCUS) to assess service intensity across domains such as risk of harm and functional status. This tool is embedded within the Child and Family Team (CFT) model, which guides individualized service planning and coordination for children with complex behavioral health needs. Residential treatment options, such as Desert River, offer short-term, intensive behavioral health services using applied behavioral analysis and trauma-informed interventions.

For adults, the system transitions to the Adult Recovery Team (ART) model, which emphasizes recovery-oriented planning, peer support, and coordination with housing, employment, and justice systems. Adults with co-occurring I/DD and mental health conditions may also receive services through the Arizona Long Term Care System (ALTCS), which provides integrated physical and behavioral health care, including crisis services, medication management, and supported employment. Evidence-based practices supported by SAMHSA—such as Assertive Community Treatment (ACT), Supported Employment (SE), Consumer Operated Services (COS), and Permanent Supportive Housing (PSH)—are available to all members, including those with I/DD.

Managed Care Organizations (MCOs), such as Mercy Care, play a vital role in delivering integrated services. They collaborate with DDD and community-based providers to ensure services are accessible and tailored to individual needs. Each member is assigned a Case Manager (Support Coordinator) who conducts annual screenings for health-related social needs (HRSN) using the Closed Loop Referral System (CLRS), which connects members to community-based supports. If additional support is needed, a Care Manager may be assigned through the health plan.

To address barriers such as workforce shortages and service fragmentation, Arizona has invested in technical assistance, fidelity monitoring, and network development. The state's 2021 ARPA Mental Health Block Grant Plan outlines efforts to expand provider capacity and ensure adherence to evidence-based practices.

In summary, Arizona's integrated system for individuals with co-occurring I/DD and mental health conditions is built on early screening, provider training, and individualized care planning. The system differentiates between youth and adults through developmentally appropriate models—CFT for children and ART for adults—and ensures continuity through structured transitions. These efforts aim to reduce disparities, improve outcomes, and promote independence and community integration.

8. Please indicate areas of **technical assistance needs** related to this section.

No technical assistance needs at time

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Footnotes:

Environmental Factors and Plan

2. Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI) – 10 percent set aside – Required for MHBG

Narrative Question

Much of the mental health treatment and recovery service efforts are focused on the later stages of illness, intervening only when things have reached the level of a crisis. While this kind of treatment is critical, it is also costly in terms of increased financial burdens for public mental health systems, lost economic productivity, and the toll taken on individuals and families. There are growing concerns among individuals and family members that the mental health system needs to do more when people first experience these conditions to prevent long-term adverse consequences. Early intervention is critical to treating mental illness as soon as possible following initial symptoms and reducing possible lifelong negative impacts such as loss of family and social supports, unemployment, incarceration, and increased hospitalizations *[Note: MHBG funds cannot be used for primary prevention activities. States cannot use MHBG funds for prodromal symptoms (specific group of symptoms that may precede the onset and diagnosis of a mental illness) and/or those who are not diagnosed with SMI or SED].* The duration of untreated mental illness, defined as the time interval between the onset of symptoms and when an individual gets into appropriate treatment, has been a predictor of outcomes across different mental illnesses. Evidence indicates that a prolonged duration of untreated mental illness may be a negative prognostic factor. However, earlier treatment and interventions not only reduce acute symptoms but may also improve long-term outcomes.

The working definition of an Early Serious Mental Illness is "An early serious mental illness or ESMI is a condition that affects an individual regardless of their age and that is a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-5TR (APA, 2022). For a significant portion of the time since the onset of the disturbance, the individual has not achieved or is at risk for not achieving the expected level of interpersonal, academic, or occupational functioning. This definition is not intended to include conditions that are attributable to the physiologic effects of a substance use disorder, are attributable to an intellectual/developmental disorder or are attributable to another medical condition. The term ESMI is intended for the initial period of onset."

States may implement models that have demonstrated efficacy, including the range of services and principles identified by the Recovery After an Initial Schizophrenia Episode **(RAISE)** initiative.Utilizing these principles, regardless of the amount of investment, and by leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, states should move their system to address the needs of individuals experiencing first episode of psychosis (FEP). RAISE was a set of federal government- sponsored studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP. The RAISE studies, as well as similar early intervention programs tested worldwide, consist of multiple evidence-based treatment components used in tandem as part of a Coordinated Specialty Care (CSC) model, and have been shown to improve symptoms, reduce relapse, and lead to better outcomes.

States shall expend not less than 10 percent of the MHBG amount the State receives for carrying out this section for each fiscal year to support evidence-based programs that address the needs of individuals experiencing early serious mental illness, including psychotic disorders, regardless of the age of the individual at onset. In lieu of expending 10 percent of the amount, the state receives under this section for a fiscal year as required, a state may elect to expend not less than 20 percent of such amount by the end of such succeeding fiscal year.

Please respond to the following items:

1. Please name the evidence-based model(s) for ESMI, including psychotic disorders, that the state implemented using MHBG funds including the number of programs for each.

Model(s)/EBP(s) for ESMI	Number of programs
Navigate	6.00
OnTrack	3.00
Acceptance and Commitment Therapy (ACT)	9.00
Cognitive Behavior Therapy for psychosis (CBTp)	9.00

Cognitive Enhancement Therapy (CET)	9.00
Somatic Experiencing	9.00

2. Please provide the total budget/planned expenditure for ESMI for FY 26 and FY 27 (only include MHBG funds).

FY2026	FY2027
2,304,884.90	2,304,884.90

3. Please describe the status of billing Medicaid or other insurances for ESMI services. How are components of the model currently being billed? Please explain.

The Arizona Health Care Cost Containment System (AHCCCS) has developed a comprehensive billing framework to support Early Serious Mental Illness (ESMI) services, ensuring individuals experiencing early psychosis receive timely, integrated care. This framework is built on a multi-funding strategy that includes Medicaid (Title XIX/XXI), Non-Title XIX/XXI (NTXIX), and the Mental Health Block Grant (MHBG), with funding applied based on individual eligibility and the nature of services provided.

For individuals eligible for Medicaid, ESMI services are billed directly to Medicaid using standard procedure codes aligned with the Coordinated Specialty Care (CSC) model, such as NAVIGATE and OnTrackNY. These services encompass a wide range of supports, including case management, counseling, family education, medication management, peer support, supported employment and education, and primary care coordination.

For those who are uninsured or not eligible for Medicaid, AHCCCS utilizes MHBG and NTXIX funds to ensure access to care. These services are tracked through quarterly reporting by the ACC-RBHAs and include specific billing codes such as S9485 for per diem crisis stabilization. AHCCCS maintains clear distinctions between Medicaid-funded and grant-funded encounters to ensure compliance and transparency.

Community Psychiatric Supportive Treatment Programs also play a vital role in the ESMI model, offering structured, medically supervised services like behavioral health counseling, skills training, medication support, and peer recovery support. Key billing codes used in these programs include H0036 for face-to-face services billed in 15-minute units, H0037 for per diem supportive treatment, and H2041 for coordinated specialty care for first episode psychosis, which requires AHCCCS approval.

To maintain billing integrity, AHCCCS enforces specific limitations, such as allowing only one per diem code per member per day, bundling meal costs, billing transportation separately, and ensuring education hours do not overlap. Group services are permitted without size limits as long as the provider-to-member ratio remains at or below 1:20.

To support providers and ensure accurate reimbursement, AHCCCS conducts regular technical assistance meetings with clinical and finance teams. These sessions help refine billing practices, clarify policy requirements, and address code attribution issues—such as the appropriate use of S9485. Through this ongoing collaboration, AHCCCS reinforces its commitment to effective service delivery and financial sustainability for ESMI programs.

4. Please provide a description of the programs that the state funds to implement evidence-based practices for those with ESMI.

AHCCCS mandates the Coordinated Specialty Care (CSC) model as the foundational framework for all evidence-based practices (EBP) implemented in early serious mental illness (ESMI), including First Episode Psychosis (FEP). Currently, providers have adopted two CSC model programs: NAVIGATE and OnTrackNY. In addition to the CSC foundation, the following EBPs are integrated within programs across the state: Acceptance and Commitment Therapy (ACT), Cognitive Behavioral Therapy for psychosis (CBTp), Cognitive Enhancement Therapy (CET), Cognitive Remediation, Personal Medicine, Certified Clinical Trauma Specialist–Individual (CCTSI), Dialectical Behavior Therapy (DBT), Eye Movement Desensitization and Reprocessing (EMDR), Family Therapy Model, Motivational Interviewing (MI), Peer Support, Solution-Focused Brief Therapy (SFBT), and Somatic Experiencing.
AHCCCS employs ACC-Regional Behavioral Health Agreements (ACC-RBHAs) for the selection and fidelity oversight of FEP programs within each geographic service area (GSA). In Northern Arizona, Arizona Complete Health - Complete Care Plan Northern Region serves as the contracted ACC-RBHA, overseeing Mohave Mental Health Center, Southwest Behavioral and Health Services, and The Guidance Center. In Central Arizona, Mercy Care is the contracted ACC-RBHA, selecting Horizon Health and Wellness and Valleywise Health as FEP providers. In Southern Arizona, Arizona Complete Health - Complete Care Plan Southern Region is the contracted ACC-RBHA, with Banner (EPICenter) and Intermountain Center for Human Development (ICHD) designated as FEP providers. Descriptions of each program are provided below.

Mohave Mental Health Center (MMHC) is located in Mohave County, Arizona and serves the communities and surrounding areas of Kingman, Bullhead City, and Lake Havasu City, AZ and was established as an FEP provider in October of 2017. MMHC accepts individuals between the ages of 12-30 and utilize the CSC model by utilizing NAVIGATE in addition to other EBP as determined

clinically applicable to meet each member's needs. Although MMHC does not provide PCP services on site, their case managers coordinate with local Federally Qualified Health Centers to ensure integrated and effective continuum of care in relation to primary care services. Their assigned FEP personnel consist of a clinical director and 2 Behavioral Health Technicians. Members are able to receive medication management/psychiatric services at each clinic via tele-health or in-person appointments.

Southwest Behavioral and Health Services (SBWH) is located in Mohave County and Yavapai County, Arizona and serves the communities and surrounding areas of Kingman, Bullhead City, Lake Havasu City and Prescott Valley, AZ and was established as an FEP provider in October of 2024. SBWH accepts individuals between the ages of 15-40 and utilize the CSC model by utilizing NAVIGATE in addition to other EBP as determined clinically applicable to meet each member's needs. Although SBWH does not provide PCP services on site, their case managers coordinate with local Federally Qualified Health Centers to ensure integrated and effective continuum of care in relation to primary care services. Their assigned FEP personnel consist of a Peer Support Specialist and a Prescriber. Members are able to receive medication management/psychiatric services at each clinic via tele-health or in-person appointments.
The Guidance Center (TGC), located in Flagstaff, AZ, serves the Coconino County region and was established as an FEP provider in October of 2017. TGC accepts individuals between the ages of 12-30 and implements the CSC model by utilizing NAVIGATE. Although TGC does not provide PCP services on site, they do coordinate with local Federally Qualified Health Centers to ensure integrated and effective continuum of care in relation to primary care services. TGC's FEP personnel consist of a program manager, therapist, Behavioral Health Medical Practitioner, and (2) FEP care managers.

Banner Early Psychosis Intervention Center (EPICenter) is located in Tucson, AZ, and was established in 2010. The center was developed based on the CSC model using NAVIGATE programming. Banner EPICenter operates as a five-year program providing evidence-based, intensive, stage-specific treatment, including wraparound services for adolescents and young adults (aged 15 to 35) who are in the early stages of psychotic illness. The program has three primary functions: (a) early detection, (b) acute care during and immediately after a psychiatric crisis, and (c) recovery-focused continuing care. These include interventions intended to help young people maintain or regain their social, academic, and career paths during the initial 2-5 years after illness onset. Since 2015, Banner EPICenter has operated within the Banner University Whole Health Clinic (WHC), an integrated facility offering both primary and behavioral health services. The FEP team includes three psychologists, two psychology externs, a specialized recovery coordinator, a peer support specialist, and a communication specialist.

Intermountain Center for Human Development (ICHD), based in Tucson, delivers services through both satellite offices and rural clinicians in Cochise, Santa Cruz, and Yuma Counties. ICHD became an FEP (First Episode Psychosis) provider in October 2021 and began accepting referrals in January 2022. Established on the CSC (Coordinated Specialty Care) model, ICHD offers NAVIGATE programming to individuals. Comprehensive wraparound resources are available for clients aged 15-25 who have experienced a psychotic episode within the previous year. Treatment typically lasts between 12 and 18 months, with duration tailored to individual needs. ICHD collaborates with community partners to educate and promote early detection of psychosis, supporting timely identification and connection to specialized services. Referral pathways are developed with inpatient facilities, emergency departments, schools, crisis intervention programs, and the criminal justice system. Integrated health clinics providing both FEP and primary care are operational in Pima, Cochise, and Yuma Counties, with plans to establish primary care services in Santa Cruz County. The FEP team includes a clinical director, four clinicians, two outreach engagement specialists, a care coordinator, peer support staff, a behavioral health medical provider (BHMP), and a family nurse practitioner (FNP), ensuring comprehensive and integrated onsite service delivery.

The Valleywise Health First Episode Center manages two facilities serving Maricopa County, the most populous county in Arizona, with a third location currently under development. Plans are also being considered to introduce mobile FEP services to extend coverage to Pinal and Gila counties. All locations deliver care to individuals aged 15-25 who have received a qualifying diagnosis within the past two years. Each center implements the CSC model and integrates OnTrackNY programming to alter the typical progression associated with primary psychotic disorder diagnoses. The program emphasizes member education regarding their diagnosis and provides tools and resources to help address the disruptions that psychosis symptoms may cause in adolescents and young adults. Valleywise Health FEP programs employ evidence-based strategies such as Shared Decision Making, Cognitive Enhancement Therapy, mindfulness meditation, integrated and primary care, among others.
The West Valley facility, established in Avondale, AZ in February 2017, was the first Valleywise Health site to offer FEP services, staffed by a clinical director, clinical coordinator, medical assistant, patient services specialist, peer support specialist, program assistant, rehabilitation specialist, and team specialist. The East Valley location in Mesa, AZ, began providing FEP services in November 2022 and is staffed by a clinical director, clinical coordinator, peer support specialist, two team specialists, and a rehabilitation specialist.

Horizon Health and Wellness (HHW) operates multiple locations in Gila and Pinal counties. HHW serves individuals aged 15-25 who have received a qualifying diagnosis within the past two years. The organization implements the CSC model and utilizes OnTrack NY programming to address primary psychotic disorders. The program provides education about diagnoses and information on tools and resources to support individuals managing symptoms of psychosis. The HHW team includes skills trainers, team leaders, peer support specialists, clinicians, psychiatrists, recovery coaches, employment and education specialists, nurses, medical assistants, and community liaisons to offer services throughout these remote counties.

5. Does the state monitor fidelity of the chosen EBP(s)? (●) Yes ( ) No

6. Does the state or another entity provide trainings to increase capacity of providers to deliver interventions related to ESMI? (●) Yes ( ) No

7. Explain how programs increase access to essential services and improve client outcomes for those with an ESMI.

Arizona increases access to essential services and improves outcomes for individuals with Early Serious Mental Illness (ESMI) through a fully integrated, person-centered system of care led by the Arizona Health Care Cost Containment System (AHCCCS). This integrated model combines medical and behavioral health coverage under a single managed care plan, enabling more than two million Arizonans to receive coordinated services from a network of over 104,000 providers.

Three of the seven AHCCCS Complete Care Plans are designated as ACC–Regional Behavioral Health Agreements (ACC-RBHAs). These plans are fully integrated and specifically responsible for coordinating acute and behavioral health services for individuals with ESMI, first episode psychosis (FEP), serious emotional disturbance (SED), and serious mental illness (SMI). By aligning medical and behavioral health providers within the same network, AHCCCS reduces service fragmentation and promotes better health outcomes through consistent, whole-person care.

For children in foster care—who are at elevated risk for psychosis—AHCCCS integrates physical, dental, and behavioral health services under one plan. This ensures early identification and intervention, which is critical for improving long-term outcomes. The use of Child and Family Teams (CFTs) for youth and Adult Recovery Teams (ARTs) for adults further supports integrated care planning, ensuring that individuals with psychosis receive evidence-based treatment for both mental and physical health needs.

At the core of Arizona's ESMI strategy is the Coordinated Specialty Care (CSC) model, which serves as the foundation for all evidence-based practices (EBPs) funded through the 10% set-aside for ESMI/FEP programs. Northern and Southern Arizona implement the NAVIGATE program, while Central Arizona uses OnTrackNY. These models are supported by ongoing training and consultation to ensure fidelity and up-to-date clinical practice.

In addition to CSC, providers across the state utilize a wide range of EBPs tailored to the needs of individuals with early psychosis. These include Acceptance and Commitment Therapy (ACT), Cognitive Behavioral Therapy (CBT) for psychosis, Cognitive Enhancement Therapy (CET), Cognitive Remediation, Personal Medicine, Certified Clinical Trauma Specialist–Individual (CCTSI), Dialectical Behavior Therapy (DBT), Eye Movement Desensitization and Reprocessing (EMDR), Family Therapy, Motivational Interviewing (MI), Peer Support, Solution-Focused Brief Therapy (SFBT), and Somatic Experiencing.

To ensure quality and consistency, AHCCCS monitors the implementation of these practices through contractual deliverables and policy requirements. Regular training, recertification, and performance tracking are built into the system to maintain high standards of care.

The CSC model, validated through the Recovery After an Initial Schizophrenia Episode (RAISE) project, emphasizes a recovery-oriented approach that includes psychotherapy, medication management, family education and support, case management, and supported education and employment. Services are delivered through multidisciplinary teams that collaborate with individuals and their families to develop personalized treatment plans, ensuring that care is both effective and empowering.

This comprehensive, integrated approach not only increases access to essential services for individuals with ESMI but also fosters long-term recovery, resilience, and improved quality of life.

8. Please describe the planned activities in FY2026 and FY2027 for your state's ESMI programs.

For Fiscal Years 2026 and 2027, the Arizona Health Care Cost Containment System (AHCCCS) will continue to advance its Early Serious Mental Illness (ESMI) programs through comprehensive oversight and strengthened partnerships with ACC–Regional Behavioral Health Agreements (ACC-RBHAs) and contracted providers. These efforts are designed to enhance infrastructure, expand service delivery, and improve outcomes for individuals experiencing early psychosis or related conditions.

As part of this initiative, ACC-RBHAs are required to submit detailed ESMI and First Episode Psychosis (FEP) grant proposals to the Mental Health Block Grant (MHBG) team. These proposals must be comprehensive, outlining plans for infrastructure development, direct service provision, program expansion, and full utilization of MHBG FEP funding. Each plan must include a framework for identifying quantifiable ESMI objectives, which are refined iteratively to ensure clarity and alignment with program goals.

The proposals also detail methodologies and data sources used to identify FEP-eligible individuals, including children in school systems, individuals at risk of suicide, and those living in rural or homeless settings. Additional components include targeted outreach, suicide prevention strategies, and oversight of person-centered care. AHCCCS provides templates to guide providers in outlining specific initiatives and establishing clear metrics for evaluating success.

AHCCCS remains committed to rigorous monitoring of the Coordinated Specialty Care (CSC) model, ensuring that all essential components—such as case management, group counseling, family education, individual therapy, medication management, peer support, primary care coordination, and supported employment and education—are consistently available statewide for individuals diagnosed with ESMI or FEP.

In the upcoming federal fiscal year, AHCCCS will continue collaborating with ACC-RBHAs to support initial certification or

recertification in approved evidence-based practices (EBPs), including NAVIGATE and OnTrackNY. These partnerships will also focus on enhancing and expanding ESMI/FEP services, with particular attention to underserved rural and frontier regions, as well as planned growth within central Arizona.

Through these strategic activities, AHCCCS aims to strengthen Arizona's behavioral health infrastructure, improve access to early intervention services, and promote recovery-oriented outcomes for individuals with ESMI.

9. Please list the diagnostic categories identified for each of your state's ESMI programs.

In accordance with the Arizona Health Care Cost Containment System (AHCCCS) Medical Policy Manual (AMPM) Policy 320-T1, the following diagnostic categories are recognized as qualifying under Early Serious Mental Illness (ESMI) and First Episode Psychosis (FEP) programs. These categories exclude conditions primarily attributable to the physiological effects of a substance use disorder (SUD), intellectual or developmental disabilities, or other medical conditions:
a. Delusional Disorder

b. Brief Psychotic Disorder

c. Schizophreniform Disorder

d. Schizophrenia

e. Schizoaffective Disorder

f. Other Specified Schizophrenia Spectrum and Other Psychotic Disorder

g. Unspecified Schizophrenia Spectrum and Other Psychotic Disorder

h. Bipolar and Related Disorders with Psychotic Features

i. Depressive Disorders with Psychotic Features
All individuals currently served through Arizona's ESMI/FEP programs have diagnoses that fall within the categories listed above.

10. What is the estimated incidence of individuals experiencing first episode psychosis in the state?

To estimate the incidence of individuals experiencing first episode psychosis in the state, AHCCCS utilized two primary data sources: internal deliverables from ACC-Regional Behavioral Health Agreements (ACC-RBHAs) and projections from the OnTrackNY interactive tool.
• According to the OnTrackNY tool, the estimated number of new active individuals receiving services per year is 276, while the projected number of incident cases approached is 553.
• In comparison, AHCCCS deliverable data for fiscal year 2022 reported 150 new active individuals receiving services and 462 incident cases approached.
These estimates suggest that the annual incidence of individuals experiencing first episode psychosis in Arizona likely falls within the range of 462 to 553 individuals approached, with 150 to 276 individuals actively entering services.

11. What is the state's plan to outreach and engage those experiencing ESMI who need support from the public mental health system?

Arizona's plan to outreach and engage individuals experiencing Early Serious Mental Illness (ESMI) is led by the Arizona Health Care Cost Containment System (AHCCCS) through a comprehensive, multi-layered strategy embedded within its integrated health care model. By unifying medical and behavioral health services under a single managed care plan, AHCCCS ensures that outreach and engagement efforts are consistently applied across the full continuum of care.

Central to this strategy are the ACC–Regional Behavioral Health Authorities (ACC-RBHAs), which are contracted to monitor the fidelity of ESMI programs within their designated Geographic Service Areas (GSAs). These entities implement a wide range of outreach initiatives, including community education, provider training, and public awareness campaigns designed to connect individuals with ESMI to available services.

The outreach approach is multifaceted, focusing on increasing awareness, improving engagement, and facilitating access to care. Key components include:
• Community Involvement and Education: ACC-RBHAs and provider organizations host public meetings, professional training sessions, and informational events to raise awareness and build relationships with schools, local organizations, and referral sources. These efforts help identify individuals early and connect them to appropriate services.
• Media and Digital Outreach: AHCCCS collaborates with media outlets to produce radio segments and digital advertisements that promote ESMI services. These campaigns direct the public to online platforms featuring resources, success stories, and guidance on accessing care.
• Stakeholder Collaboration: Regular communication with providers and community partners—including clinical case reviews and formal presentations—ensures transparency and strengthens referral pathways. This intersectoral cooperation supports timely identification and engagement of eligible individuals.
• Targeted Communications: Using data such as location, diagnosis, age, and behavioral health claims, organizations proactively

identify individuals who may benefit from ESMI services. Outreach through email and mailed materials ensures that prospective members receive timely information about available resources and how to access them.
• Ongoing Education and Training: AHCCCS prioritizes continuous education for stakeholders, offering specialized training to educators, correctional officers, crisis responders, and healthcare professionals. These efforts equip frontline personnel to recognize signs of early serious mental illness and respond effectively.
• Referral Network Development: Strengthening referral networks is a key focus, particularly for individuals in rural or homeless settings. AHCCCS supports relationship-building with healthcare and educational institutions and leverages digital outreach, print materials, and community-based activities to ensure efficient connection to care.

Together, these coordinated efforts form a robust framework that enhances visibility, accessibility, and enrollment in ESMI services. By proactively engaging individuals and their communities, Arizona ensures that those in need receive timely, comprehensive support from the public mental health system.

12. Please indicate area of technical assistance needs related to this section.

No technical assistance needs a this time.

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Footnotes:

Environmental Factors and Plan

3. Person Centered Planning (PCP) – Required for MHBG, Requested for SUPTRS BG

Narrative Question

States must engage adults with a serious mental illness or children with a serious emotional disturbance and their caregivers in making health care decisions, including activities that enhance communication among individuals, families, caregivers, and treatment providers. Person-centered planning (PCP) is a process through which individuals develop their plan of service based on their chosen, individualized goals to improve their quality of life. The PCP process may include a representative who the person has freely chosen, and/or who is authorized to make personal or health decisions for the person. The PCP team may include family members, legal guardians, friends, caregivers and others that the person or his/her representative wishes to include. The PCP should involve the person receiving services and supports to the maximum extent possible, even if the person has a legal representative. The PCP approach identifies the person's strengths, goals, preferences, needs and desired outcome. The role of state and agency workers (for example, options counselors, support brokers, social workers, peer support workers, and others) in the PCP process is to enable and assist people to identify and access a unique mix of paid and unpaid services to meet their needs and provide support during planning. The person's goals and preferences in areas such as recreation, transportation, friendships, therapies, home, employment, education, family relationships, and treatments are part of a written plan that is consistent with the person's needs and desires.

In addition to adopting PCP at the service level, for PCP to be fully implemented it is important for states to develop systems which incorporate the concepts throughout all levels of the mental health network. PCP resources may be accessed from **https://acl.gov/news-and-events/announcements/person-centered-practices-resources**

1. Does your state have policies related to person centered planning? (●) Yes ( ) No

2. If no, describe any action steps planned by the state in developing PCP initiatives in the future.

N/A

3. Describe how the state engages people with SMI and their caregivers in making health care decisions, and enhances communication.

AHCCCS has implemented person-centered planning for populations we serve.?This has been a collaborative effort and partnership with the individuals we serve, family members, advocates, and community stakeholders.?

An essential part of person-centered planning is that the person drives the process.?They are the experts of their own lives and are at the center of the “person-centered planning” process. It is essential to gather their input, hear their voice and choice of treatment/services, who they want involved in their treatment planning process, and ensure access to care is timely and efficient.?

Person-Centered Planning is based upon a foundation of Person-Centered Thinking (PCT), which inspires and guides respectful listening leading to actions, resulting in individuals who:

Have positive control over the life they desire and find satisfying

Are recognized and valued for their contributions to their journey toward recovery and to their families, people of support and their community/ies

Are supported by a network of relationships, both natural and paid, within their community

Are offered employment opportunities, education, vocational training, and opportunities to work/not work depending on an individual’s needs and choices.

The AHCCCS Medical Policy Manual (AMPM) Policy 320-O: Behavioral Health Assessments and Treatment Service Planning https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/300/320-O.pdf specifies provision for Behavioral health assessment, services and/or treatment planning for individuals we serve. Including outlining additional requirements for individuals with SMI designations. Provider case managers are responsible for monitoring the member’s current needs, services, and progress through regular and ongoing contact. Treatment plans are to be reviewed and updated annually at a minimum or based on individual needs.

4. Describe the person-centered planning process in your state.

Arizona’s Medicaid agency, the Arizona Health Care Cost Containment System (AHCCCS), has established a comprehensive and person-centered approach to service planning across its long-term care, developmental disabilities, and behavioral health systems. This approach ensures that individuals receiving services are actively involved in shaping their care, with a focus on dignity, autonomy, and community involvement.

Person-centered service planning is a foundational requirement for all members enrolled in the Arizona Long Term Care System (ALTCS). The process begins with a thorough assessment of the member's functional needs and results in the development of a Person-Centered Service Plan (PCSP). This written plan outlines both paid and unpaid supports—including behavioral health services—that are important to and for the member. The PCSP also identifies potential risks, including those affecting member rights, and includes contingency strategies to mitigate those risks. ALTCS case managers play a critical role in facilitating this process. They assess needs, identify barriers, and support members in creating a life aligned with their aspirations. The planning process is standardized to ensure consistency in documentation and promotes meaningful conversations that inform goal development and service delivery.

Support Coordinators within the Division of Developmental Disabilities (DDD) are trained in person-centered planning and apply this approach to empower individuals with developmental disabilities. The planning process emphasizes the member's voice and choice, fostering independence and self-determination. Support Coordinators assist individuals in identifying their goals and ensuring that services are responsive to their needs and preferences, enabling them to live the life they choose.

AHCCCS' Adult System of Care (ASOC) provides a continuum of coordinated services for adults with behavioral health challenges. The system is guided by Nine Principles of Recovery. The planning process is collaborative, involving individuals served, their families, advocates, and service providers in shared decision-making. In addition, Arizona/AHCCCS collaborated with the child, family, and others to provide services that are tailored to meet the needs of children with serious emotional disturbances and their caregivers. The goal is to ensure that services are provided to the child and family in the most appropriate setting, in a timely manner, in accordance with the best practices and respecting the child and family

For children with serious emotional disturbances, AHCCCS has developed Twelve Principles that guide behavioral health service delivery. These principles emphasize collaboration with families, functional outcomes, accessibility, cultural respect, and stability. Service plans are developed through joint assessments involving families and multi-agency teams, ensuring that services are tailored to the child's unique strengths and needs. The planning process also anticipates change and crises, providing strategies to maintain stability and continuity of care.

Across all systems, AHCCCS fosters a person-centered planning environment that is transparent, flexible, and responsive. The planning process is a living document that evolves with the individual's needs and goals. By centering services around the person, Arizona ensures that individuals have full access to community living, meaningful support, and the opportunity to lead self-directed lives.

5. What methods does the SMHA use to encourage people who use the public mental health system to develop Psychiatric Advance Directives (for example, through resources such as **A Practical Guide to Psychiatric Advance Directives**)?

The Arizona State Mental Health Authority (SMHA), through the Arizona Health Care Cost Containment System (AHCCCS), employs a multifaceted approach to encourage individuals who utilize the public mental health system to develop Psychiatric Advance Directives (PADs). These efforts are guided by the provisions outlined in the AHCCCS Medical Policy Manual (AMPM) Policy 640 – Advance Directives.

Under Policy 640, AHCCCS mandates that adult members—and when incapacitated, their legally authorized family members or surrogates as defined in A.R.S. §36-3231—receive comprehensive written information regarding Advance Directives. This includes a clear explanation of the member's rights under Arizona law, the provider's policies regarding the implementation of those rights, and any limitations due to conscientious objections. Providers must also describe applicable state laws, inform members of their right to file complaints with the Arizona Department of Health Services (ADHS) Division of Licensing Services, and outline procedures for follow-up when a member regains capacity.

To ensure consistent access to this information, providers are required to deliver it at key points of care, including at enrollment, upon admission to hospitals or nursing facilities, and when initiating services with home health agencies, hospices, or personal care providers. These requirements align with federal regulations under 42 CFR 489.102(e) and 42 U.S.C. § 1396a(w)(2).

In addition to these regulatory measures, Arizona's Regional Behavioral Health Authorities (RBHAs) offer supplemental resources and educational materials to support the development of PADs. Providers are expected to disperse these resources into their standard practices, thereby reinforcing the importance of proactive treatment planning.

A cornerstone of Arizona's strategy is the widespread use of the Wellness Recovery Action Plan (WRAP), an evidence-based, self-directed tool that empowers individuals to manage their mental health and maintain autonomy during periods of crisis. Section 5 of the WRAP serves as a Psychiatric Advance Directive, enabling individuals to identify early warning signs, designate trusted supporters, communicate treatment preferences, and outline helpful and unhelpful interventions. This approach not only promotes self-determination but also ensures that care remains aligned with the members values and goals, even when they are unable to advocate for themselves.

Together, these methods reflect Arizona's commitment to person-centered care and align with national best practices, such as those outlined in SAMHSA's A Practical Guide to Psychiatric Advance Directives.

6. Please indicate areas of technical assistance needs related to this section.

No technical assistance needs at this time

Footnotes:

Environmental Factors and Plan

4. Program Integrity – Required for MHBG & SUPTRS BG

Narrative Question

There is a strong emphasis on ensuring that Block Grant funds are expended in amanner consistent with the statutory and regulatory framework. This requires that the federal government and the states have a strong approach to assuring program integrity. Currently, the primary goals of the federal government's program integrity efforts are to promote the proper expenditure of Block Grant funds, improve Block Grant program compliance nationally, and demonstrate the effective use of Block Grant funds

While some states have indicated an interest in using Block Grant funds for individual co-pays deductibles and other types of co-insurance for behavioral health services, states are reminded of restrictions on the use of Block Grant funds outlined in **42 U.S.C. § 300x–5** and **42 U.S.C § 300x-31**, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under **42 U.S.C. § 300x-55(g)**, there are periodic site visits to MHBG and SUPTRS BG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services made available to adults with SMI and children with SED and SUPTRS BG funds can only be used for individuals with or at risk for SUD. The 20% minimum primary prevention set-aside of SUPTRS BG funds should be used for universal, selective, and indicated substance use prevention. Guidance on the use of block grant funding for co-pays, deductibles, and premiums can be found at: **http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf**. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The MHBG and SUPTRS BG resources are to be used to support, not supplant, services that will be covered through private and public insurance. In addition, the federal government and states need to work together to identify strategies for sharing data, protocols, and information to assist Block Grant program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SUPTRS BG funds are allocated to support evidence-based substance use primary prevention, treatment and recovery programs, and activities for adults with SMI and children with SED.

States traditionally have employed a variety of strategies to procure and pay for behavioral health services funded by the MHBG and SUPTRS BG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered mental health and SUD benefits; (3) ensuring that consumers of mental health and SUD services have full confidence in the confidentiality of their medical information; and (4) monitoring the use of mental health and SUD benefits in light of utilization review, medical necessity, etc. Consequently, states may have to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

Please respond to the following items:

1. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers? (●) Yes ( ) No
2. Does the state provide technical assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards? (●) Yes ( ) No
3. Does the state have any activities related to this section that you would like to highlight?

   No activities that AHCCCS would like to highlight.
4. Please indicate areas of technical assistance needs related to this section.

   No technical assistance needs at this time.

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Footnotes:

Environmental Factors and Plan

5. Primary Prevention – Required for SUPTRS BG

Narrative Question

SUPTRS BG statute requires states to spend a minimum of 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment which programs (A) educate and counsel the individuals on substance use and substance use disorders; and (B) provide for activities to reduce the risk of substance use and substance use disorders by the individual. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SUPTRS BG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must serve both the general population and sub-groups that are at high risk for substance use. The program must include, but is not limited to, the following strategies:

1. ***Information dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, misuse and substance use disorders on individuals families and communities.
2. ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. ***Alternative programs*** that provide for the participation of priority populations in activities that exclude alcohol, tobacco, and other drug use.
4. ***Problem identification and Referral*** that aims at identification of those who have engaged in illegal/age-inappropriate use of tobacco or alcohol, and those individuals who have engaged in initial use of illicit drugs, in order to assess if the behavior can be addressed by education or other interventions to prevent further use.
5. ***Community-based processes*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. ***Environmental strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the use of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that serve populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Assessment

1. Does your state have an active State Epidemiological and Outcomes Workgroup (SEOW)? (●) Yes ( ) No

2. Does your state collect the following types of data as part of its primary prevention needs assessment process? (check all that apply):

- **a)** ☑ Data on consequences of substance-using behaviors
- **b)** ☑ Substance-using behaviors
- **c)** ☑ Intervening variables (including risk and protective factors)
- **d)** ☐ Other (please list)

3. Does your state collect needs assesment data that include analysis of primary prevention needs for the following population groups? (check all that apply)

- **a)** ☑ Children (under age 12)
- **b)** ☑ Youth (ages 12-17)
- **c)** ☑ Young adults/college age (ages 18-26)
- **d)** ☐ Adults (ages 27-54)
- **e)** ☑ Older adults (age 55 and above)
- **f)** ☑ Rural communities

i) ☐ Other (please list)

4. Does your state use data from the following sources in its primary prevention needs assesment? (check all that apply):

a) ☐ Archival indicators (Please list)

b) ☑ National survey on Drug Use and Health (NSDUH)

c) ☑ Behavioral Risk Factor Surveillance System (BRFSS)

d) ☑ Youth Risk Behavioral Surveillance System (YRBS)

e) ☐ Monitoring the Future

f) ☐ Communities that Care

g) ☑ State-developed survey instrument

h) ☐ Other (please list)

5. Does your state use needs assessment data to make decisions about the allocation of SUPTRS BG primary prevention funds? ◉ Yes ○ No

a) If yes, (please explain in the box below)

AHCCCS recently (2025) contracted with LeCroy & Milligan Associates (LMA) to complete a comprehensive Statewide Prevention Needs Assessment to evaluate the current state of substance use prevention efforts across Arizona. This assessment was conducted to inform strategic decision-making and ensure that prevention initiatives are responsive to the evolving needs of communities throughout the state.

Upon reviewing the findings, AHCCCS determined that many of the identified needs are already being addressed through existing funding mechanisms. However, to maximize impact and reach more Arizonans, AHCCCS has identified key strategic priorities that will guide future planning and resource allocation.

The first priority focuses on expanding and strengthening the prevention workforce to better meet the unique needs of local communities. AHCCCS recognizes the importance of recruiting and retaining qualified professionals, particularly in rural areas where access to services is limited. The second priority emphasizes strengthening access and reach in programming. AHCCCS is committed to prioritizing funding for high-need and under-reached populations, including rural communities. To better serve these groups, improving prevention messaging and education represents the third strategic priority. Youth-developed social media campaigns are recommended to amplify peer-to-peer messaging, as well as training for school staff to help them recognize and respond to new substance use trends and devices. The fourth priority centers on promoting systemic coordination and cross-sector collaboration. AHCCCS is reviewing these recommendations to put plans and funding allocations in place to build a more responsive, effective prevention system that addresses the root causes of substance use and promotes the health and well-being of all Arizonans.

b) If no, please explain how SUPTRS BG funds are allocated:

Narratve Question

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The SUPTRS BG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must serve both the general population and sub-groups that are at high risk for substance use. The program must include, but is not limited to, the following strategies:

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Capacity Building

1. Does your state have a statewide licensing or certification program for the substance use primary prevention workforce? ○ Yes ◉ No

a) If yes, please describe.

N/A

2. Does your state have a formal mechanism to provide training and technical assistance to the substance use primary prevention workforce? ◉ Yes ○ No

a) If yes, please describe mechanism used.

Arizona has a formal mechanism to provide training and technical assistance (TA) to its substance use primary prevention workforce through partnerships with national and regional organizations. AHCCCS collaborates with the Prevention Technology Transfer Center (PTTC) and the Strategic Prevention Technical Assistance Center (SPTAC), both supported by SAMHSA. PTTC offers webinars, certification programs, and workshops focused on trauma-informed care, emerging substance use trends, and addressing community-specific needs. SPTAC provides specialized TA specific to SUBG subrecipients. In July 2025, AHCCCS partnered with SPTAC to offer evaluation basics training to subrecipients. To further assess and support workforce needs, AHCCCS and LeCroy & Milligan Associates (LMA) conducted a statewide workforce survey as part of the 2025 Prevention Needs Assessment. The survey, along with listening sessions and stakeholder interviews, identified training gaps in areas such as fentanyl awareness, effective communication to reach all Arizonans, and support for rural and tribal staff. These findings inform AHCCCS's ongoing TA efforts and help shape a responsive, community-informed prevention infrastructure across Arizona.

3. Does your state have a formal mechanism to assess community readiness to implement prevention strategies? ◉ Yes ○ No

a) If yes, please describe mechanism used.

Arizona uses the Strategic Prevention Framework (SPF) model to assess community readiness for implementing prevention strategies. As part of this model, AHCCCS conducts a statewide prevention needs assessment every 3–5 years, with the most recent completed in June 2025. This assessment identified readiness factors such as workforce capacity, funding

gaps, and community relevance of prevention programming. It recommends expanding resources, supporting peer-led models, and integrating community values like Indigenous healing traditions to improve local engagement and effectiveness. In addition to the statewide assessment, AHCCCS requires prevention coalition subrecipients to submit annual workforce development plans. These plans outline staff training and development strategies to ensure providers are equipped to deliver prevention services effectively, especially in areas with high turnover. Together, these mechanisms help AHCCCS evaluate and strengthen community readiness across Arizona regions and populations.

Narratve Question

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Planning

1. Does your state have a strategic plan that addresses substance use primary prevention that was developed within the last five years? (●) Yes ( ) No

If yes, please attach the plan in WebBGAS

Plan will be attached

2. Does your state use the strategic plan to make decisions about use of the primary prevention set-aside of the SUPTRS BG?

- [x] Yes
- [ ] No
- [ ] Not applicable (no prevention strategic plan)

3. Does your state's prevention strategic plan include the following components? (check all that apply):

- **a)** [x] Based on needs assessment datasets the priorities that guide the allocation of SUPTRS BG primary prevention funds
- **b)** [x] Timelines
- **c)** [x] Roles and responsibilities
- **d)** [x] Process indicators
- **e)** [x] Outcome indicators
- **f)** [ ] Not applicable/no prevention strategic plan

4. Does your state have an Advisory Council that provides input into decisions about the use of SUPTRS BG primary prevention funds? (●) Yes ( ) No

a) Does the composition of the Advisory Council represent the demographics of the State? (●) Yes ( ) No

5. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SUPTRS BG primary prevention funds? (●) Yes ( ) No

a) If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based?

Arizona does not have a formal Evidence-Based Workgroup dedicated solely to SUPTRS BG primary prevention funds, but AHCCCS prevention staff actively lead decision-making on appropriate strategies with support from State, regional, and local partners. These decisions are guided by SAMHSA's evidence-based criteria as well as contract requirements that mandate the use of evidence-based, research-based, or promising practices. AHCCCS also allows for innovative interventions under strict conditions, requiring providers to submit a formal protocol for review and approval that includes justification, evaluation methodology, and risk mitigation strategies.

To ensure quality and alignment with evidence-based standards, AHCCCS staff are trained in Substance Abuse Prevention Skills Training (SAPST) and/or Core Competencies in Prevention, Prevention Ethics, and other best practices trainings through national and regional training platforms. AHCCCS collaborates with entities such as the Pacific Southwest PTTC and the Arizona Substance Abuse Partnership (ASAP) to stay informed on current evidence-based practices.

Narratve Question

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In implementing the comprehensive primary prevention program, states should use a variety of strategies that serve populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Implementation

1. States distribute SUPTRS BG primary prevention funds in a variety of different ways. Please check all that apply to your state:

- **a)** ☐ SSA staff directly implements primary prevention programs and strategies.
- **b)** ☑ The SSA has statewide contracts (e.g. statewide needs assessment contract, statewide workforce training contract, statewide media campaign contract).
- **c)** ☑ The SSA funds regional entities that are autonomous in that they issue and manage their own sub-contracts.
- **d)** ☑ The SSA funds regional entities that provide training and technical assistance.
- **e)** ☑ The SSA funds regional entities to provide prevention services.
- **f)** ☑ The SSA funds county, city, or tribal governments to provide prevention services.
- **g)** ☑ The SSA funds community coalitions to provide prevention services.
- **h)** ☑ The SSA funds individual programs that are not part of a larger community effort.
- **i)** ☑ The SSA directly funds other state agency prevention programs.
- **j)** ☐ Other (please describe)

2. Please list the specific primary prevention programs, practices, and strategies that are funded with SUPTRS BG primary prevention dollars in at least one of the six prevention strategies. Please see the introduction above for definitions of the six strategies:

a) Information Dissemination:

Social media campaigns
· Printed material dissemination
· Radio advertising
· Billboards
· Newsletters
· Resource fairs

· Speaking engagements

b) Education:

• Evidence-based and promising practice curriculum administered in schools and summer camps
• Community prevention education workshops for youth and adults
• Examples include: Too Good for Drugs, Lion's Quest, Rx360, Alcohol360, Botvin's Life Skills, PAX Good Behavior Game, PAX Tools, Thrive, and many more.

c) Alternatives:

Substance free community events for youth and families.
Red ribbon week activities
Youth summer camps·
Youth and adult leadership activities
On campus Sober nights (IHEs)

d) Problem Identification and Referral:

Collaborative partnerships with direct service agencies.
multiple coalitions collaborated to identify youth and families in need of substance use prevention and provided targeted referrals and educational interventions.
LPKNC partnered with juvenile probation to deliver alcohol and marijuana education to referred students.
MATFORCE supported schools and juvenile probation by distributing parent folders and sanction packets, and delivering educational sessions in juvenile detention centers, accommodation schools, and adult diversion programs
AZYP engaged with an alternative school to present marijuana and vaping education to diversion students.
PAACE implemented the evidence-based "Catch My Breath" curriculum as a diversion strategy for students caught vaping on campus, aiming to reduce suspension time and increase classroom reintegration. The program was successfully launched in two schools, with five students completing it and plans for continued education and focus groups.
Child & Family Resources identified five individuals with substance use or mental health needs and referred them to appropriate community services. Casa Grande Alliance facilitated planning meetings with local schools to implement the Catch My Breath program and explore additional interventions to address vaping-related suspensions.
Community Bridges responded promptly to its first referral from the Boys & Girls Club, enrolling a youth in services within 24 hours, demonstrating effective coordination and responsiveness.
The Hopi Foundation exemplified trauma-informed care by immediately enrolling a walk-in community member into prevention and peer recovery services, showcasing person-first practices.

e) Community-Based Processes:

Monthly coalition meetings
Youth leadership committees
Community and volunteer training
Systematic planning

f) Environmental:

Collaboration with schools and community stakeholders.
· Community drug take back events
· Council meetings
· Review board participation
· Distribution of medication lock boxes
· Promoting/reviewing alcohol, tobacco, and drug use policies in schools

3. Does your state have a process in place to ensure that SUPTRS BG dollars are used only to fund primary prevention services not funded through other means? (●) Yes ( ) No

a) Yes (if so, please describe)

AHCCCS has established a multi-layered process to ensure that Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUPTRS BG) dollars are used exclusively for primary prevention services not funded through other means. All contracted prevention providers are required to submit detailed budgets for review prior to the start of work, allowing AHCCCS program and finance staff to assess planned activities and expenditures for duplication with other funding sources such as State Opioid Response or other State and federal grants. If potential overlap or supplanting is identified, AHCCCS provides feedback and requires cost allocation or adjustments to ensure compliance.

To further prevent duplication, AHCCCS actively participates in statewide collaborations with entities such the Substance Awareness Coalition Leaders of Arizona (SACLAz), Arizona Substance Abuse Partnership (ASAP), Governor's Office of Youth Faith and Family (GOYFF), Matforce, others, maintaining a crosswalk of providers funded through various streams. This coordination helps identify gaps and avoid overlapping primary prevention efforts. Additionally, AHCCCS enforces contract deliverables—including strategic plans, evaluation plans, and expenditure reports—which are reviewed for alignment with grant requirements. Prevention staff are trained in prevention ethics and best practices, and AHCCCS works closely with GOYFF and Matforce who asisst in administering the grant to community-based and direct service providers to monitor provider activities and ensure that SUPTRS BG funds are used appropriately and effectively to support primary prevention efforts across Arizona.

Narratve Question

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Evaluation

1. Does your state have an evaluation plan for substance use primary prevention that was developed within the last five years? (●) Yes ( ) No

If yes, please attach the plan in WebBGAS

Will be attached

2. Does your state's prevention evaluation plan include the following components? (check all that apply):

- **a)** ☑ Establishes methods for monitoring progress towards outcomes, such as prioritized benchmarks
- **b)** ☑ Includes evaluation information from sub-recipients
- **c)** ☑ Includes National Outcome Measurement (NOMs) requirements
- **d)** ☑ Establishes a process for providing timely evaluation information to stakeholders
- **e)** ☑ Formalizes processes for incorporating evaluation findings into resource allocation and decision-making
- **f)** ☐ Other (please describe):
- **g)** ☐ Not applicable/no prevention evaluation plan

3. Please check those process measures listed below that your state collects on its SUPTRS BG funded prevention services:

- **a)** ☑ Numbers served
- **b)** ☑ Implementation fidelity
- **c)** ☐ Participant satisfaction
- **d)** ☑ Number of evidence based programs/practices/policies implemented
- **e)** ☑ Attendance
- **f)** ☑ Demographic information
- **g)** ☑ Other (please describe):

Narrative reports are optional, requesting subrecipients to provide a brief narrative to report on items that are not otherwise captured.

4. Please check those outcome measures listed below that your state collects on its SUPTRS BG funded prevention services:

- **a)** ☑ 30-day use of alcohol, tobacco, prescription drugs, etc
- **b)** ☑ Heavy alcohol use
- **c)** ☑ Binge alcohol use
- **d)** ☑ Perception of harm
- **e)** ☑ Disapproval of use
- **f)** ☑ Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)
- **g)** ☑ Other (please describe):

AHCCCS worked with a contracted evaluation consultant to develop pre- and post-survey tools for SUBG subrecipients to administer as part of prevention direct service education programming. The tool is based off of National Outcome Measures (NOMs) and also includes additional optional measures for prevention programs to choose from. The pre- and post-surveys are to be customized to the program being implemented to measure the most appropriate outcomes being targeted by the programming.

Footnotes:

1. A prevention needs assessment was completed in May 2025. However, AHCCCS opts to not attach it to the application due to some findings and recommendations within the report not being in alignment with current Presidential Executive Orders (EOs) and SAMHSA Strategic Priorities. The needs assessment is used to guide state prevention efforts, but recommendations from the needs assessment that are in conflict with EOs and SAMHSA Strategic Priorities will not be implemented. - EH 11/6/25.
2. A prevention strategic plan was last completed in 2020. However, AHCCCS opts not to attach it because it is not reflective of current prevention efforts, and a new strategic plan is planned for 2025-2026. - EH 11/6/25.

Environmental Factors and Plan

6. Statutory Criterion for MHBG - Required for MHBG

Narrative Question

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness, including those with co-occurring mental and substance use disorders. Describes available services and resources within a comprehensive system of care, provided with federal, state, and other public and private resources, in order to enable such individual to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

Please respond to the following items

Criterion 1

1. Describe available services and resources in order to enable individuals with mental illness, including those with co-occurring mental and substance use disorders to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

AHCCCS is committed to supporting individuals with mental illness, including those with co-occurring substance use disorders, in living independently and functioning outside of inpatient or residential institutions to the fullest extent of their capabilities. This commitment is realized through a robust network of services administered by AHCCCS Complete Care Regional Behavioral Health Agreements (ACC-RBHAs), Tribal Regional Behavioral Health Authorities (TRBHAs), and Managed Care Organizations (MCOs), which oversee the delivery of comprehensive physical and behavioral health care across the state.

Arizona's system of care offers a wide range of outpatient services for individuals experiencing Serious Mental Illness (SMI), Serious Emotional Disturbance (SED), Early Serious Mental Illness/First Episode Psychosis (ESMI/FEP), general mental health conditions, substance use disorders (SUDs), and co-occurring conditions. These services are primarily delivered through Integrated Health Homes, Outpatient Treatment Clinics, Substance Use Clinics, Medication-Assisted Treatment (MAT) Clinics, and Federally Qualified Health Centers (FQHCs). Many of these facilities include on-site Primary Care Physicians, pharmacy, and laboratory services to address physical health needs. When primary care is not available on-site, Health Homes are expected to coordinate care across behavioral, medical, and physical health providers to ensure whole-person care.

The service array includes case management, psychiatric evaluations, medication management, nursing, rehabilitation, vocational and employment support, and educational services. Housing assistance is also available, including help with rental applications and community living supports. Integrated care is a central priority, with seamless coordination between behavioral health and primary care providers to improve health outcomes and reduce service fragmentation.

Substance use treatment is readily accessible and includes MAT, individual and group counseling, and coordinated care. Crisis services, such as 24/7 mobile crisis team interventions, are available to stabilize individuals experiencing acute symptoms and prevent unnecessary hospitalization.

Members can also access a variety of counseling options—individual, group, family, and couples therapy—alongside peer and family support services. Non-emergency transportation and assistance with applying for benefits such as Medicaid, Social Security, food stamps, and public assistance are provided to reduce barriers to care.

All services are guided by evidence-based practices, including Assertive Community Treatment (ACT), Cognitive Behavioral Therapy (CBT), Dialectical Behavior Therapy (DBT), Applied Behavior Analysis (ABA), Permanent Supportive Housing (PSH), trauma-informed care, and motivational interviewing. Each member's care is coordinated through an Individual Service Plan (ISP), which is tailored to their unique needs and connects them with both clinical and community-based supports. Through this integrated and person-centered approach, AHCCCS ensures that individuals can thrive in their communities with the supports necessary to maintain stability and independence.

2. Does your state coordinate the following services under comprehensive community-based mental health service systems?

a)	Physical Health	(•) Yes	( ) No
b)	Mental Health	(•) Yes	( ) No
c)	Rehabilitation services	(•) Yes	( ) No
d)	Employment services	(•) Yes	( ) No
e)	Housing services	(•) Yes	( ) No
f)	Educational services	(•) Yes	( ) No
g)	Substance use prevention and SUD treatment services	(•) Yes	( ) No

h)	Medical and dental services	(●) Yes	( ) No
i)	Recovery Support services	( ) Yes	( ) No
j)	Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA)	(●) Yes	( ) No
k)	Services for persons with co-occuring M/SUDs	(●) Yes	( ) No

Please describe or clarify the services coordinated, as needed (for example, best practices, service needs, concerns, etc.)

3. Describe your state's case management services

Arizona's case management services, administered through AHCCCS, are designed to support individuals with behavioral health needs in achieving their treatment goals and maintaining stability in the community. These services are available across all AHCCCS-contracted health plans, including AHCCCS Complete Care Regional Behavioral Health Agreements (ACC-RBHAs), Tribal Behavioral Health Authorities (TRBHAs), and Managed Care Organizations (MCOs), and are tailored to meet the unique needs of each member.

Case management includes a wide range of activities such as coordinating behavioral health and medical services, assisting with access to community resources, supporting transitions between levels of care, and helping individuals apply for benefits. Case managers also provide outreach and follow-up after crisis contacts or missed appointments, ensuring continuity of care.

Services are delivered at varying levels of intensity based on clinical need. Assertive Community Treatment (ACT) teams serve adults with severe and persistent mental illness through a multidisciplinary approach that integrates care across systems. High Needs Case Management is available for children and adolescents with complex needs and multiple system involvement. Medium and Low Intensity Case Management supports adults based on their level of functioning and recovery progress.

Specialized teams such as Forensic Assertive Community Treatment (FACT) in Maricopa County address the needs of individuals with SMI who have had contact with the criminal justice system. These teams use evidence-based practices to reduce recidivism, improve health outcomes, and strengthen community supports. Similarly, Medical Assertive Community Treatment (MACT) teams serve individuals with both SMI and significant medical conditions, offering integrated behavioral and physical health care through a team that includes primary care providers.

All MCOs are required to submit annual Provider Case Management Plans detailing how they implement and monitor standards, caseload ratios, and performance outcomes. These plans also ensure that members and families are actively involved in decision-making, quality improvement, and service enhancement efforts. Through this structured and person-centered approach, Arizona's case management system promotes recovery, independence, and improved quality of life for individuals with mental health and co-occurring substance use disorders.

4. Describe activities intended to reduce hospitalizations and hospital stays.

AHCCCS implements a wide range of activities aimed at reducing hospitalizations and minimizing hospital stays for individuals with behavioral health needs. Central to this effort is Arizona's integrated System of Care, which offers coordinated community and facility-based services for both adults and children. The system emphasizes serving individuals in the least restrictive environment possible by providing personalized outpatient services and engaging natural supports to prevent crises and avoid inpatient admissions.

Case managers play a vital role in this approach by maintaining regular contact with individuals, monitoring their needs, and adjusting services through collaborative treatment planning. These efforts are supported by Arizona's nationally recognized crisis system, which includes 24/7 mobile crisis teams, crisis hotlines, stabilization centers, and peer-run respite programs. Crisis services are designed to be recovery-oriented and person-centered, with interventions tailored to stabilize individuals quickly and return them to baseline functioning.

Preventive strategies such as Wellness Recovery Action Plans (WRAP), psychiatric advance directives, safety planning, and peer-operated warm lines help individuals manage symptoms before they escalate. Post-crisis supports—including peer recovery coaching, family engagement, and follow-up outreach—further reduce the likelihood of hospitalization by ensuring continuity of care and connection to community resources.

AHCCCS also leads the Targeted Investment (TI) Program, which incentivizes providers to deliver integrated physical and behavioral health care. This program improves coordination, reduces fragmentation, and enhances outcomes for those with serious mental illness, substance use disorders, and co-occurring conditions. TI-supported practices include trauma-informed care, standardized behavioral health screenings in primary care, and real-time data sharing through Arizona's Health Information Exchange.

When hospitalizations do occur, Managed Care Organizations (MCOs), ACC-RBHAs, and providers are required to track admissions, monitor lengths of stay, and coordinate discharge planning. Care managers maintain contact with inpatient teams to ensure smooth transitions back into the community and prevent readmissions.

Together, these strategies reflect AHCCCS's commitment to proactive, integrated, and person-centered care that supports recovery and reduces reliance on inpatient treatment.

5. Please indicate areas of technical assistance needs related to this section.

No technical assistance needs at this time

Criterion 2: Mental Health System Data Epidemiology

Contains an estimate of the incidence and prevalence in the state of SMI among adults and SED among children; and have quantitative targets to be achieved in the implementation of the system of care described under Criterion 1.

Criterion 2

1. In order to complete column B of the table, please use the most recent federal prevalence estimate from the National Survey on Drug Use and Health or other federal/state data that describes the populations of focus.

Column C requires that the state indicate the expected incidence rate of individuals with SMI/SED who may require services in the state's M/SUD system.

MHBG Estimate of statewide prevalence and incidence rates of individuals with SMI/SED

Target Population (A)	Statewide prevalence (B)	Statewide incidence (C)
1.Adults with SMI	314875	.15%
2.Children with SED	215748	.25%

2. Describe the process by which your state calculates prevalence and incidence rates and provide an explanation as to how this information is used for planning purposes. If your state does not calculate these rates, but obtains them from another source, please describe. If your state does not use prevalence and incidence rates for planning purposes, indicate how system planning occurs in their absence.

Arizona calculates prevalence and incidence rates of serious mental illness (SMI) and serious emotional disturbance (SED) through a standardized eligibility determination process managed by AHCCCS. For adults, this process is outlined in AMPM Policy 320-P and involves behavioral health professionals evaluating individuals with qualifying diagnoses and submitting eligibility determinations to a third-party vendor. The vendor's psychiatrists review current and historical treatment records to assess whether the individual meets the diagnostic and functional criteria for SMI designation.
For children and adolescents under 18, SED identification is based on both a qualifying diagnosis and a functional impairment, measured using the Child and Adolescent Level of Care Utilization System (CALOCUS). A score of 2 or higher is required to meet the functional criteria, although the tool is not validated for children under five.
Once individuals are determined to meet SMI or SED criteria, they are assigned to a Regional Behavioral Health Authority (RBHA) and connected to a behavioral health home within their geographic service area. AHCCCS uses standardized reporting—based on expenditure and demographic data—to calculate the number of individuals served under these designations. These figures are then compared to the broader state population within the same demographic to estimate prevalence and incidence rates.
This data is essential for system planning. It informs the allocation of resources, guides service delivery through RBHAs and Tribal RBHAs (TRBHAs), and helps identify geographic or population-specific areas of need. By using prevalence and incidence rates in this way, Arizona ensures its behavioral health system remains responsive, equitable, and data-driven.

3. Please indicate areas of technical assistance needs related to this section.

No technical assistance needs at this time.

Criterion 3: Children's Services

Provides for a system of integrated services for children to receive care for their multiple needs.

Criterion 3

1. Does your state integrate the following services into a comprehensive system of care?[1]

a)	Social Services	◉ Yes	○ No
b)	Educational services, including services provided under IDEA	◉ Yes	○ No
c)	Juvenile justice services	◉ Yes	○ No
d)	Substance use prevention and SUD treatment services	◉ Yes	○ No
e)	Health and mental health services	◉ Yes	○ No
f)	Establishes defined geographic area for the provision of services of such systems	◉ Yes	○ No

2. Please indicate areas of technical assistance needs related to this section.

No technical assistance needed

[1] *A system of care is a spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families, that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help them to function better at home, in school, in the community, and throughout life.*

Criterion 4

a. Describe your state's tailored services to rural population with SMI/SED. See the federal **Rural Behavioral Health** page for program resources.

Arizona delivers tailored behavioral health services to rural populations with Serious Mental Illness (SMI) and Serious Emotional Disturbance (SED) through a regionally structured system overseen by AHCCCS. The state is divided into three Geographic Service Areas (GSAs), each served by ACC-Regional Behavioral Health Agreements (ACC-RBHAs), which are contracted to provide comprehensive behavioral and physical health services. These GSAs include extensive rural and tribal regions, with the Northern and Southern GSAs encompassing the majority of Arizona's rural counties. Additionally, four Tribal Regional Behavioral Health Authorities (TRBHAs) to serve tribal communities.
Each RBHA and TRBHA is responsible for building a service network that meets statewide standards while addressing the unique needs of their rural populations. This includes the use of Non-Title XIX/XXI state general funds to provide housing subsidies for individuals are unhoused, and who have been determined to have SMI. These subsidies are distributed across GSAs to ensure access in both urban and rural areas.
To further efforts the Arizona Health Improvement Plan (AzHIP) 2021–2025 outlines strategies to expand access to mental health services in rural areas. These include increasing telehealth options, promoting mental health outreach, enhancing suicide prevention training, and building a healthcare workforce through education and financial support initiatives.
To address unhoused individuals with SMI in rural areas, AHCCCS requires RBHAs and TRBHAs to participate in the HUD Continuum of Care (CoC) system. For rural counties lacking traditional homeless service infrastructure, Arizona Complete Health mandates that its health homes and housing providers serve as CoC Coordinated Entry sites. These sites conduct housing assessments, enter data into the Homeless Management Information System (HMIS), and enroll individuals in both CoC and AHCCCS housing programs.
Arizona also leverages the federally funded Project for Assistance in Transition from Homelessness (PATH) to support rural outreach. PATH teams operate in counties such as Coconino, Mohave, Yavapai, Cochise, and Pima, offering services like case management, peer support, housing assistance, SMI screening, substance use treatment, and referrals to healthcare and employment resources. These efforts are critical in linking individuals to the behavioral health system and reducing homelessness in rural communities.
Through this multi-layered approach—combining regional service delivery, housing coordination, telehealth expansion, and targeted outreach—Arizona ensures that rural residents with SMI and SED receive accessible, integrated, and person-centered care.

b. Describe your state's tailored services to people with SMI/SED experiencing homelessness. See the federal **Homeless Programs and Resources** for program resources[1]

Arizona provides a comprehensive and coordinated system of tailored services for individuals with Serious Mental Illness (SMI) or Serious Emotional Disturbance (SED) who are experiencing or at risk of homelessness. Administered by the Arizona Health Care Cost Containment System (AHCCCS), these services align with federal best practices, providing trauma-informed care, to promote housing stability, health, and recovery.
A cornerstone of Arizona's approach is the Project for Assistance in Transition from Homelessness (PATH), funded by SAMHSA. PATH supports outreach and engagement for individuals with SMI, including those with co-occurring substance use disorders, across six counties: Maricopa, Pima, Cochise, Coconino, Yavapai, and Mohave. Services include community health screenings, case management, field assessments, and assistance with basic needs such as food, Medicaid, and SSI/SSDI applications. PATH teams conduct outreach in areas where individuals experiencing homelessness are likely to be found and use evidence-based practices to prioritize the most vulnerable individuals. Once enrolled, individuals receive ongoing support and access to behavioral health care, with case plans reviewed quarterly.
PATH teams are fully integrated into the Continuum of Care (CoC) system, participating in coordinated entry, case conferencing, and the Homeless Management Information System (HMIS). They also contribute to the annual Point-in-Time (PIT) count, which helps track homelessness trends and inform planning. In 2024, notable reductions in homelessness were recorded, including a 5.6% decrease in Pima County and a 28.6% drop in Balance of State counties.
The AHCCCS Housing Program (AHP) further supports individuals with SMI by offering permanent supportive housing through scattered site rentals, community living programs, and project-based vouchers. These units meet federal Housing Quality Standards, and members contribute up to 30% of their income toward rent. Supportive services are funded through Medicaid and delivered by managed care health plans, ensuring a wraparound approach to care.
To expand these efforts, AHCCCS received approval for the Housing and Health Opportunities (H2O) demonstration under its 1115 Waiver. This initiative targets individuals with behavioral health needs, high service utilization, chronic conditions, and those transitioning from institutional settings. The H2O demonstration aims to improve health outcomes, reduce emergency service use, and increase housing stability.
Oversight and coordination are maintained through the Mental Health Block Grant (MHBG) team, which collaborates with PATH and monitors subrecipients through annual operational reviews. Subrecipients are required to maintain Memorandums of

Understanding (MOUs) with local ACC-RBHAs and TRBHAs to ensure seamless referrals and service integration.
Through these targeted programs and partnerships, Arizona is advancing a responsive, evidence-based system that addresses the complex needs of individuals with SMI/SED experiencing homelessness.

c. Describe your state's tailored services to the older adult population with SMI. See the federal **Resources for Older Adults** webpage for resources[2]

Arizona provides tailored services to older adults with Serious Mental Illness (SMI) through a coordinated and integrated system of care managed by the Arizona Health Care Cost Containment System (AHCCCS). All eligible members, including older adults, have access to physical health, behavioral health, children's rehabilitative, and long-term care services based on clinical need, as outlined in AHCCCS's Delivery System Integration framework.

A key component of Arizona's approach is the Arizona Long Term Care System (ALTCS), which serves elderly individuals (65 and older), those with physical disabilities, and others at risk of institutionalization. ALTCS health plan contractors deliver comprehensive care—including medical services, behavioral health treatment, long-term supports, and prescriptions—within a community-based model that prioritizes home-based care over institutional settings. To further support housing stability, ALTCS health plans are required to designate Housing Administrators who identify members experiencing homelessness or housing insecurity and connect them to community resources.
For older adults who are dually eligible for Medicare and Medicaid, AHCCCS promotes system alignment through contracts with Medicare Advantage Dual Special Needs Plans (D-SNPs). Each D-SNP is affiliated with an AHCCCS Complete Care Medicaid Health Plan, allowing dual-eligible members to receive all services—including behavioral health and prescription drug coverage—through a single, integrated plan. This model reduces fragmentation and improves care coordination for over 180,000 Arizonans navigating both systems.

Additionally, Mental Health Block Grant (MHBG) subrecipients are contractually required to conduct outreach to older adult populations with SMI. AHCCCS monitors compliance through annual Operational Reviews, which include documentation of outreach efforts, engagement strategies, and administrative policies. If subrecipients fall short of requirements, AHCCCS implements Corrective Action Plans and provides technical assistance to ensure services reach Arizona's most vulnerable older adults.

Through these integrated programs and oversight mechanisms, Arizona ensures that older adults with SMI receive comprehensive, accessible, and person-centered care that supports their health, independence, and quality of life.

d. Please indicate areas of technical assistance needs related to this section.

No technical assistance needs at this time

[1] **https://www.samhsa.gov/homelessness-programs-resources**

[2] **https://www.samhsa.gov/resources-serving-older-adults**

Criterion 5: Management Systems

States describe their financial resources, staffing, and training for mental health services providers necessary for the plan; provides for training of providers of emergency health services regarding SMI and SED; and how the state intends to expend this grant for the fiscal years involved.

Criterion 5

1. Describe your state's management systems.

Arizona's behavioral health management system, overseen by AHCCCS, is built on a coordinated framework that integrates funding, workforce development, training, and assessment tools to ensure high-quality service delivery across the State. AHCCCS leverages multiple funding streams—including Title XIX/XXI Medicaid dollars and Non-Title XIX/XXI sources such as the Mental Health Block Grant (MHBG), county funds, and state general funds—to support a robust network of behavioral health providers. These funds cover a wide range of services for insured, underinsured, and uninsured individuals, including those with SMI, SED, and co-occurring conditions.

To maintain a competent and responsive provider workforce, AHCCCS requires all contracted health plans to establish a Workforce Development Operation (WFDO) and designate a Workforce Development Administrator. These administrators collaborate with network and quality management teams to monitor workforce capacity, plan for future needs, and deliver technical assistance. AHCCCS also mandates participation in a statewide Learning Management System (LMS), operated by RELIAS, which supports training delivery, documentation, and compliance reporting. The LMS hosts training modules on evidence-based practices, including those related to the MHBG, peer support, and clinical supervision.

Contractors must provide annual training for law enforcement on behavioral health emergencies and maintain ongoing education for providers on accessing Medicaid and Non-Medicaid services. AHCCCS also promotes medical residency engagement and encourages contracting with new providers, especially in rural communities, to strengthen the behavioral health workforce. Training and credentialing standards are reinforced through the Office of Individual and Family Affairs (OIFA), which conducts educational sessions and oversees peer support certification. The Division of Fee for Service Management (DFSM) supports provider training and technical assistance, including billing and coding guidance.

AHCCCS uses standardized assessment tools to guide service planning and care coordination. The CALOCUS tool determines case management intensity for children ages 6–18. For substance use disorders, the ASAM CONTINUUM® tool ensures accurate level-of-care placement and treatment fidelity. Training for these tools is integrated into the RELIAS LMS to ensure statewide consistency.

Together, these systems form a comprehensive management infrastructure that supports Arizona's behavioral health goals—ensuring access, quality, and accountability across all populations and regions.

Telehealth is a mode of service delivery that has been used in clinical settings for over 60 years and empirically studied for just over 20 years. Telehealth is not an intervention itself, but rather a mode of delivering services. This mode of service delivery increases access to screening, assessment, treatment, recovery supports, crisis support, and medication management across diverse behavioral health and primary care settings. Practitioners can offer telehealth through synchronous and asynchronous methods. A priority topic is increasing access to treatment for SMI and SUD using telehealth modalities. Telehealth is the use of telecommunication technologies and electronic information to provide care and facilitate client-provider interactions. Practitioners can use telehealth with a hybrid approach for increased flexibility. For instance, a client can receive both in-person and telehealth visits throughout their treatment process depending on their needs and preferences. Telehealth methods can be implemented during public health emergencies (e.g., pandemics, infectious disease outbreaks, wildfires, flooding, tornadoes, hurricanes) to extend networks of providers (e.g., tapping into out-of-state providers to increase capacity). They can also expand capacity to provide direct client care when in-person, face-to-face interactions are not possible due to geographic barriers or a lack of providers or treatments in a given area. However, implementation of telehealth methods should not be reserved for emergencies or to serve as a bridge between providers and rural areas. Telehealth can be integrated into an organization's standard practices, providing low-barrier pathways for clients and providers to connect to and assess treatment needs, create treatment plans, initiate treatment, and provide long-term continuity of care. States are encouraged to access the federal resource guide **Telehealth for the Treatment of Serious Mental Illness and Substance Use Disorders.**

2. Describe your state's current telehealth capabilities, how your state uses telehealth modalities to treat individuals with SMI/SED, and any plans/initiatives to expand its use.

Arizona has developed a robust telehealth infrastructure to support behavioral health and integrated care services across the state, including for individuals with Serious Mental Illness (SMI), Serious Emotional Disturbance (SED), Early Serious Mental Illness/First Episode Psychosis (ESMI/FEP), and Substance Use Disorders (SUD). According to the Arizona Telemedicine Program at the University of Arizona, more than 100 companies currently offer telehealth services statewide, reaching individuals in various settings such as correctional facilities, rural and urban hospitals, educational institutions, urgent care centers, and emergency departments.

Telehealth services are accessible from a person's immediate location or designated community sites. For individuals who lack the necessary technology, transportation to a telehealth-enabled site is a covered service under both the Mental Health Block Grant (MHBG) and Substance Use Prevention and Treatment Block Grant (SUPTRS). AHCCCS is actively assessing opportunities to expand

telehealth access by establishing additional service locations in remote and rural communities, further reducing transportation barriers.

The Arizona Telemedicine Program and the Southwest Telehealth Resource Center play a key role in supporting statewide telehealth efforts. These organizations offer provider directories, training, webinars, and updates, and have been nationally recognized for their leadership in distance learning. Their resources are publicly accessible through social media and their website.

To ensure quality and consistency, Arizona established the Telehealth Advisory Committee in 2021. This committee developed and adopted best practice guidelines for telehealth delivery, which were formally submitted to state leadership in 2022. These guidelines are reviewed annually and updated based on national standards and peer-reviewed research. The full report is available on the AHCCCS website.

AHCCCS Medical Policy 320-I outlines expectations for telehealth services, emphasizing that there are no geographic restrictions for telehealth delivery in Arizona. Both managed care and fee-for-service programs must cover telehealth services in rural and urban areas without imposing limitations beyond those applicable to in-person care. Exceptions are only permitted when evidence-based guidelines or recommendations from the Telehealth Advisory Committee deem a service inappropriate for telehealth delivery.

Through these coordinated efforts, Arizona continues to expand and refine its telehealth capabilities, ensuring that individuals with SMI/SED and other behavioral health needs have equitable access to timely, high-quality care regardless of location.

3. Please indicate areas of technical assistance needs related to this section.

No technical assistance at this time.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Environmental Factors and Plan

7. Substance Use Disorder Treatment – Required for SUPTRS BG

Narrative Question

Criterion 1: Prevention and Treatment Services - Improving Access and Maintaining a Continuum of Services to Meet State Needs

Criterion 1

Improving access to treatment services

1. Does your state provide:

a) A full continuum of services (with medications for addiction treatment included in v-x):

i)	Screening	◉ Yes	○ No
ii)	Education	◉ Yes	○ No
iii)	Brief intervention	◉ Yes	○ No
iv)	Assessment	◉ Yes	○ No
v)	Withdrawal Management (inpatient/residential)	◉ Yes	○ No
vi)	Outpatient	◉ Yes	○ No
vii)	Intensive outpatient	◉ Yes	○ No
viii)	Inpatient/residential	◉ Yes	○ No
ix)	Aftercare/Continuing Care	◉ Yes	○ No
x)	Recovery support	◉ Yes	○ No

b) Services for special populations:

i)	Prioritized services for veterans?	◉ Yes	○ No
ii)	Adolescents?	◉ Yes	○ No
iii)	Older Adults?	◉ Yes	○ No

Criterion 2

Criterion 3

1. Does your state meet the performance requirement to establish and or maintain new programs or expand programs to ensure treatment availability? (●) Yes ( ) No

2. Does your state make prenatal care available to PWWDC receiving services, either directly or through an arrangement with public or private nonprofit entities? (●) Yes ( ) No

3. Does your state have an agreement to ensure pregnant women are given preference in admission to treatment facilities or make available interim services within 48 hours, including prenatal care? (●) Yes ( ) No

4. Does your state have an arrangement for ensuring the provision of required supportive services? (●) Yes ( ) No

5 Has your state identified a need for any of the following:

a) Open assessment and intake scheduling? (●) Yes ( ) No

b) Establishment of an electronic system to identify available treatment slots? (●) Yes ( ) No

c) Expanded community network for supportive services and healthcare? (●) Yes ( ) No

d) Inclusion of recovery support services? (●) Yes ( ) No

e) Health navigators to assist clients with community linkages? (●) Yes ( ) No

f) Expanded capability for family services, relationship restoration, and custody issues? (●) Yes ( ) No

g) Providing employment assistance? (●) Yes ( ) No

h) Providing transportation to and from services? (●) Yes ( ) No

i) Educational assistance? (●) Yes ( ) No

6. States are required to monitor program compliance related to activities and services for PWWDC. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

AHCCCS monitors program compliance for Pregnant Women and Women with Dependent Children (PWWDC) through a multi-layered strategy involving contractual oversight, regular engagement with ACC-RBHAs, TRBHAs, and provider networks, and formal evaluation mechanisms. Contracts with ACC-RBHAs and TRBHAs include specific requirements for preferential access and interim services for PWWDC, as outlined in the AHCCCS Medical Policy Manual. AHCCCS staff participate in regular meetings with ACC-RBHAs and sometimes their providers network meeting, to review service delivery, address concerns, and ensure compliance with block grant priorities. These meetings also serve as a platform for technical assistance and policy updates, including expectations for PWWDC programs.

Compliance is further supported through deliverables such as performance progress reports, waitlist tracking, and expenditure reviews. The AHCCCS Division of Behavioral Health and Housing employs a Compliance Manager who works with the SUBG team to monitor adherence to contract and policy requirements, issue corrective action plans when needed, and also coordinates with the Division for Fee For Service Management for TRBHA oversight. Additionally, AHCCCS conducts Operational Reviews using a standardized tool that assesses compliance with federal requirements for SUBG services including PWWDC.

To complement these efforts, AHCCCS contracts with a professional vendor to conduct Independent Case Reviews (ICR) of SUBG-funded services. These reviews assess the quality and appropriateness of care, including services for PWWDC, and incorporate focus groups with providers and members to contextualize findings. While the ICR primarily informs system-level improvements, it also contributes to identifying potential compliance issues and enhancing service delivery practices.

Finally, the SUBG team coordinates with the State Opioid Treatment Authority (SOTA) and the Women's Services Network representative as needed for subject matter expertise in PWWDC SUD issues.

Criterion 4,5&6

Persons Who Inject Drugs (PWID)

1. Does your state fulfill the:

a)	90 percent capacity reporting requirement?	(●) Yes	( ) No
b)	14-120 day performance requirement with provision of interim services?	(●) Yes	( ) No
c)	Outreach activities?	(●) Yes	( ) No
d)	Monitoring requirements as outlined in the authorizing **statute** and implementing **regulation**?	(●) Yes	( ) No

2. Has your state identified a need for any of the following:

a)	Electronic system with alert when 90 percent capacity is reached?	(●) Yes	( ) No
b)	Automatic reminder system associated with 14-120 day performance requirement?	( ) Yes	(●) No
c)	Use of peer recovery supports to maintain contact and support?	(●) Yes	( ) No
d)	Service expansion to specific populations (e.g., military families, veterans, adolescents, older adults)?	(●) Yes	( ) No

3. States are required to monitor program compliance related to activites and services for PWID. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

AHCCCS monitors program compliance for services provided to People Who Inject Drugs (PWID) through contractual oversight, data review, and regular engagement with ACC-RBHAs and service providers. Contracts include specific language requiring preferential access and interim services for PWID, and AHCCCS ensures compliance through review of claims, contractor deliverables, and implementation of corrective action plans when necessary. AHCCCS staff also attend standing meetings with ACC-RBHAs and providers to monitor service delivery, address concerns, and ensure block grant priorities are met.
AHCCCS further ensures compliance through Operational Reviews of ACC-RBHAs and TRBHAs, ensuring subrecipients adhere to contracts/agreements and policy requirements.

The SUBG Independent Case Review (ICR) also provides an opportunity to monitor program compliance for activities and services for PWID through case file reviews, and focus groups with members and providers.

Together, these strategies provide a comprehensive system for identifying compliance issues and implementing corrective actions related to services for PWID.

Tuberculosis (TB)

1. Does your state currently maintain an agreement, either directly or through arrangements with other public and nonprofit private entities to make available tuberculosis services to individuals receiving SUD treatment and to monitor the service delivery? (●) Yes ( ) No

2. Has your state identified a need for any of the following:

a)	Business agreement/MOU with primary healthcare providers?	( ) Yes	(●) No
b)	Cooperative agreement/MOU with public health entity for testing and treatment?	( ) Yes	(●) No
c)	Established co-located SUD professionals within FQHCs?	( ) Yes	(●) No

3. States are required to monitor program compliance related to tuberculosis services made available to individuals receiving SUD treatment. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

RESPONSE -

AHCCCS supports Tuberculosis (TB) services making them available to individuals receiving SUD treatment through partnerships with the ACC-RBHAs, TRBHAs, and Arizona Department of Health Services (ADHS). Respectively, TB services are outlined in the Non-

Title XIX/XXI contract, AMPM 320-T1, and in the Interagency Service Agreement (ISA) with ADHS. AHCCCS monitors program compliance through a deliverable required for the ACC-RBHAs, called a SUBG TB Services Treatment Procedure and Protocol, through the ICR, Operational Reviews, and regular and ad hoc meetings with subrecipients of the grant.

Pursuant to the 45 CFR Part 96 Sect. 127, AHCCCS is required to routinely make available TB services as defined in §96.121 to each individual receiving treatment for substance use, implement infection control procedures including the screening of patients, and identify those individuals who are at high risk of becoming infected. AHCCCS passes this requirement down into contracting language to ensure all parties involved are aware and in compliance with TB requirements. The ACC-RBHAs are required to conduct site visits to SUBG providers as a part of their oversight and monitoring, and this is one way that the SUBG providers may be assessed for compliance.

The Independent Case Review (ICR) also measures what percentage of case files reviewed include a documented screening for TB. AHCCCS uses this data source to communicate with the ACC-RBHAs about system improvement needs. ACC-RBHAs are then required to report back to AHCCCS on strategies used to correct issues identified by the ICR, which includes TB compliance.

In an effort to enhance TB oversight, AHCCCS has made improvements in the SUBG team's relationship with the ADHS TB Officer and collaborates on how to best oversee the SUBG TB requirements. We made strides in this collaborative effort in 2024-2025, and we will continue to consult and collaborate with ADHS as the overseer of infectious diseases. AHCCCS and ADHS meet quarterly to oversee the TB, HIV, and Synar work.

Early Intervention Services for HIV (for "Designated States" Only)

1. Does your state currently have an agreement to provide treatment for persons with substance use disorders with an emphasis on making available within existing programs early intervention services for HIV in areas that have the greatest need for such services and monitoring such service delivery?

(●) Yes ( ) No

2. Has your state identified a need for any of the following:

a) Establishment of EIS-HIV service hubs in rural areas?

( ) Yes (●) No

b) Establishment or expansion of tele-health and social media support services?

( ) Yes (●) No

c) Business agreement/MOU with established community agencies/organizations serving persons with HIV/AIDS?

( ) Yes (●) No

Hypodermic Needle Prohibition

1. Does your state have in place an agreement to ensure that SUPTRS BG funds are NOT expended to provide individuals with hypodermic needles or syringes for the purpose of injecting illicit substances **(42 U.S.C.§ 300x-31(a)(1)(F))**?

(●) Yes ( ) No

Criterion 8,9&10

Service System Needs

1. Does your state have in place an agreement to ensure that the state has conducted a statewide assessment of need, which defines prevention, and treatment authorized services available, identified gaps in service, and outlines the state's approach for improvement? (●) Yes ( ) No

2. Has your state identified a need for any of the following:

a) Workforce development efforts to expand service access? (●) Yes ( ) No

b) Establishment of a statewide council to address gaps and formulate a strategic plan to coordinate services? ( ) Yes (●) No

c) Establish a peer recovery support network to assist in filling the gaps? (●) Yes ( ) No

d) Incorporate input from special populations (military families, service members, veterans, tribal entities, older adults, persons experiencing homelessness)? (●) Yes ( ) No

e) Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, such as primary healthcare, public health, VA, and community organizations? (●) Yes ( ) No

Service Coordination

1. Does your state have a current system of coordination and collaboration related to the provision of person -centered care? (●) Yes ( ) No

2. Has your state identified a need for any of the following:

a) Identify MOUs/Business Agreements related to coordinate care for persons receiving SUD treatment and/or recovery services (●) Yes ( ) No

b) Establish a program to provide trauma-informed care (●) Yes ( ) No

c) Identify current and perspective partners to be included in building a system of care, such as FQHCs, primary healthcare, recovery community organizations, juvenile justice system, adult criminal justice system, and education. (●) Yes ( ) No

Charitable Choice

1. Does your state have in place an agreement to ensure the system can comply with the services provided by nongovernment organizations (**42 U.S.C.§ 300x-65**, 42 CF Part 54 (**§54.8(b) and §54.8(c)(4)**) and **68 FR 56430-56449**)? (●) Yes ( ) No

2. Does your state provide any of the following:

a) Notice to Program Beneficiaries? (●) Yes ( ) No

b) An organized referral system to identify alternative providers? (●) Yes ( ) No

c) A system to maintain a list of referrals made by religious organizations? (●) Yes ( ) No

Referrals

1. Does your state have an agreement to improve the process for referring individuals to the treatment modality that is most appropriate for their needs? (●) Yes ( ) No

2. Has your state identified a need for any of the following:

a) Review and update of screening and assessment instruments? (●) Yes ( ) No

b) Review of current levels of care to determine changes or additions? (●) Yes ( ) No

c) Identify workforce needs to expand service capabilities? (●) Yes ( ) No

Patient Records

1. Does your state have an agreement to ensure the protection of client records? (●) Yes ( ) No

2. Has your state identified a need for any of the following:

a) Training staff and community partners on confidentiality requirements? (●) Yes ( ) No

b) Training on responding to requests asking for acknowledgement of the presence of clients? (●) Yes ( ) No

c) Updating written procedures which regulate and control access to records? (●) Yes ( ) No

d) Review and update of the procedure by which clients are notified of the confidentiality of their records including the exceptions for disclosure? (●) Yes ( ) No

Independent Peer Review

1. Does your state have an agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers? (●) Yes ( ) No

2. Section 1943(a) of Title XIX, Part B, Subpart III of the Public Health Service Act (**42 U.S.C.§300x-52(a)**) and **45 §CFR 96.136** require states to conduct independent peer review of not fewer than 5 percent of the Block Grant sub-recipients providing services under the program involved.

a) Please provide an estimate of the number of Block Grant sub-recipients identified to undergo such a review during the fiscal year(s) involved.

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3. Has your state identified a need for any of the following:

a) Development of a quality improvement plan? (●) Yes ( ) No

b) Establishment of policies and procedures related to independent peer review? (●) Yes ( ) No

c) Development of long-term planning for service revision and expansion to meet the needs of specific populations? (●) Yes ( ) No

4. Does your state require a Block Grant sub-recipient to apply for and receive accreditation from an independent accreditation organization, such as the Commission on the Accreditation of Rehabilitation Facilities (CARF), The Joint Commission, or similar organization as an eligibility criterion for Block Grant funds? ( ) Yes (●) No

If Yes, please identify the accreditation organization(s)

i) ☐ Commission on the Accreditation of Rehabilitation Facilities

ii) ☐ The Joint Commission

iii) ☐ Other (please specify)

Criterion 7&11

Group Homes

1. Does your state have an agreement to provide for and encourage the development of group homes for persons in recovery through a revolving loan program? (●) Yes ( ) No

2. Has your state identified a need for any of the following:

a) Implementing or expanding the revolving loan fund to support recovery home development as part of the expansion of recovery support service? (●) Yes ( ) No

b) Implementing MOUs to facilitate communication between block grant service providers and group homes to assist in placing clients in need of housing? (●) Yes ( ) No

Professional Development

1. Does your state have an agreement to ensure that prevention, treatment and recovery personnel operating in the state's substance use disorder prevention, treatment and recovery systems have an opportunity to receive training on an ongoing basis, concerning:

a) Recent trends in substance use disorders in the state? (●) Yes ( ) No

b) Improved methods and evidence-based practices for providing substance use disorder prevention and treatment services? (●) Yes ( ) No

c) Performance-based accountability? ( ) Yes (●) No

d) Data collection and reporting requirements? ( ) Yes (●) No

If the answer is No to any of the above, please explain the reason.

Prevention subrecipients are supported by a statewide evaluator that provides training on data collection and reporting requirements.

2. Has your state identified a need for any of the following:

a) A comprehensive review of the current training schedule and identification of additional training needs? (●) Yes ( ) No

b) Addition of training sessions designed to increase employee understanding of recovery support services? (●) Yes ( ) No

c) Collaborative training sessions for employees and community agencies' staff to coordinate and increase integrated services? ( ) Yes (●) No

d) State office staff training across departments and divisions to increase staff knowledge of programs and initiatives, which contribute to increased collaboration and decreased duplication of effort? ( ) Yes (●) No

3. Has your state utilized the Regional Prevention, Treatment and/or Mental Health Training and Technical Assistance Centers[1] (TTCs)?

a) Prevention TTC? (●) Yes ( ) No

b) SMI Adviser (●) Yes ( ) No

c) Addiction TTC? (●) Yes ( ) No

d) State Opioid Response Network? ( ) Yes (●) No

e) Strategic Prevention Technical Assistance Center (SPTAC) (●) Yes ( ) No

Waivers

*Upon the request of a state, the Secretary may waive the requirements of all or part of the sections **42 U.S.C.§ 300x-22(b)**,**300x-23**,**300x-24**, and **300x-28** (**42 U.S.C.§ 300x-32(e)**).*

1. Is your state considering requesting a waiver of any requirements related to:

a) Allocations regarding women (300x-22(b)) ( ) Yes (●) No

2. Is your state considering requesting a waiver of any requirements related to:

a) Intravenous substance use (300x-23) ○ Yes ◉ No

3. Is Your State Considering Requesting a Waiver of any Requirements Related to Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus (300x-24)

a) Tuberculosis ○ Yes ◉ No

b) Early Intervention Services Regarding HIV ○ Yes ◉ No

4. Is Your State Considering Requesting a Waiver of any Requirements Related to Additional Agreements (**42 U.S.C. § 300x-28**)

a) Improvement of Process for Appropriate Referrals for Treatment ○ Yes ◉ No

b) Professional Development ○ Yes ◉ No

c) Coordination of Various Activities and Services ○ Yes ◉ No

Please provide a link to the state administrative regulations that govern the Mental Health and Substance Use Disorder Programs.

Arizona Administrative Code Title 9. Health Services.

Chapter 21. Department of Health Services Behavioral Health Services for Persons with Serious Mental Illness https://apps.azsos.gov/public_services/Title_09/9-21.pdf

Chapter 10. Department of Health Services - Health Care Institutions: Licensing https://apps.azsos.gov/public_services/Title_09/9-10.pdf

Arizona Revised Statute Title 36 https://www.azleg.gov/arsDetail/?title=36

Chapter 1 State and Local Boards and Departments of Health

Chapter 2 State Health Institutions and Agencies

Chapter 5 Mental Health Services

Chapter 18 Alcohol and Drug Abuse

Chapter 28 Controlled Substances Prescription Monitoring Program

Chapter 34 Behavioral Health Services

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[1] **https://www.samhsa.gov/technology-transfer-centers-ttc-program**

Footnotes:

Independent Case File Review Findings

State Fiscal Year 2024

Substance Use Block Grant

Arizona Health Care Cost Containment System
Division of Behavioral Health and Housing

August 1, 2025

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Section 1

Executive Summary

The State of Arizona (Arizona or State), Arizona Health Care Cost Containment System (AHCCCS), engaged Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits LLC, to develop and implement an independent peer review for members who received substance use treatment services through federal Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUBG) funds between July 1, 2023, and June 30, 2024. To ensure compliance with 45 CFR § 96.136, Mercer uses an independent case review (ICR) process. Mercer completed ICRs for the State in state fiscal year (SFY) 2020, SFY 2021, SFY 2022, and SFY 2023 for AHCCCS, with this report representing the fifth year, allowing identification of year-over-year trends in continuous improvement of services.

Building upon the last two years of seeking member and provider feedback, this current ICR process included a qualitative data collection component using focus groups. Focus groups were conducted with providers and members. Previous years included a focus group with AHCCCS Complete Care Contractors with Regional Behavioral Health Agreements (ACC-RBHAs). This year, an additional member focus group was added, as AHCCCS has more continuous direct interaction with the ACC-RBHAs throughout the year. Findings from the ICRs helped frame a guided interview format to use with focus group participants, creating a collaborative environment to help enhance program application and practice. As with the quantitative data, any trends from the focus groups are noted below and in Appendix D.

The core dimensions and elements of the ICR tool have remained substantively the same for SFY 2020–SFY 2023, predating the involvement of Mercer. Mercer worked with AHCCCS to refine the tool from year to year, to review the data elements collected, ensuring they are still relevant. Annually, Mercer performed interrater reliability testing to measure the degree of consistency among the review team's findings. In calendar year 2024, AHCCCS decided to incorporate formal validation activities that include face, construct, and content validity of the review tool. The purpose of this validation is to evaluate the degree to which the survey measures what it intends to measure. The results of the validation have been provided to AHCCCS in a separate report. Changes to the tool were not incorporated into the SFY 2023 ICR but were incorporated into this year's tool.

The purpose of the annual review is to examine the compliance of participating Medicaid-enrolled agencies serving persons who received substance use services through the Block Grant against treatment standards, including quality, appropriateness, and efficacy

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of treatment services, as documented in the member records. The ICR also provides a process to continuously improve the treatment services provided to members diagnosed with substance use disorder within the state (see 45 CFR § 96.136 for ICR requirements) to improve member outcomes and recovery.

Consistent with the statute, Mercer licensed clinicians, experienced with alcohol and drug abuse treatment (i.e., licensed clinical social worker, two registered nurses, licensed clinical mental health counselor, licensed clinical addictions specialist, certified alcohol and drug counselor), examined the following aspects of the treatment records as part of the case file review process:

- Admission criteria (e.g., American Society of Addiction Medicines) intake process
- Assessments and ongoing criteria (e.g., American Society of Addiction Medicines)
- Treatment planning, including appropriate referrals, (e.g., prenatal care, tuberculosis, and human immunodeficiency virus services)
- Documentation of implementation of treatment services as indicated in the treatment plan
- Engagement and reengagement
- Discharge and continuing care planning, including relapse planning
- Indications of treatment and national outcomes (e.g., employment, education, law enforcement involvement)

In addition to the statutorily required treatment, Mercer also examined aspects of the treatment records related to assessment and addressing social determinants of health, evidence-based treatment practices, peer support services, gender-specific services for women[1], and opioid-specific services.

The State provided a universe of 259 records for the ICR. Of those 259 records, 56 were deemed unusable due to reasons such as the record not being complete, the member not returning after their initial assessment, or the treatment episode being for a service other than substance use such as anger management. Additionally, three records were determined to be an oversample, leading Mercer to analyze the data from a total of 200 usable records for the ICR. The files included in this review sample represented 63% of the provider

[1] Gender-specific services for women included female and female-identified individuals.

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agencies in Arizona who receive SUBG funds, which exceeds the minimum statutory requirement of 5% for this review.

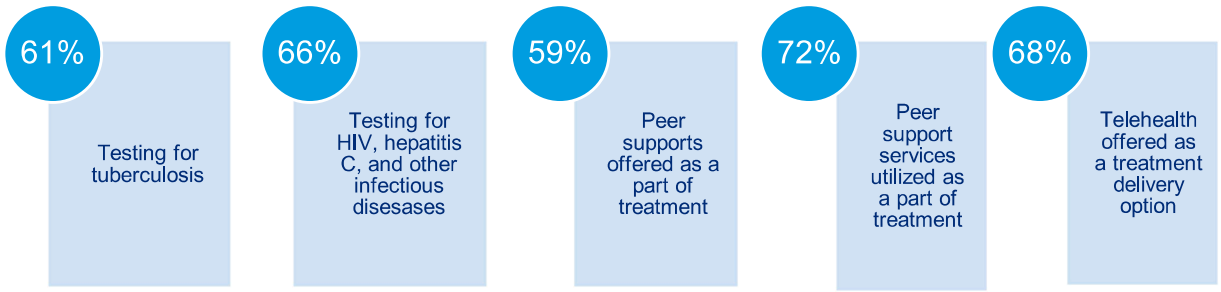
Overview of Key Findings

Specific findings from the ICR are presented in the body of the report, in aggregate, and broken down by ACC-RBHA:

- Arizona Complete Health (Southern Arizona)
- Care1st (Northern Arizona)
- Mercy Care (Central Arizona)

Key findings identify how the documentation demonstrates the overall effectiveness and quality of the SUBG service delivery system in Arizona. This includes how providers perform in identifying, engaging, and responding to member needs through providing substance use disorder treatment services. Mercer also aggregated and analyzed the data by rendering providers and will make this information available separately to AHCCCS for program oversight and improvement. The following section on strengths and opportunities represents a summary of the major themes found across the system.

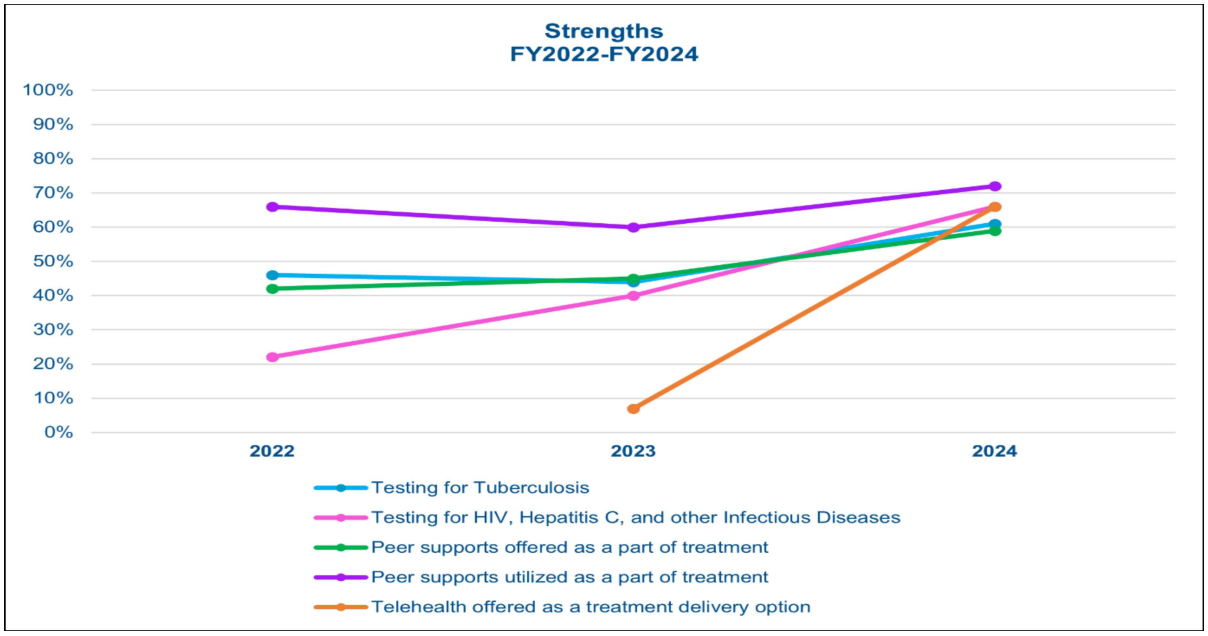
Strengths



In the review of the SFY 2024 statewide aggregate data, there were several areas of strength identified that have demonstrated improvement each year over the periods of SFY 2022, SFY 2023, and SFY 2024 (reflected in Graph 1 below). Of note, there was an increase in cases in which there was documentation of testing for tuberculosis, which occurred in 61% of cases in SFY 2024, a significant increase from SFY 2023 and SFY 2022, which were 44% and 46%, respectively. Documentation of testing for human

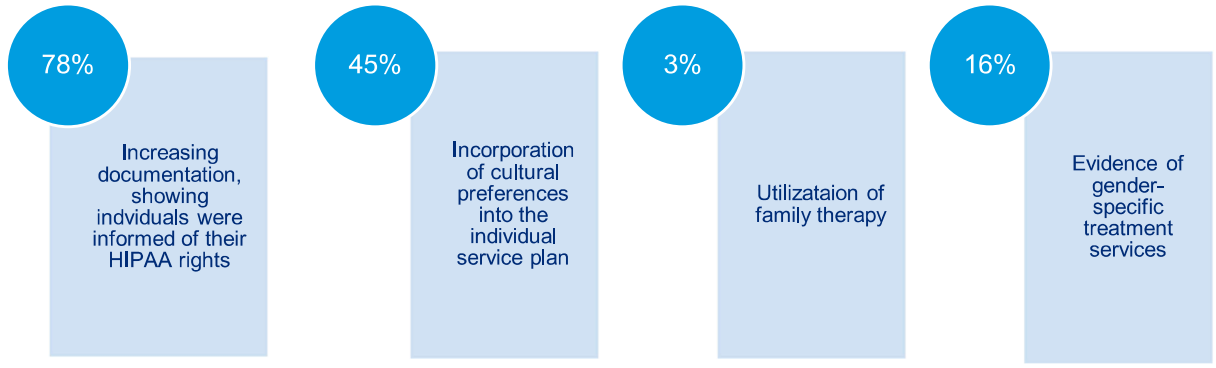
immunodeficiency virus, hepatitis C, and other infectious diseases also showed improvement, as results increased from 40% in SFY 2023 to 66% in SFY 2024. This is also an improvement over SFY 2022, which was 22%. Two other areas of improvement were the use of peer support services and the availability of telehealth. Peer support services were offered in 59% of cases in SFY 2024, an increase from 45% in SFY 2023 and 42% in SFY 2022. Peer support services were also utilized more often when offered in 72% of cases in SFY 2024, as compared with 60% of cases in SFY 2023 and 66% of cases in SFY 2022. Telehealth was offered as an option in 68% of cases, an increase of 7% over last year.[2]

Graph 1: Year-Over-Year Aggregate Strengths



[2]SFY 2023 was the first year this information was collected.

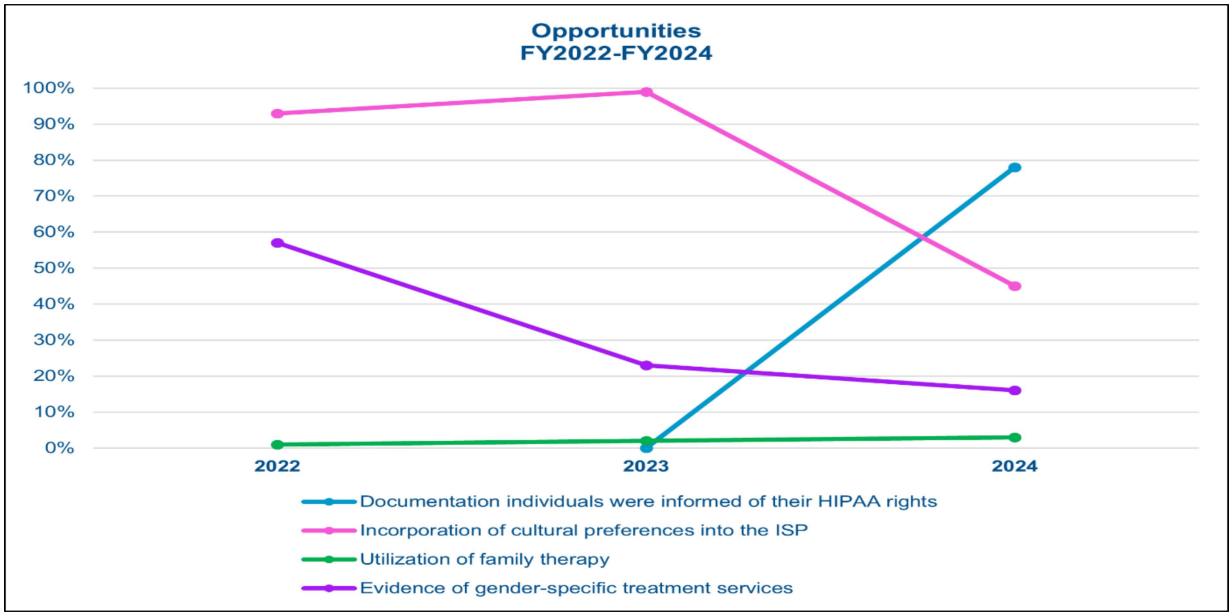
Opportunities



Opportunities identified (see Graph 2 below) because of the 2024 ICR potentially include increasing documentation that the member was informed of their Health Insurance Portability & Accountability Act (HIPAA) rights. This is the first year this information has been collected, but the result of 78% suggests an area for opportunity. Additionally, the number of individual service plans incorporating the cultural preferences of the member dropped significantly in SFY 2024 to 45%. The results for this measure were 99% in SFY 2023 and 93% in SFY 2022, indicating a significant decline. Utilization of family therapy is another area of opportunity. Although utilization has increased from 1% in SFY 2022 to 2% in SFY 2023, and 3% in SFY 2024, the low overall utilization presents an area for potential growth, as positive family and community systems help with recovery and stability. Additionally, gender-specific services for women are an area of opportunity, as this finding has steadily declined from 57% in SFY 2022, to 23% in SFY 2023, and 16% in SFY 2024.

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Graph 2: Year-Over-Year Aggregate Opportunities



Recommendations

The following recommendations are presented as areas of improvement for consideration, based on the analysis of documented services through the ICR process. A more detailed outline of recommendations can be found in Section 6 of this report.

Education and technical assistance for providers would assist in ensuring all regulatory requirements are met, including documentation of informed consent, HIPAA notification, and charitable choice. Other areas of potential training and technical assistance could be additional training on the use of American Society of Addiction Medicines (ASAM) criteria in determining level of care, as this year's ICR found a 4% decline in this area, down to 79% from 83% in the previous two years.

An additional recommendation continues to be on specific population and evidence-based practices. In general, as noted above, there was a decline in incorporating cultural preferences into treatment planning. Gender-based services would benefit from a focus on increased evidence-based practices, such as trauma-informed care, and assessment for co-occurring conditions such as eating disorders.[3]

AHCCCS currently utilizes the ASAM 3rd Edition criteria in treatment and in determining level of care. ASAM 4th Edition criteria were recently released, and both sets of criteria are

[3] TIP 51 Substance Abuse Treatment Addressing the Specific Needs of Women (samhsa.gov)

currently acceptable. AHCCCS should consider a timeframe and process, including provider and staff training, for transition to the updated ASAM 4th Edition criteria. The ASAM 4th Edition criteria also emphasize co-occurring mental health conditions, and a focus on this population will align Arizona with best practices in the substance use treatment field.

A final area of recommendation focuses on reengagement efforts for members who have left treatment before completion. There was a decline, from 97% in the previous year to 60% in the current ICR review, of outreach phone calls to members not attending treatment. There were a few instances of utilizing texts and emails to attempt to reengage members due to the member's preference, showing some evidence of person-centered outreach but, in general, efforts in outreach have declined.

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Section 2

Background and Introduction

Arizona Health Care Cost Containment System (AHCCCS) serves as the single State authority to provide coordination, planning, administration, regulation, and monitoring of all facets of the State public behavioral health (BH) system. AHCCCS contracts with managed care organizations, known as AHCCCS Complete Care (ACC) plans to administer the Medicaid and Kids Care (Title XIX/XXI) programs. Three of the ACC plans are plans with Regional Behavioral Health Authorities (RBHAs), known as ACC-RBHAs, which administer Non-Title XIX/XXI BH programs, including the Substance Use Block Grant (SUBG). The current ACC-RBHAs are Arizona Complete Health (AzCH) in Southern Arizona, Care1st in Northern Arizona, and Mercy Care (MC) in Central Arizona.

Consistent with the requirements of 45 CFR § 96.136, AHCCCS contracted with Mercer as the independent peer review contractor to perform the annual SUBG independent case review (ICR) for state fiscal year (SFY) 2024. Mercer also completed the independent review of the four previous years (SFY 2020, SFY 2021, SFY 2022, and SFY 2023). Mercer does not have any reviewers employed as treatment providers or who have administrative oversight for any programs under review. Further, Mercer's peer review personnel performed this review independently (i.e., separately) from SUBG funding decision makers. The Substance Abuse and Mental Health Services Administration (SAMHSA) awarded the SUBG to AHCCCS each year since the current program was established in 1993. The block grant requires AHCCCS to produce, on an annual basis, an independent peer review of the treatment services provided with SUBG funds.

Goals of the Independent Case Review

The primary objective of this review is to determine that the level of quality and appropriateness of care being provided using SUBG funds is in accordance with federal SUBG requirements noted in 45 CFR § 96.136 and to determine whether the provision of substance use disorder (SUD) services aligns with the program goals for the Arizona SUBG. According to State guidance, quality is the provision of treatment services, which, within the constraints of technology, resources, and patient/member circumstances, will meet accepted standards and practices to improve patient/member health and safety status in the context of recovery. Appropriateness means the provision of treatment services consistent with the member's identified clinical needs and level of functioning.

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For the current year, SFY 2024, AHCCCS program goals for the SUBG include:[4]

- Identify and address known health disparities related to SUD, and 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
- Improve direct service provision among SUD treatment providers, including use of standardized treatment planning and placement such as ASAM 3rd Edition criteria, screening for infectious diseases (including tuberculosis and human immunodeficiency virus [HIV]), and increasing the use of scientifically based outreach strategies and low-barrier programming to engage and reengage members, especially those who disengage early from treatment.
- Improve access to SUD treatment services, particularly for underserved and high-risk populations, increasing the access of digital therapeutics in treatment such as telehealth.
- Improve gender-specific services, including services for pregnant and parenting women, addressing healthy relationships, sexual and physical abuse, reproductive wellness, and other culturally responsive treatment services.
- Increase the capacity of the service-delivery system to meet the evolving needs of members served such as increasing the access to outpatient clinics by expanding the hours of operation to evenings and weekends.
- Expand and enhance a range of recovery support services to include access and engagement with peer support services.

AHCCCS decided to assess the level of quality and appropriateness of SUD treatment in the state through an examination of clinical records maintained by programs receiving SUBG funds. A team of Mercer licensed and certified clinicians (who have expertise in managed care, block grants, SUD treatment, American Society of Addiction Medicine [ASAM] criteria, and clinical best practices) systematically reviewed each of the files selected as part of the review sample. These independent clinicians examined SUD treatment records for the presence (or absence) of previously selected, evidence-based factors that are expected to be present in high-quality, appropriate treatment (including engagement, planning, and discharge).

[4] FY2024_2025_BlockGrantApplication.pdf

The following domains were examined to determine the appropriate treatment engagement, planning, and discharge activities (see Appendix A for specific review items in each domain):

- Intake and treatment planning, to include identification of Social Determinants of Health (SDoH)[5] needs
- Placement criteria and assessment
- Best practices
- Treatment, support services, and rehabilitation services
- Gender-specific treatment services for women
- Opioid-specific treatment services
- Discharge and continuing care planning (only for successful treatment completions or decline of further services)
- Reengagement (only for members who declined further services or chose not to appear for services)
- National Outcome Measures (NOMs) at intake and discharge

Content of Records Reviewed

Based upon the requirements of the annual ICR report to SAMHSA, a sample of treatment records was requested and provided by the ACC-RBHAs. Clinical records vary from provider to provider but, typically, include the following key documents and captured data elements, which were evaluated:

- Demographic information
- Initial assessment
- Risk assessment and safety plan
- Crisis plan
- Individual service plan (ISP)
- ASAM patient placement criteria (initial and ongoing)

[5] Updated terminology for next year's ICR should reflect current federal language, such as social drivers of health or health-related social needs. Social Drivers of Health and Health-Related Social Needs | CMS

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- Medication record
- Medical screenings
- Results of diagnostic testing, including illicit substance use testing
- Progress notes (e.g., therapy [individual and group], case management, etc.)
- Medication-assisted treatment (MAT) documentation
- Evidence of outreach, engagement, and reengagement efforts
- Discharge or termination of treatment summary

Mercer used these documents, and any others contained in the individual records, to assess the level to which providers receiving SUBG funds in Arizona are providing comprehensive and timely assessment, planning, engagement, treatment, and discharge services to members with a SUD diagnosis, in accordance with need, acuity, and preference.

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Section 3

Methodology

AHCCCS provided the files for the ICR through the State's secure file transfer protocol. No files were downloaded or saved to Mercer staff computers or hard drives. All Mercer staff that had access to AHCCCS files completed Protected Health Information and Health Insurance Portability & Accountability Act (HIPAA) training annually and were also debriefed on AHCCCS privacy practice expectations. All member record files were stored and accessed through a secure file transfer protocol site managed by AHCCCS. Each Mercer reviewer received a secured sign-in to the agency's site to ensure all file health information remained protected. Each case was assigned a sample ID for data entry of the results of the case review. Mercer completed all ICR activities virtually, with no on-site reviews or in-person team meetings during the ICR part of the independent peer review.

Data entry of findings from each case review was entered by Mercer clinicians into a customized, password-protected, Microsoft Access review tool.

Sampling

AHCCCS, with assistance from Mercer, developed and implemented the sampling methodology for this review and used the following inclusion criteria:

- Substance use members with a substance use treatment service and an episode of care (EOC) funded by the SUBG during SFY 2024: July 1, 2023, through June 30, 2024
- Disenrolled/EOC end date before or on June 30, 2024
- At least 18 years of age during the treatment episode
- Disenrolled due to completing treatment, declining further service, or lack of contact
- Must have received substance use treatment and counseling during the treatment period. Treatment was defined by identifying members having at least one paid claim for a substance use service during SFY 2024 for any ASAM 3rd Edition level of care (LOC)
- Must have been enrolled in a treatment center for at least 30 days
- Must not be enrolled in a Tribal Regional Behavioral Health Authority
- The sampling methodology used by AHCCCS excluded members who:
  - Did not have any service encounters during the treatment episode

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- Only had a crisis encounter during the treatment episode
- Only had assessment services during the treatment episode
- Did not have any counseling encounters during the treatment episode
- Only had a detoxification hospitalization encounter during the treatment episode
- Only had services provided by a member private provider

Based on these inclusion and exclusion criteria, AHCCCS supplied 259 treatment records for the ICR. Mercer randomly selected 200 files to be used in the initial review, with the remainder being held as an oversample. Fifty-six files were determined to be unusable for review purposes (e.g., an exclusion criterion was found in the file or the treatment dates were out of range) and were replaced from the oversample.

File Tool Review

The Mercer team used the tool validated during the SFY 2023 review for development of the SFY 2024 ICR tool. The validation approach employed activities to evaluate the tool, including content and face validity. Content validity concerns the adequacy of a tool or survey content being measured, how questions represent the topic under consideration, and what the questions aim to measure. Face validity addresses the suitability of the tool or instrument content used. Mercer used the Delphi Method to determine face and content validity and engaged subject matter specialists in the area of substance use, who have not been involved in the Arizona SUBG Independent Case Review process, to conduct a content and face validity review.

As a result of the validation activities, the following updates were made to the previous tool.

- The “Behavioral Health Assessment” referenced in the previous tool of sub-items appeared to indicate a more comprehensive psychosocial and medical assessment, rather than just a “Behavioral Health Assessment.” Additionally, the question included two aspects: the assessment's importance and the importance of completing the assessment within 45 days, noting that both the completion of the assessment and its timeliness should be captured. A third discovery regarding the item was that, in its current form, it did not appear to contribute to the identification of SDoH, which needs to be addressed in the individual treatment plan.

  The tool was updated to split the behavioral health assessment into two questions, one to determine whether the assessment was completed and a second to determine whether it was completed within 45 days. Additionally, SDoH items were added to the

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assessment section to reflect areas of SDoH need scored in previous years as a part of the ISP. A link to a definition of an assessment was also included.

- Importance of charitable choice requirements: The specialist panelists identified this as a regulatory component and not an item reviewing program effectiveness regarding program completion rate, abstinence post-discharge, and addressing SDoH.

  A regulatory section was, therefore, added under the "Intake/Treatment Planning" domain. Two other items were also added to the regulatory section: documentation of whether members were provided with information about HIPAA rights and whether members were provided with information on informed consent.

- Similar to the behavioral health assessment question, ISP completion included two aspects: the importance of the ISP and the importance of completion of the ISP within 90 days.

  The tool was updated to split the ISP into two questions: one to determine whether the ISP was completed and a second to determine whether it was completed within 90 days.

- Certified peer support offered as part of treatment: This item raised questions related to the term "certified." The question includes two aspects: the importance of offering peer support and the importance of offering "certified" peer support.

- The tool was updated to split up the question to determine whether peer support in any form was provided and, if so, whether the peer support provided is from a "certified" peer support specialist.

The e-version of the tool, which was developed in Microsoft Access, allowed the review team to record review results in a format more conducive to analyzing the data and producing year-over-year trending, with useful tables to present areas that were not updated as a part of validation.

Medication-Assisted Treatment

In addition to updates to validate the tool, AHCCCS requested that Mercer also review the current best practices in MAT. Previous independent case reviews included the following medications:

- Alcohol use disorder:
  - Acamprosate (Campral)
  - Disulfiram (Antabuse)

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- Opioid use disorder:
  - Subutex (buprenorphine)
  - Methadone/Levo-Alpha-Acetylmethadol (LAAM)
  - Narcan (naloxone)
  - Vivitrol (long-acting naltrexone)
  - Suboxone (buprenorphine-naloxone)
- Nicotine replacement therapy – reviewed, in general, as an informational measure

Medications for Alcohol Use Disorder[6]

According to the 2023 National Survey on Drug Use and Health (NSDUH), only 1.9% of the 28.9 million people aged 12 years and older, with an alcohol use disorder in the past year, received MAT for their alcohol use. Evidence-based treatment and supports for alcohol use disorder may include US Food and Drug Administration-approved medications, although they are not as commonly used as those for opioid use disorder (OUD). A common barrier to medication for alcohol use disorder utilization includes lack of education for providers and beneficiaries on MAT for alcohol use disorder.[7] In addition to the medications previously reviewed, the tool was updated to reflect all evidence-based medications available for the treatment of alcohol use disorder:

- Acamprosate calcium (Campral): Maintenance of abstinence from alcohol in patients dependent on alcohol, who are abstinent at treatment initiation
- Disulfiram (Antabuse): Management of selected patients who want to remain in a state of enforced sobriety so that supportive and psychotherapeutic treatment may be applied to best advantage
- Oral naltrexone (Vivitrol®, Revia) (naltrexone hydrochloride tablet): Treatment of alcohol dependence
- Extended-release injectable naltrexone: Treatment of alcohol dependence in patients who have been able to abstain from alcohol in an outpatient setting

[6] Medication for the Treatment of Alcohol Use Disorder: A Brief Guide | SAMHSA Publications and Digital Products

[7] SAMHSA. (2024). Key substance use and mental health indicators in the United States: Results from the 2023 National Survey on Drug Use and Health (HHS Publication No. PEP24-07-021, NSDUH Series H-59). Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration

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Medications for Opioid Use Disorder[8]

- The 2023 NSDUH report found that of the 5.7 million people aged 12 years or older with a past year OUD, 18% (1.0 million people) received MAT in the past year for their opioid use. MAT continues to be an evidence-based treatment option used in addressing OUD.[9] The tool has been updated to reflect current best practice medication options.
- Buprenorphine (Brixadi®, Sublocade®): Continuous release of the medicine buprenorphine all month, at sustained levels, for moderate to severe opioid addiction (dependence) to opioid drugs (prescription or illegal).
- Buprenorphine and naloxone (Suboxone, Zubsolv®): Combination of buprenorphine and naloxone used to reduce withdrawal symptoms and cravings associated with stopping opioid use.
- Methadone: Long-acting opioid medication used to reduce withdrawal symptoms in people addicted to heroin or other narcotic drugs, and it can also be used as a pain reliever.
- Naltrexone (Vivitrol®, Revia): Reduces cravings and helps control physiological dependence by blocking the effects of opioid medications, preventing the euphoria and intoxication as well as helping reduce the urge or cravings to use opioids.

Medication for Smoking Cessation[10]

Tobacco use and cessation has been of interest to the funders of the SUBG, with the Tobacco Regulations for Substance Use Prevention, Treatment, and Recovery Services Block Grant; Final Rule, 61 Federal Register 1492 (PDF |259 KB) published on
January 19, 1996. One of the targeted populations and service areas of the SUBG is primary prevention services. Primary prevention strategies of interest include problem identification and referral to identify members who have indulged in illegal or age-inappropriate use of tobacco or alcohol and members who have indulged in the first use of illicit drugs. Although not a main focus of the ICR, part of the review does look for whether smoking cessation and associated MAT interventions have been provided for informational purposes. Specific MAT options have been added to this year's iteration of the ICR tool.

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[8] 23.04.06_CCBHC-Evidence-Based-Practice-Reference-Guide_v2.pdf

[9] SAMHSA. (2024). Key substance use and mental health indicators in the United States: Results from the 2023 National Survey on Drug Use and Health (HHS Publication No. PEP24-07-021, NSDUH Series H-59). Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration

[10] Clinical Interventions to Treat Tobacco Use and Dependence Among Adults | Smoking and Tobacco Use | CDC

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- **Nicotine replacement therapy:**
  - Over-the-counter patch, gum, or lozenge
  - Prescription inhaler or nasal spray
- **Varenicline** prescription (Chantix®): Reduction of nicotine withdrawal symptoms by blocking nicotinic receptors
- **Bupropion** prescription (Wellbutrin, Aplezin®, Forfivo®, Zyban®): Dopamine and norepinephrine re-uptake inhibitor, with nicotine receptor antagonist properties

Inter-Rater Reliability

The review team from Mercer consisted of licensed clinicians and certified counselors (two registered nurses, two master's level BH providers, and one certified alcohol and drug counselor). A sixth member of the team provided data analytic services and ensured consistency in the application of project standards. All of the reviewers participated in conducting ICRs in the previous year.

To ensure consistency in the use of the file review tool, the Mercer review team participated in an inter-rater reliability (IRR) training session, followed by an IRR test, prior to the initiation of the review process. The test consisted of reviewing two unique live records. Participants used the ICR tool to score the live records, consistent with the review training session provided by the senior engagement advisor, who is a licensed clinical social worker, and the ICR Tool Instructions (Appendix B).

The Mercer senior engagement advisor facilitated the IRR and recorded the answers from each individual reviewer. Any items yielding inconsistent results were discussed with each reviewer. As a result of this discussion, the team reached a consensus decision on how items would be scored. The initial review of the live records yielded an IRR average score of 95%, exceeding the 90% threshold requirements; the team reached 100% agreement following discussion and consensus building.

Throughout the evaluation, which occurred during March and April 2025, the senior engagement manager maintained frequent contact with individual reviewers, answered questions regarding the application of the ICR Tool Instructions, and ensured the consistent application of the tool's scoring methodology. Additionally, to ensure fidelity to the scoring approach, the team met biweekly during the review process for group debriefs and problem solving related to the application of the ICR Tool Instructions

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Data Analysis

Mercer clinicians entered findings from each individual case review into a customized, password-protected, Microsoft Access review tool. After the reviews were complete, the data was exported into Microsoft Excel and aggregated into a final, blinded dataset for analysis purposes. Data checks were performed to ensure consistent and complete data was received. Descriptive statistics were calculated to summarize the characteristics of the findings from the case reviews. The analysis focused on measures of variability, with tables and graphs reflecting the dispersion of data for key case review goals. Output tables were programmed with formulas reflecting the instructions for record review data entry (Appendix B). Results were technically peer reviewed for accuracy and reasonableness.

Limitations

Although IRR methodology, tool training, and reviewer coaching facilitate accurate review findings for the ICR results, individual experience, as well as discipline-specific education in substance use treatment, may still result in some irregularities in interpretation of case review contents. A validated tool was used as a part of this year's ICR process, reducing the potential for variance due to a tool that has not been determined as reliable and valid.

The data collection period of review for this project (July 1, 2023–June 30, 2024) is after the federal unwinding of the Public Health Emergency that occurred March 31, 2023, and there should no longer be any further impact from the pandemic in next year's ICR. There is no reliable way to fully account for COVID-19's multiple impacts on individual member choices (e.g., reactions to the shift to telehealth interventions, treatment efficacy of virtual SUD treatment, and the resultant treatment outcomes). Many providers have maintained a hybrid model, allowing members to receive services both in-person and virtually, which has been of benefit for SDoH concerns, such as transportation and lack of childcare, which may have prevented access to services in the past. Use of telehealth services continues to be captured in the *Best Practice* section of the tool, and digital therapeutics have been identified as a goal of AHCCCS for the SUBG.

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Section 4

Aggregate Case File Review Findings

The SUBG ICR findings are organized throughout this section, in aggregate, by both ACC-RBHA and individual evaluation measures. This also includes demographic snapshots, records reviewed (broken down by ACC-RBHA), as well as gender and age of the population sampled. Additionally, statistics on the reasons for case closure, referral to the program, and SUBG-funded providers sampled are included for comparison purposes as in past years' reports.

Sample Demographics

The State provided a universe of 259 records for the ICR. Of those 259 records, 56 were deemed unusable due to such reasons as the record not being complete, the member not returning after their initial assessment, or the treatment being for a different service such as anger management. Also, three records were determined to be an oversample, leading Mercer to analyze the data from 200 usable records for the ICR. The 56 records that were unusable represent an exceptionally high number compared to previous years and may reflect a quality concern with some of the charts, as many unusable charts were excluded due to missing information. Mercer's record review represented 26% of the AzCH records, 11% of the Care1st records, and 64% of the MC records, of the respective records provided (see Table 4-1 below).

The sample of records reviewed closely mirrors the percentages of members enrolled in each ACC-RBHA. This reflects a comparably sufficient sample for each of the ACC-RBHAs, based upon the records that were made available at the time of the review.

Table 4-1: Distribution of Case File Review Sample by ACC-RBHA

ACC-RBHA	Universe of Records Received for ICR Review (including oversample)	Number of Usable ICR Records Reviewed	Number of ICR Records Reviewed but Unusable	Unusable ICR Records Reviewed as a Percent of Universe	ICR Sample Records Reviewed as a Percent of Universe	Percent of ICR Records Reviewed
AzCH	64	61	3	5%	95%	31%
Care1st	41	37	4	10%	90%	19%

MC	154	102	49	32%	66%	51%
Total	**259**	**200**	**56**	**22%**	**77%**	**100%**

Table 4-2 shows the gender and age distribution by ACC-RBHA. Overall, the mean age served in the sample was 38.5 years, with a median of 36.0 years. Thirty three percent of the sample identified as female, 68% male, and no members (0%) identified as "Other." The youngest age represented in the total sample was 19 years of age. The age of the oldest represented was 76 years.

Table 4-2: Distribution of Case File Review Sample by Gender and Age

ACC-RBHA	Sample Cases	Percent of Sample	Gender						Age (Years)	
			Female		Male		Other			
			N	%	N	%	N	%	Mean	Median
AzCH	61	31%	14	23%	47	77%	0	0%	39.6	36.0
Care1st	37	19%	17	46%	20	54%	0	0%	39.1	38.0
MC	102	51%	34	33%	68	67%	0	0%	37.7	36.0
Total	**200**	**100%**	**65**	**33%**	**135**	**68%**	**0**	**0%**	**38.5**	**36.0**

Sample Characteristics

Members chosen for the sample must have been disenrolled or have had an EOC with a closure date within SFY 2024 (July 1, 2023, to June 30, 2024), with a final case closure date no later than June 30, 2024. Any documentation included in records that was outside of this date range was not considered for this review. Closure reasons include member declined further service, lack of contact, treatment completion, and transfer (member was incarcerated, moved, or no longer on Medicaid). The most frequent reason for case closure during this period was treatment completion (41%), followed by lack of contact (36%). This represents a reversal over last year's findings, as lack of contact was the most common reason for case closure.

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Table 4-3: Distribution Based on Case Closure Reason

ACC-RBHA	Number of Sample Cases	Client Declined Further Treatment		Lack of Contact		Treatment Completion		Transfer	
	N	N	%	N	%	N	%	N	%
AzCH	61	18	30%	22	36%	21	34%	0	0%
Care1st	37	8	22%	13	35%	15	41%	1	3%
MC	102	18	18%	36	35%	45	44%	3	3%
Total	**200**	**44**	**22%**	**71**	**36%**	**81**	**41%**	**4**	**2%**

The rates for the most frequent source of referral to SUD treatment are shown in Table 4-4 below. “Criminal Justice/Correctional” includes the Administrative Office of the Courts, Arizona Department of Corrections, Arizona Department of Juvenile Corrections, jail/prison, and probation. “Other” includes physical health providers, State agencies, crisis, and unknown sources. Overwhelmingly, self-referral or referral by family or friends was the most frequent referral source at 53%. This is 6% lower than the previous period of 59%. It should also be noted that Criminal Justice/Correctional referrals increased to 33% in this year’s sample compared to last year’s sample, which was 25%.

Table 4-4: Source for Referral

ACC-RBHA	Sample Cases	Criminal Justice/ Correctional		Other BH Provider		Self/Family/ Friend		Other	
		N	%	N	%	N	%	N	%
AzCH	61	30	49%	4	7%	23	38%	4	7%
Care1st	37	18	49%	1	3%	18	49%	0	0%
MC	102	18	17%	7	7%	64	63%	13	13%
Total	**200**	**66**	**33%**	**12**	**6%**	**105**	**53%**	**17**	**9%**

Aggregate Review Findings

The tables below (4-5 through 4-15) contain the aggregate record of review findings. As noted in the Methodology section, most measures remain the same as those used in the

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previous year. Tables reflecting new measures do not have a comparison to previous years' findings, and the new measure is flagged in the previous years' findings column. The denominators primarily consisted of the sum of "Yes" or "No" responses and, as such, differentiates across the measures. The denominators of certain indicators were based on the number of "Yes" responses from a prior question when applicable. For example, the denominators for I.C.1 through 9 equate to the numerator for *I.C. Was a behavioral health assessment completed at intake (within 45 days of initial appointment)?*

Certain measures allowed for a response of "Not Applicable" (N/A); N/As are not included in any denominator, consistent with prior years' analyses. Measures marked with an asterisk indicate that "N/A" was not a valid response option for that measure, and a dash was used instead of a number in the "N/A" column. Additionally, certain measures included an option for missing documentation.

Narrative information was also collected on the following measures (see full set and description of measures in Appendix A) and incorporated into the Findings section prior to the respective table. Throughout each table, improvements (green) and declines (pink) have been color coded to reflect the comparison of findings from the previous year's review period. **In some cases, a number may be higher than the previous year but is coded pink because the outcome is a negative trend**. For example, a question about whether documentation was present may have a higher number of responses but is a negative finding, as the documentation should have been present. **These items are noted with a double asterisk**. For findings in which the results are the same from one year to the next, results have been shaded in grey to indicate no change.

Finally, a Comments tab allowed reviewers to enter narrative detail regarding the reviewed record, to complete the clinical picture as needed.

Although these findings represent an aggregation of data from record reviews and an underlying root cause analysis for trends has not been conducted, additional qualitative information on the potential reasons for the findings in different areas can be found in Appendix D, under focus group summary discussions. These discussions point to strengths and areas of opportunities and concerns, as noted by providers and ACC-RBHAs, that could have an impact on results from record reviews.

Measure I — Intake/Treatment Planning Key Findings

Initial Behavioral Health Assessment

Mercer reviewed 200 total records for the State and found the most commonly used substances were alcohol, at 37%, followed by opioids, at 30%. This is a 12% decline in opioid

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use from SFY 2023. Two substances identified under the category of “Other” included one instance of Xanax and one of psilocybin. Smoking was the most common method of ingestion, at 47%, followed by oral consumption, at 41%. In one case, the method of ingestion was unidentified.

There was a slight decrease in the number of behavioral health assessments completed. Assessments were completed 96% of the time, a 1% drop from both SFY 2023 and SFY 2022. The new measure of whether an assessment was completed within 45 days was 95%, as one assessment was not completed within the 45-day timeframe. The completion of a risk assessment continues to be an area of strength, with a result of 100% over the current period as well as the previous two fiscal years. There was a noticeable improvement in screening for tuberculosis, from 44% to 61%, in this year’s cycle, an area of priority for AHCCCS. Screening for hepatitis C, HIV, and other infectious diseases also significantly improved, increasing from 40% to 66%.

SDoH were added to the assessment process this year. Further discussion below summarized findings of the assessment that are also included in the ISP. Other determinants listed under the option of “Other” include difficulty with finances, not practicing safe sex, having legal concerns, difficulty paying for utilities, lack of adequate clothing, dental concerns, and lack of childcare.

Regulatory Requirements

Charitable choice regulation compliance remained consistent over the past three years, with a slight increase to 89% from 85%. Both of the two new regulatory requirements reviewed this year could represent areas of opportunity for RHBAs to provide technical assistance to substance use providers. Members were provided with information on informed consent in 85% of cases reviewed. Documentation was present, showing members were informed of their HIPAA rights in 78% of cases reviewed.

Individual Service Plan

An ISP was completed in 97% of cases, a slight increase from the previous year’s result of 94%. The ISP was completed within 90 days in 98% of cases. Participation of the family or support network in development of the ISP declined from 13% in the previous two reviews to 9%. A more significant finding was a reduction in the number of cases incorporating the cultural preferences of the member, from 99% to 45%, indicating another area in which providers may benefit from ACC-RHBA technical assistance. There was a slight drop in the number of ISPs incorporating SDoH, from 45% to 37%. Unemployment is the highest area of SDoH need addressed in ISPs, at 21%, followed by access to medical care at 20%. These findings align with assessment determinations of SDoH need, with unemployment at 87%

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and access to medical care at 67%. Although housing was identified to be a need in 83% of assessments, it was only addressed in 14% of ISPs. Members of the provider focus group identified training on inclusion of SDoH in ISPs as a potential area for additional staff training.

Table 4-5: Assessment and Individual Service Plan

Question	Denominator	# of Yes 2024	% of Yes 2024	# of N/A 2024	# of Yes 2023	% of Yes 2023
A. What was the primary substance used?[11]*						
• Opioids	200	59	30%	-	84	42%
• Marijuana	200	28	14%	-	34	17%
• Alcohol	200	73	37%	-	82	41%
• Amphetamines	200	47	24%	-	50	25%
• Cocaine	200	15	8%	-	21	11%
• Other (please list)	200	2	1%	-	8	4%
B. What was the method of ingestion?[9]*						
• Smoking	200	93	47%	-	94	47%
• Oral	200	82	41%	-	88	44%
• Inhalation	200	22	11%	-	22	11%
• Injection	200	8	4%	-	13	7%
• Transdermal	200	0	0%	-	0	0%
• Other (please list)	200	1	1%	-	15	8%
Behavioral Health Assessment						

[11] Substance used and method of ingestion represent information on preferred substances. In some cases, multiple substances were reported as the primary substance for members with polysubstance use conditions because it was hard to discern in the record.

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Question	Denominator	# of Yes 2024	% of Yes 2024	# of N/A 2024	# of Yes 2023	% of Yes 2023
C. Was a behavioral health assessment completed?[12]*	200	191	96%	-	97%	97%
i. Was the behavioral health assessment completed within 45 days of the initial appointment?	200	190	95%	0	New measure	New measure
D. Did the behavioral health assessment:*						
Address substance-related disorder(s)?	191	167	87%	-	87%	99%
ii. Describe the intensity/frequency of substance use?	191	183	96%	-	95%	93%
iii. Include the effect of substance use on daily functioning?	191	179	94%	-	96%	93%
iv. Include the effect of substance use on interpersonal relationships?	191	170	89%	-	94%	95%
v. Include a completed risk assessment?	191	191	100%	-	100%	100%
vi. Document screening for tuberculosis?	191	116	61%	-	44%	46%
vii. Document screening for hepatitis C, HIV, and other infectious diseases?	191	126	66%	-	40%	53%
viii. Document screening for emotional and/or physical abuse/trauma issues?	191	189	99%	-	96%	95%
ix. Document that review of the Prescription Drug Monitoring Program (PDMP) was completed?	175	22	13%	-	18%	22%

[12] Item C and C.1. were split into two questions for the 2024 review due to tool validation.

Question	Denominator	# of Yes 2024	% of Yes 2024	# of N/A 2024	# of Yes 2023	% of Yes 2023
E. Were SDoHs documented as a part of the assessment?*	191	184	96%	-	New measure	New measure
Access to medical care?	191	145	76%	-	New measure	New measure
x. Housing?	191	158	83%	-	New measure	New measure
xi. Food insecurity?	191	100	52%	-	New measure	New measure
xii. Domestic violence?	191	128	67%	-	New measure	New measure
xiii. Unemployment?	191	166	87%	-	New measure	New measure
xiv. Transportation?	191	137	72%	-	New measure	New measure
xv. Other?	191	17	9%	-	New measure	New measure
F. Regulatory requirements:						
Was there documentation that charitable choice requirements were followed, if applicable?	27	24	89%	168	85%	69%
xvi. Was there documentation that individuals were informed of their HIPAA rights?*	196	152	78%	-	New measure	New measure
xvii. Was there documentation that individuals were given information on informed consent?*	196	167	85%	-	New measure	New measure

Question	Denominator	# of Yes 2024	% of Yes 2024	# of N/A 2024	# of Yes 2023	% of Yes 2023
G. Was an ISP completed?*[13]	197	191	97%	-	94%	99%
Was the ISP completed within 90 days of the initial appointment?	191	188	88%	0	New measure	New measure
H. Was the ISP:						
Developed with participation of the family/support network?	188	17	9%	151	13%	13%
xviii. Congruent with the diagnosis(es) and presenting concern(s)?*	188	185	98%	-	100%	98%
xix. Containing measurable objectives and timeframes to address the identified needs?*	188	186	99%	-	100%	96%
xx. Addressing the unique cultural preferences of the individual?*	188	84	45%	-	99%	93%
xxi. Considering SDoH issues as part of, and incorporated into, the ISP?	188	69	37%	0	45%	53%
If yes, which domains?*						
• Access to medical care	188	37	20%	-	20%	23%
• Housing	188	26	14%	-	21%	39%
• Food insecurity	188	3	2%	-	4%	4%
• Domestic violence	188	4	2%	-	3%	5%
• Unemployment	188	40	21%	-	24%	41%
• Transportation	188	13	7%	-	11%	New Measure

[13] Items G and G.i. were split into two questions for the 2024 review due to tool validation.

Question	Denominator	# of Yes 2024	% of Yes 2024	# of N/A 2024	# of Yes 2023	% of Yes 2023
• Other	188	9	5%	-	12%	7%

Measure II — Placement Criteria/Assessment Key Findings

ASAM 3rd Edition criteria was used in determining the appropriate LOC in 79% of cases, a slight decrease from 83% in the past two preceding reviews. Provider training on utilization of ASAM criteria in determining LOC continues to be an identified area of opportunity. Level 1 Outpatient Treatment remains the most common LOC, at 51%, followed by Level 2.1 Intensive Outpatient at 27%. Members received the LOC indicated in their assessment in 99% of cases, an improvement over last year's result of 87%, and the member was reassessed against ASAM criteria during the course of treatment more often, increasing from 43% last year to 59% this year. Additional assessment tools were used in 63% of cases and included:

- Patient Health Questionnaire: 9 (37 cases)
- Generalized Anxiety Disorder: 7 (32 cases)
- Adverse Childhood Experiences Questionnaire: (23 cases)
- Protocol for Responding To & Assessing Patients' Assets, Risks & Experiences: (18 cases)
- Columbia Suicide Severity Rating Scale: (16 cases)
- Drug Abuse Screening Test: (13 cases)
- Diagnostic and Statistical Manual of Mental Disorders 5: (10 cases)
- Michigan Alcohol Screening Test: (10 cases)
- Alcohol Use Disorders Identification Test – Consumption: (6 cases)
- Child and Adolescent Level of Care Utilization System: (6 cases)

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Table 4-6: Placement Criteria/Assessment

Question	Denominator	# of Yes 2024	% of Yes FY 2024	% of Yes FY 2023	% of Yes FY 2022
A. Was there documentation that ASAM dimensions were used to determine the proper level of care at intake?	200	158	79%	83%	83%
If the ASAM Placement Criteria were used, the level of service identified was:					
Level 0.5: Early Intervention	158	1	1%	1%	1%
OMT: Opioid Maintenance Therapy	158	24	15%	27%	16%
Level 1: Outpatient Treatment	158	80	51%	42%	45%
Level 2: Intensive Outpatient Treatment/Partial Hospitalization	158	43	27%	19%	12%
Level 3: Residential/Inpatient Treatment	158	24	15%	20%	42%
Level 4: Medically Managed Intensive Inpatient Treatment	158	1	1%	0%	1%
B. Did the member receive the level of services identified by the placement criteria/assessment?	158	156	99%	87%	96%
C. Were the ASAM dimensions reassessed (with documentation) during the course of treatment?	158	94	59%	43%	54%
D. Were additional assessment tools (in addition to ASAM or in lieu of) utilized during the course of treatment?	200	125	63%	58%	50%

Measure III — Best Practices Key Findings

Evidence-based practices (EBPs) were found to be used in treatment 84% of the time, an increase from 74% in SFY 2023 and 77% in SFY 2022. Relapse prevention therapy was the

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most commonly used, at 64%, a marked increase from the previous year's finding of 27%, followed by motivational enhancement/interviewing therapy at 45%, and cognitive behavioral therapy at 36%. Additional interventions (17%) used by providers included:

- Living In Balance (10 cases)
- Rational Emotive Behavior Therapy (8 cases)
- Thinking for Good (3 cases)
- Relaxation Therapy (2 cases)
- Eye Movement Desensitization and Reprocessing (3 cases)
- Mindfulness (2 cases)
- Community Reinforcement Approach (2 cases)

The use of MAT declined in SFY 2024, from 37% last year to 26% this year. Campral was used in one alcohol use disorder case, and oral naltrexone was used in nine. For OUD cases, methadone was used 40% of the time, a decrease from 74%. Suboxone was used in 31% of cases.

Certified peer support services were used 72% of the time, an increase from 60% the previous year. Eighty-six percent (86%) of peer support personnel utilized were credentialed. In addition, telehealth services increased from 61% to 68%. Both outcomes align with AHCCCS goals.

Table 4-7: Best Practices

Question	Denominator FY 2024	# of Yes FY 2024	% of Yes FY 2024	% of Yes FY 2023	% of Yes FY 2022
Were EBPs used in treatment?	200	168	84%	74%	77%
• Cognitive Behavioral Therapy	168	60	36%	44%	82%
• Dialectal Behavioral Therapy	168	18	11%	13%	12%
• Helping Women Recover	168	0	0%	1%	0%
• Matrix	168	15	9%	9%	10%
• Moral Re-conation Therapy	168	11	7%	0%	1%

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Question	Denominator FY 2024	# of Yes FY 2024	% of Yes FY 2024	% of Yes FY 2023	% of Yes FY 2022
• Motivational Enhancement/ Interviewing Therapy	168	75	45%	53%	44%
• Relapse Prevention Therapy	168	108	64%	27%	54%
• Seeking Safety	168	11	7%	1%	11%
• SMART Recovery	168	14	8%	8%	18%
• Thinking for a Change	168	0	0%	0%	1%
• Trauma Recovery and Empowerment Model	168	0	0%	1%	1%
• Trauma-Informed Care	168	6	4%	1%	11%
• Wellness Recovery Action Plan	168	1	1%	2%	0%
• Other Practices or Program	168	28	17%	7%	24%

Table 4-8: Medication Assisted Treatment, Peer Support, and Telehealth

Question	Denominator FY 2024	# of Yes FY 2024	% of Yes FY 2024	% of Yes FY 2023	% of Yes FY 2022
MAT[14]	200	52	26%	37%	41%
A. The following medication was used in treatment:					
Alcohol-Related					
• Acamprosate (Campral)	52	1	2%	1%	0%
• Disulfiram (Antabuse)	52	0	0%	1%	1%

[14] MAT options updated from 2023 to current evidence-based best practices

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Question	Denominator FY 2024	# of Yes FY 2024	% of Yes FY 2024	% of Yes FY 2023	% of Yes FY 2022
• Oral naltrexone (Vivitrol®, Revia) (naltrexone hydrochloride tablet)	52	9	17%	New measure	New measure
Opioid-Related					
• Buprenorphine and naloxone (Suboxone, Zubsolv®)	52	16	31%	12%	22%
• Subutex (buprenorphine)	52	1	2%	3%	4%
• Methadone/ LAAM	52	21	40%	74%	69%
• Naltrexone (Vivitrol®, Revia)	52	6	12%	4%	5%
Nicotine-Related (Information Only)					
• Use of nicotine replacement therapy •	52	2	1%	4%	New measure
• Over-the-counter patch, gum, or lozenge	52	2	4%	New measure	New measure
• Prescription inhaler or nasal spray	52	0	0%	New measure	New measure
• Varenicline prescription (Chantix®)	52	0	0%	New measure	New measure
• Bupropion prescription (Wellbutrin, Aplezin®, Forfivo®, Zyban®)	52	0	0%	New measure	New measure
B. Was screening for substance use/abuse conducted during the course of treatment?	200	101	51%	55%	66%
C. Was certified peer support offered as part of treatment?	200	117	59%	45%	42%

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Question	Denominator FY 2024	# of Yes FY 2024	% of Yes FY 2024	% of Yes FY 2023	% of Yes FY 2022
xxii. If yes to C, were certified peer support services used as a part of treatment?	117	84	72%	60%	66%
xxiii. If peer support services were used, were the peer support specialists credentialed?	84	72	86%	New measure	New measure
D. Was telehealth offered as an option to receive treatment?	200	135	68%	61%	New measure

Measure IV — Treatment/Support Services/Rehabilitation Services Key Findings

The types of treatment services used remained fairly consistent over the past three years. Case management remains the most common service at 91%, followed by group therapy at 75%. There was a 1% increase in family counseling, from 2% to 3%. Family counseling continues to be a potential area for improvement. Most members continue to complete 11 sessions or more at a fairly consistent percentage, 55% in this year's cycle and 51% and 57% in the previous two years, respectively. Lack of documentation of information provided on self-help groups also continues to be consistent, with 63% reported this year, 66% last year, and 57% the year before. This may represent an area of lacking documentation, rather than a lack of education and referral, and may be an opportunity for technical assistance to be offered to providers. Documentation that substance use services have been provided has been consistently increasing, with 97% this year, from 96% in SFY 2023, and 91% in SFY 2022.

Table 4-9: Treatment/Support Services/Rehabilitation Services

Question	Denominator	# of Yes FY 2024	% of Yes FY 2024	# of N/A 2024	% of Yes FY 2023	% of Yes FY 2022
A. The following services were used in treatment:*						
• Individual counseling/ therapy	200	145	73%	-	75%	79%

Question	Denominator	# of Yes FY 2024	% of Yes FY 2024	# of N/A 2024	% of Yes FY 2023	% of Yes FY 2022
• Group counseling/ therapy	200	149	75%	-	69%	80%
• Family counseling/ therapy	200	5	3%	-	2%	1%
• Case management	200	181	91%	-	92%	82%
B. Was there clear documentation of progress or lack of progress towards the identified ISP goals?*	200	180	90%	-	92%	89%
The number of completed counseling/ therapy sessions during treatment was:*						
• 0–5 sessions	199	65	33%	-	34%	32%
• 6–10 sessions	199	24	12%	-	15%	11%
• 11 sessions or more	199	110	55%	-	51%	57%
C. Was the individual given any education on self-help or recovery groups?	199	126	63%	_	66%	74%
D. Documentation showed the member reported attending self-help or recovery groups the following number of times:*						
• No documentation	200	126	63%	-	66%	57%
• 0 times during treatment	200	27	14%	-	10%	4%
• 1–4 times during treatment	200	13	7%	-	4%	6%
• 5–12 times during treatment	200	12	6%	-	7%	6%
• 13–20 times during treatment	200	4	2%	-	2%	6%
• 21 or more times during treatment	200	18	9%	-	13%	23%
E. If there was evidence of lack of progress towards the identified goal, did the provider revise the treatment approach	100	69	69%	98	66%	60%

Question	Denominator	# of Yes FY 2024	% of Yes FY 2024	# of N/A 2024	% of Yes FY 2023	% of Yes FY 2022
and/or seek consultation to facilitate positive outcomes?						
F. If the member was unemployed during intake, was there evidence the individual's interest in finding employment was explored?	98	75	77%	100	81%	84%
G. If the member was not involved in an educational or vocational training program, was there evidence the individual's interest in becoming involved in such a program explored?	71	42	59%	127	71%	64%
H. If the member was not involved with a meaningful community activity (e.g., volunteering, caregiving to family or friends, and/or any active community participation), was there evidence the individual's interest in such an activity was explored?	82	55	67%	116	72%	64%
I. Does the documentation reflect that substance abuse services were provided?*	200	193	97%	_	96%	91%
J. Was member's access to a primary care physician (PCP) or other medical provider explored?	200	166	83%	12	81%	79%

Measure V — Gender-Specific Key Findings

There were 65 women in the state sample, representing 33% of all cases. There was a significant increase in domestic violence safety plans completed in cases in which there was a history of domestic violence, with 29% completed in SFY 2023 and 57% completed in SFY 2024. In the one case in which the female was pregnant, there was documentation of coordination of care with the PCP or obstetrician. There has been an overall decline in gender-specific services, from 57% in SFY 2022 to 23% in SFY 2023 and 16% in

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SFY 2024. One identified goal of AHCCCS is to increase services for women, and increasing gender-specific programming is one opportunity to do so.

Table 4-10: Gender-Specific for Women

Question	Denominator	# of Yes FY 2024	% of Yes FY 2024	# of N/A 2024	% of Yes FY 2023	% of Yes FY 2022
A. If there was a history of domestic violence, was there evidence a safety plan was completed?	21	12	57%	44	29%	45%
B. If the female was pregnant, was there documentation of coordination of care efforts with the PCP and/or obstetrician?	1	1	100%	64	0%	50%
C. If the female was pregnant, did documentation show evidence of education on the effects of substance use on fetal development?	1	0	0%	64	0%	50%
D. If the female had a child less than one year of age, was there evidence a screening was completed for postpartum depression/ psychosis?	4	3	75%	61	33%	67%
E. If the female had dependent children, was there documentation to show childcare was addressed?	21	15	71%	44	81%	83%
F. Was there evidence of gender-specific treatment services (e.g., women's-only group therapy sessions)?	49	8	16%	16	23%	57%

Measure VI — Opioid-Specific Key Findings

There has been a year-over-year decline in opioid use diagnoses, from 54% in SFY 2022 to 45% in SFY 2023 and 32% in SFY 2024. There was a decline in documentation that members were provided with education about MAT as a treatment option, dropping from 81% last year to 77% this year. There has also been a decline in providing members with education on naloxone, dropping from 67% last year to 53% this year.

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Table 4-11: Opioid-Specific Key Findings

Question	Denominator	# of Yes 2024	%of Yes FY 2024	# of N/A 2024	% of Yes FY 2023	% of Yes FY 2022
A. Was there documentation of a diagnosed OUD?*	200	64	32%	-	45%	54%
B. Was there documentation the member was provided MAT education as a treatment option?*	64	49	77%	-	81%	85%
If yes, were they referred to a MAT provider?	49	45	92%	8	97%	93%
C. If withdrawal symptoms were present, were they addressed via referral and/or intervention with a medical provider?	27	26	96%	38	97%	98%
D. If a physical health concern related to pain was identified, were alternative pain management options addressed?	16	13	81%	49	72%	76%
E. If member is a pregnant female, did documentation show evidence of education about the safety of methadone and/or buprenorphine during the course of pregnancy?*	N/A	0	0%	-	0%	33%
F. Was there documentation the member was provided with relevant information related to overdose, naloxone education, and actions to take in the event of an opioid overdose?*	64	34	53%	-	67%	47%
G. Was the individual provided with naloxone or information on how to obtain naloxone?*	64	35	55%	-	66%	48%
H. Were family members/ natural supports provided information on how to obtain naloxone/provided naloxone, and actions to take in the event of an opioid overdose, if applicable?	64	0	0%	0	57%	New measure

Question	Denominator	# of Yes 2024	%of Yes FY 2024	# of N/A 2024	% of Yes FY 2023	% of Yes FY 2022
I. Was there documentation the member was provided education on the effects of polysubstance use with opioids?	64	32	50%	0	68%	54%

Measure VII — Discharge and Continuing Care Planning Key Findings

There was a significant decrease in documentation of completion of relapse prevention plans. Relapse prevention plans were present in 70% of cases in SFY 2022 and 2023 but dropped to 54% in SFY 2024. Other findings in discharge and continuing care findings included an increase in the reassessment of ASAM at the time of discharge, increasing 11% from SFY 2023 to 39% in SFY 2024, although there was a decrease in referrals to the ASAM-indicated LOC, from 98% in SFY 2023 to 87% in SFY 2024.

Other methods of outreach used by providers included:

- Internal staffing discussions to determine reengagement strategies
- Email communication

Table 4-12: Discharge and Continuing Care Planning (completed only if member completed treatment or declined further services)

Question	Denominator	# of Yes FY 2024	% of Yes FY 2024	# of N/A FY 2024	% of Yes FY 2023	% of Yes FY 2022
A. Was there documentation present that a relapse prevention plan was completed?*	177	95	54%	-	70%	70%
B. Was the individual reassessed at the time of discharge using ASAM criteria to determine an appropriate LOC?*	178	70	39%	-	28%	48%
C. Was the individual referred to the appropriate LOC based on the ASAM determination?	60	52	87%	39	98%	95%

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Question	Denominator	# of Yes FY 2024	% of Yes FY 2024	# of N/A FY 2024	% of Yes FY 2023	% of Yes FY 2022
D. Was there documentation staff offered resources pertaining to community supports, including recovery self-help and/or other individualized support services (e.g., crisis line)?*	177	104	59%	-	58%	67%
E. Was there documentation staff actively coordinated with other involved agencies at the time of discharge?	110	75	68%	68	68%	61%

Measure VIII — Reengagement Key Findings

Telephonic reengagement efforts decreased 8% in SFY 2024, dropping to 76% from 84% in both SFY 2023 and SFY 2022. If telephone contact was unsuccessful, outreach letters sent also decreased, from 65% in SFY 2023 to 60% in SFY 2024. Some other efforts did include sending emails or texts, as that was the preferred method indicated by the individual. Increased efforts toward reengagement could lead to increased retention and completion of treatment.

Table 4-13: Reengagement Key Findings (completed only if members decline further services or choose not to appear for scheduled services)

Question	Denominator	# of Yes FY 2024	% of Yes FY 2024	# of N/A FY 2024	% of Yes FY 2023	% of Yes FY 2022
A. Was the member (or legal guardian, if applicable) contacted by telephone at times when the member was expected to be available (e.g., after work or school)?*	115	87	76%	_	84%	84%
B. If telephone contact was unsuccessful, was a letter mailed requesting contact?	94	56	60%	20	65%	59%
C. Were other attempts made to reengage the individual such as*:						
• Home visit?	21	5	24%	-	43%	31%

Question	Denominator	# of Yes FY 2024	% of Yes FY 2024	# of N/A FY 2024	% of Yes FY 2023	% of Yes FY 2022
• Call emergency contact(s)?	21	8	38%	-	10%	25%
• Contact other involved agencies?	21	7	33%	-	3%	31%
• Street outreach?	21	0	0%	-	0%	0%

Measure IX — National Outcome Measures Key Findings

National outcome measures showed improvement from intake in most categories in SFY 2024. The greatest increases were in abstinence, which increased from 37% to 83%, and participation in social support, which increased from 25% to 80%. These areas of improvement were also the biggest areas of improvement in SFY 2023, with 65% of cases demonstrating abstinence and 64% participation in social support at the time of discharge. Improvements (green) versus decreases or negative outcomes (pink), such as arrests, from intake to discharge are reflected at the point of discharge in Tables 4-14 (2024) and 4-15 (2023).

Table 4-14: 2024 National Outcome Measures

2024	At Intake				At Discharge			
	Denominator	# Yes	% Yes	Missing	Denominator	# Yes	% Yes	Missing
A. Employed?	195	91	47%	4	105	60	57%	94
B. Enrolled in school or vocational educational program?	178	9	5%	21	91	8	9%	108
C. On disability or retired?	155	21	14%	44	88	14	16%	111
D. Lived in a stable housing environment	194	162	84%	5	98	95	97%	101

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2024	At Intake				At Discharge			
	Denominator	# Yes	% Yes	Missing	Denominator	# Yes	% Yes	Missing
(e.g., not homeless)?								
E. Arrested in the preceding 30 days?**	182	27	15%	17	94	5	5%	105
F. Abstinent from drugs and/or alcohol?	194	71	37%	5	93	77	83%	106
G. Participated in social support recovery in the preceding 30 days?	198	50	25%	37	95	76	80%	103

Table 4-15: 2023 National Outcome Measures

2023	At Intake				At Discharge			
	Denominator	# Yes	% Yes	Missing	Denominator	# Yes	% Yes	Missing
Employed?	193	103	53%	7	132	78	59%	68
B. Enrolled in school or vocational educational program?	177	4	2%	23	130	6	5%	70
C. On disability or retired?	161	20	12%	39	126	13	10%	74
D. Lived in a stable housing environment (e.g., not homeless)?	193	154	80%	7	130	111	85%	70
E. Arrested in the preceding 30 days?**	184	15	8%	16	131	3	2%	69

2023	At Intake				At Discharge			
	Denominator	# Yes	% Yes	Missing	Denominator	# Yes	% Yes	Missing
F. Abstinent from drugs and/or alcohol?	189	56	30%	11	119	77	65%	81
G. Participated in social support recovery in the preceding 30 days?	200	42	21%	28	122	78	64%	78

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Section 5
Case File Review Findings by ACC-RBHA

This section of the report includes findings organized by ACC-RBHA, including narratives, and Tables 5-1 through 5-35. The reporting methodology remains consistent from "Section 4 — Aggregate Findings" to "Section 5 – Case File Review Findings" by ACC-RHBA. The denominators consist of the sum of 'Yes' and 'No' responses and differ across measures. Some denominators are based on the number of 'Yes' responses from a prior question when applicable. 'N/A' responses are not included in any denominator, consistent with prior years' analyses. **Measures marked with an asterisk in the 'N/A' column indicate that 'N/A' was not a valid response option for that particular measure**. Additionally, certain measures included an option for missing documentation. Additional narrative information was collected, as noted in Section 4, and is incorporated into the finding's narrative prior to the table.

Arizona Complete Health (AzCH)

AzCH has responsibility for AHCCCS members in the southern region of the state. AzCH is assigned to members living in Greenlee, Graham, Cochise, Santa Cruz, Pima, Yuma, and La Paz counties. Mercer reviewed 61 provider treatment records from nine separate clinics under AzCH's area of responsibility. In the previous review, the AzCH sample performed better than the state across multiple metrics.

Measure I — Intake/Treatment Planning Key Findings

Initial Behavioral Health Assessment

Similar to the statewide findings, alcohol was the primary substance of choice, at 31%, followed by opioids at 26%. The primary method of ingestion was smoking, at 48%, followed by oral at 36%.

The behavioral health assessment findings have been consistent over SFY 2022, SFY 2023, and SFY 2024, with a 100% completion rate. The new separate measure of whether the assessment was completed within 45 days of intake was also 100%. There has been a decline in the assessment, including the effect of substance use on personal relationships, from 100% in SFY 2022 to 96% in SFY 2023 and 87% in SFY 2024. A positive finding of note is a significant increase in the number of assessments, reflecting a screening for tuberculosis, increasing from 33% in the previous year to 73% in SFY 2024. There was a similar significant

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increase in the screenings for hepatitis C, HIV, and other infectious diseases, with an increase of 52% from SFY 2023 to SFY 2024. Regarding the new measure of SDoH in the assessment, unemployment and housing were both the areas of highest identified need, with a result of 88% of cases identifying these areas. Determinants listed under the option of "Other" include difficulty with finances, not practicing safe sex, having legal concerns, difficulty paying for utilities, lacking adequate clothing, dental concerns, and lack of childcare.

Regulatory Requirements

AzCH performed better than the state average on the new measures collected, with 88% of cases being informed of their HIPAA rights and 95% having documentation that members were given information regarding informed consent. There was also a positive increase in compliance with charitable choice requirements, as applicable, from 67% in the previous year to 83% in SFY 2024.

Individual Service Plan

There was a slight decline in ISPs completed in SFY 2024, dropping from 100% in SFY 2023 to 97%. The new measure of plan completion within 90 days was also 97%. There was also a decline in family participation in the development of the ISP, from 15% in SFY 2022 to 14% in SFY 2023 to 7% in SFY 2024. Another similarity to overall state findings was a significant drop in the incorporation of individual cultural preferences in the ISP, dropping from 98% last year to 41% in SFY 2024. Unemployment was the most common SDoH addressed, in alignment with assessment findings, at 27%, followed by access to care at 24% and housing at 19%. This may be an opportunity for technical assistance to providers to ensure ISPs are created, both with the cultural preferences of the members and addressing identified SDoH, as indicated by the assessment.

Table 5-1: AzCH Assessment and Individual Service Plan

Question	Denominator	# of Yes 2024	% of Yes 2024	# of N/A 2024	# of Yes FY 2023	% of Yes FY 2023
A. What was the primary substance used?[15]*						
• Opioids	61	16	26%	-	16	31%

[15] Substance used and method of ingestion represent information on preferred substances. In some cases, multiple substances were reported as the primary substance for members with polysubstance use conditions because it was hard to discern in the record.

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Question	Denominator	# of Yes 2024	% of Yes 2024	# of N/A 2024	# of Yes FY 2023	% of Yes FY 2023
• Marijuana	61	13	21%	-	9	18%
• Alcohol	61	19	31%	-	22	43%
• Amphetamines	61	13	21%	-	18	35%
• Cocaine	61	7	11%	-	12	24%
• Other (please list)	61	1	2%	-	1	2%
B. What was the method of ingestion?*						
• Smoking	61	29	48%	-	27	53%
• Oral	61	22	36%	-	22	43%
• Inhalation	61	8	13%	-	11	22%
• Injection	61	3	5%	-	2	4%
• Transdermal	61	0	0%	-	0	0%
• Other (please list)	61	0	0%	-	3	6%

Question	Denominator	# of Yes 2024	% of Yes 2024	# of N/A 2024	% of Yes FY 2023	% of Yes FY 2022
Behavioral Health Assessment						
C. Was a behavioral health assessment completed?[16]*	61	61	100%	-	100%	100%
i. Was the behavioral health assessment completed within 45 days of the initial appointment?	61	61	100%	0	New measure	New measure
D. Did the behavioral health assessment:*						

[16] Item C and C.1. were split into two questions for the 2024 review due to tool validation

Question	Denominator	# of Yes 2024	% of Yes 2024	# of N/A 2024	% of Yes FY 2023	% of Yes FY 2022
i. Address substance-related disorder(s)?	61	61	100%	-	100%	100%
ii. Describe the intensity/ frequency of substance use?	61	57	93%	-	100%	93%
iii. Include the effect of substance use on daily functioning?	61	56	92%	-	98%	98%
iv. Include the effect of substance use on interpersonal relationships?	61	53	87%	-	96%	100%
v. Was a risk assessment completed?	61	60	98%	-	100%	100%
vi. Document screening for tuberculosis?	61	46	75%	-	33%	51%
vii. Document screening for hepatitis C, HIV, and other infectious diseases?	61	44	72%	-	20%	44%
viii. Document screening for emotional and/or physical abuse/ trauma issues?	61	60	98%	-	94%	98%
ix. Document that review of the PDMP was completed?	53	6	11%	-	13%	8%
E. Were social determinants of health documented as a part of the assessment?*						
i. Access to medical care?	60	46	77%	-	New measure	New measure
ii. Housing?	60	53	88%	-	New measure	New measure
iii. Food insecurity?	60	33	55%	-	New measure	New measure

Question	Denominator	# of Yes 2024	% of Yes 2024	# of N/A 2024	% of Yes FY 2023	% of Yes FY 2022
iv. Domestic violence?	60	38	63%	-	New measure	New measure
v. Unemployment?	60	53	88%	-	New measure	New measure
vi. Transportation?	60	44	73%	-	New measure	New measure
vii. Other?	60	9	15%	-	New measure	New measure
F. Regulatory requirements:						
i. Was there documentation that charitable choice requirements were followed, if applicable?	6	5	83%	53	67%	0%
ii. Was there documentation that individuals were informed of their HIPAA rights?*	60	53	88%	-	New measure	New measure
iii. Was there documentation that individuals were given information on informed consent?*	60	57	95%	-	New measure	New measure
G. Was an ISP completed?[17]*	61	59	97%	-	100%	95%
i. Was the ISP completed within 90 days of the initial appointment?	61	59	97%	0	New measure	New measure
H. Was the ISP:						
i. Developed with participation of the family/support network?	59	4	7%	49	14%	15%
ii. Congruent with the diagnosis(es) and presenting concern(s)?*	59	57	97%	-	100%	97%

[17] Item G was split into two measures, G and G.i., for the 2024 review due to tool validation.

Question	Denominator	# of Yes 2024	% of Yes 2024	# of N/A 2024	% of Yes FY 2023	% of Yes FY 2022
iii. Measurable objectives and timeframes to address the identified needs?*	59	58	98%	-	98%	95%
iv. Addressing the unique cultural preferences of the individual?*	59	24	41%	-	98%	95%
v. Were SDoH issues considered as part of, and incorporated into, the ISP?	59	22	37%	17	45%	85%
If yes, which domains?*						
• Access to medical care	59	14	24%	-	16%	33%
• Housing	59	11	19%	-	8%	72%
• Food insecurity	59	0	0%	-	6%	8%
• Domestic violence	59	0	0%	-	4%	10%
• Unemployment	59	16	27%	-	27%	69%
• Transportation	59	2	3%	-	10%	New Measure
• Other	59	2	3%	-	3%	2%

Measure II — Placement Criteria/Assessment Key Findings

There has been a decline in the use of ASAM 3rd Edition criteria to determine LOC, dropping from 93% in SFY 2022 to 90% in SFY 2023, and to a low of 69% in SFY 2024, a 21% decrease from the previous year. These tools included:

- Patient Health Questionnaire: 9 (16 cases)
- Generalized Anxiety Disorder: 7 (14 cases)
- Protocol for Responding to & Assessing Patients' Assets, Risks & Experiences: (9 cases)

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- Drug Abuse Screening Test: (6 cases)
- Alcohol Use Disorders Identification Test – Consumption: (2 cases)
- Adverse Childhood Experiences Questionnaire: (5 cases)
- Columbia Suicide Severity Rating Scale: (1 case)
- Diagnostic and Statistical Manual of Mental Disorders 5: (1 case)
- Michigan Alcohol Screening Test: (1 Case)
- Level 1 Outpatient Treatment remained the most common level of care, at 57%, followed by Level 2.1 Intensive Outpatient Treatment/Partial Hospitalization at 31%. There was a 26% increase in the number of individuals receiving the LOC indicated in their assessment, from 74% in SFY 2023 to 100% in SFY 2024. When ASAM dimensions were used, there was an increase in reassessment during treatment, from 24% in the previous year to 31% in SFY 2024.

Table 5-2: AzCH Placement Criteria/Assessment

Question	Denominator	# of Yes 2024	% of Yes 2024	% of Yes FY 2023	% of Yes FY 2022
A. Was there documentation that ASAM dimensions were used to determine the proper level of care at intake?	61	42	69%	90%	93%
If the ASAM Placement Criteria were used, the level of service identified was:					
Level 0.5: Early Intervention	42	0	0%	0%	3%
OMT: Opioid Maintenance Therapy	42	5	12%	20%	8%
Level 1: Outpatient Treatment	42	24	57%	46%	24%
Level 2: Intensive Outpatient Treatment/Partial Hospitalization	42	13	31%	30%	11%
Level 3: Residential/Inpatient Treatment	42	2	5%	11%	68%

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Question	Denominator	# of Yes 2024	% of Yes 2024	% of Yes FY 2023	% of Yes FY 2022
Level 4: Medically Managed Intensive Inpatient Treatment	42	0	0%	0%	0%
B. Did the member receive the level of services identified by the placement criteria/assessment?	42	42	100%	74%	89%
C. Were the ASAM dimensions reassessed (with documentation) during the course of treatment?	42	13	31%	24%	34%
D. Were additional assessment tools (in addition to ASAM or in lieu of) utilized during the course of treatment?	61	45	74%	57%	20%

Measure III — Best Practices Key Findings

There was an increase in the use of EBPs in AzCH, increasing from 76% in SFY 2023 to 89% in SFY 2024. Modalities used were reflective of overall State findings, with relapse prevention as the primary EBP, used at 61%, and motivational enhancement/interviewing therapy at 43%. Additional interventions used by providers included:

- Rational Emotive Behavior Therapy (4 cases)
- Thinking for Good (3 cases)
- Living in Balance (3 cases)
- Community Reinforcement Approach (2 cases)

MAT for alcohol was used in only one instance, despite alcohol being the primary drug of choice for the AzCH cases reviewed. Suboxone remains the primary MAT for OUDs at 50%, followed by methadone at 40%. There was no MAT utilized for nicotine, although this was a measure reviewed for information only. Peer support services were offered in 71% of cases, an increase from last year's finding of 61%, and 85% of cases utilized peer support services, an increase from last year's result of 65%. Telehealth was offered in 64% of cases, an increase from the previous year's finding of 53%. The findings in peer support and telehealth align with AHCCCS goals for the SUBG.

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Table 5-3: AzCH Best Practices

Question	Denominator FY 2024	# of Yes FY 2024	% of Yes FY 2024	% of Yes FY 2023	% of Yes FY 2022
A. Were EBPs used in treatment?	61	54	89%	76%	90%
• Cognitive Behavioral Therapy	54	18	33%	41%	70%
• Dialectal Behavioral Therapy	54	3	6%	13%	24%
• Helping Women Recover	54	0	0%	3%	0%
• Matrix	54	9	17%	13%	3%
• Moral Re-conation Therapy	54	8	15%	0%	3%
• Motivational Enhancement/ Interviewing Therapy	54	23	43%	41%	35%
• Relapse Prevention Therapy	54	33	61%	33%	51%
• Seeking Safety	54	3	6%	0%	27%
• SMART Recovery	54	5	9%	13%	41%
• Thinking for a Change	54	0	0%	0%	3%
• Trauma Recovery and Empowerment Model	54	0	0%	3%	3%
• Trauma-Informed Care	54	0	0%	3%	11%
• Wellness Recovery Action Plan	54	1	2%	5%	0%
• Other Practices or Program	54	11	20%	10%	32%

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Table 5-4: AzCH Medication-Assisted Treatment, Peer Support, and Telehealth

Question	Denominator FY 2024	# of Yes FY 2024	% of Yes FY 2024	% of Yes FY 2023	% of Yes FY 2022
MAT[18]	61	10	16%	25%	24%
A. The following medication was used in treatment:					
Alcohol-Related					
• Acamprosate (Campral)	10	0	0%	0%	0%
• Disulfiram (Antabuse)	10	0	0%	0%	0%
• Oral naltrexone (Vivitrol®, Revia) (naltrexone hydrochloride tablet)	10	1	10%	New measure	New measure
Opioid-Related					
• Buprenorphine and naloxone (Suboxone, Zubsolv®)	10	5	50%	54%	33%
• Subutex (buprenorphine)	10	0	0%	0%	10%
• Methadone/Levo-Alpha-Acetylmethadol (LAAM)	10	4	40%	38%	60%
• Naltrexone (Vivitrol®, Revia)	10	1	10%	0%	0%
Nicotine-Related (Information Only)					
• Use of nicotine replacement therapy •	10	0	0%	8%	New measure

[18] MAT options updated from 2023 to current EBPs

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Question	Denominator FY 2024	# of Yes FY 2024	% of Yes FY 2024	% of Yes FY 2023	% of Yes FY 2022
• Over-the-counter patch, gum, or lozenge	10	0	0%	New measure	New measure
• Prescription inhaler or nasal spray	10	0	0%	New measure	New measure
• Varenicline prescription (Chantix®)	10	0	0%	New measure	New measure
• Bupropion prescription (Wellbutrin, Aplezin®, Forfivo®, Zyban®)	10	0	0%	New measure	New measure
B. Was screening for substance use/abuse conducted during the course of treatment?	61	19	31%	47%	76%
C. Was certified peer support offered as part of treatment?	61	47	77%	61%	54%
If yes to C, were certified peer support services used as a part of treatment?	47	40	85%	65%	86%
If peer support services were used, were the peer support specialists credentialed?	40	39	98%	New measure	New measure
D. Was telehealth offered as an option to receive treatment?	61	39	64%	53%	New measure

Measure IV — Treatment/Support Services/Rehabilitation Services Key Findings

Case management was the primary service modality at 90%, a reduction from last year, which was at 96%. Group therapy was the second most utilized delivery method, at 85%, an increase from last year, which was 67%. There was a slight increase in family counseling, with one member receiving family therapy. There was an increase in members receiving 11 sessions or more, from 42% last year to 67% in SFY 2024, indicating members engaged in treatment do receive an appropriate number of services for outpatient and intensive outpatient, the most commonly used levels of care. Education about self-

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help groups continues to remain an area of opportunity, with a finding of 58%, the same as the previous year. There was a 14% increase in exploring the member's need for a PCP, from 75% in SFY 2023 to 89% in SFY 2024.

Table 5-5: AzCH Treatment/Support Services/Rehabilitation Services

Question	Denominator	# of Yes FY 2024	% of Yes FY 2024	# of N/A 2024	% of Yes FY 2023	% of Yes FY 2022
A. The following services were used in treatment:*						
• Individual counseling/ therapy	61	32	52%	-	53%	93%
• Group counseling/ therapy	61	52	85%	-	67%	95%
• Family counseling/ therapy	61	1	2%	-	0%	0%
• Case management	61	55	90%	-	96%	80%
B. Was there clear documentation of progress or lack of progress towards the identified ISP goals?*	61	54	89%	-	94%	100%
C. The number of completed counseling/therapy sessions during treatment was:*						
• 0–5 sessions	60	13	22%	-	42%	10%
• 6–10 sessions	60	7	12%	-	16%	2%
• 11 sessions or more	60	40	67%	-	42%	88%
D. Was the individual given any education on self-help or recovery groups?*	60	35	58%	-	58%	85%
E. Documentation showed the member reported attending self-help or recovery groups the following number of times:*						
• No documentation	61	42	69%	-	73%	41%
• 0 times during treatment	61	7	11%	-	8%	0%
• 1–4 times during treatment	61	5	8%	-	2%	5%
• 5–12 times during treatment	61	3	5%	-	6%	5%

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Question	Denominator	# of Yes FY 2024	% of Yes FY 2024	# of N/A 2024	% of Yes FY 2023	% of Yes FY 2022
• 13–20 times during treatment	61	1	2%	-	0%	17%
• 21 or more times during treatment	61	3	5%	-	12%	32%
F. If there was evidence of lack of progress towards the identified goal, did the provider revise the treatment approach and/or seek consultation to facilitate positive outcomes?	30	21	70%	29	68%	88%
G. If the member was unemployed during intake, was there evidence the individual's interest in finding employment was explored?	29	22	76%	30	84%	88%
H. If the member was not involved in an educational or vocational training program, was there evidence the individual's interest in becoming involved in such a program was explored?	24	15	63%	35	67%	69%
I. If the member was not involved with a meaningful community activity (e.g., volunteering, caregiving to family or friends, and/or any active community participation), was there evidence the individual's interest in such an activity was explored?	20	13	65%	39	61%	84%
J. Does the documentation reflect substance abuse services were provided?*	61	56	92%	-	92%	93%
K. Was member's access to a PCP or other medical provider explored?	61	54	89%	2	75%	85%

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Measure V — Gender-Specific Key Findings

There were 14 females in the AzCH sample. There were five cases with a history of domestic violence documented, and one case had a safety plan completed in SFY 2024, for a finding of 20%. There were no pregnant women in the sample.

Gender-specific treatment services continue to remain an area of opportunity, with a decline from 76% in SFY 2022, to 38% in SFY 2023, to 30% in SFY 2024.

Table 5-6: AzCH Gender-Specific for Women

Question	Denominator	# of Yes FY 2024	% of Yes FY 2024	# of N/A 2024	% of Yes FY 2023	% of Yes FY 2022
A. If there was a history of domestic violence, was there evidence a safety plan was completed?	5	1	20%	9	0%	67%
B. If the female was pregnant, was there documentation of coordination of care efforts with the PCP and/or obstetrician?	N/A	0	-	14	N/A	0%
C. If the female was pregnant, did documentation show evidence of education on the effects of substance use on fetal development?	N/A	0	-	14	N/A	0%
D. If the female had a child less than one year of age, was there evidence a screening was completed for postpartum depression/ psychosis?	1	1	100%	13	N/A	100%
E. If the female had dependent children, was there documentation to show childcare was addressed?	3	3	100%	11	100%	100%
F. Was there evidence of gender-specific treatment services (e.g., women's only group therapy sessions)?	10	3	30%	4	38%	76%

Measure VI — Opioid-Specific Key Findings

There continues to be a decline in the percentage of cases with an opioid use diagnosis, from 49% in SFY 2022, to 35% in SFY 2023, to 26% in SFY 2024. There was a decrease in the

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number of cases referred to a MAT provider, from 100% the previous year to 82% in SFY 2024. There was also a decrease in withdrawal symptoms being addressed, if present, to 83% in SFY 2024, from 100% in the previous two years. The referral to MAT and follow up for withdrawal symptoms might be areas in which AzCH may want to provide technical assistance to providers, as these are potential areas of medical concern, especially the follow up on withdrawal symptoms. There was a positive increase in education and provision of naloxone to members, from 44% in the previous year to 56% in SFY 2024.

Table 5-7: AzCH Opioid-Specific Key Findings

Question	Denominator	# of Yes 2024	% of Yes FY 2024	# of N/A 2024	% of Yes FY 2023	% of Yes FY 2022
A. Was there documentation of a diagnosed OUD?*	61	16	26%	-	35%	49%
B. Was there documentation the member was provided MAT education as a treatment option?*	16	11	69%	-	67%	80%
If yes to B, were they referred to a MAT provider?	11	9	82%	5	100%	88%
C. If withdrawal symptoms were present, were they addressed via referral and/or intervention with a medical provider?	6	5	83%	11	100%	100%
D. If a physical health concern related to pain was identified, were alternative pain management options addressed?	2	1	50%	15	0%	50%
E. If member is a pregnant female, did documentation show evidence of education about the safety of methadone and/or buprenorphine during the course of pregnancy?*	N/A	0	--	-	N/A	0%
F. Was there documentation the member was provided with relevant information related to overdose, naloxone education, and actions to take in the event of an opioid overdose?*	16	9	56%	-	44%	25%

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Question	Denominator	# of Yes 2024	% of Yes FY 2024	# of N/A 2024	% of Yes FY 2023	% of Yes FY 2022
G. Was the individual provided with naloxone or information on how to obtain naloxone?*	16	9	56%	-	44%	30%
H. Were family members/ natural supports provided information on how to obtain naloxone/provided naloxone, and actions to take in the event of an opioid overdose, if applicable?	16	0	0%	3	6%	New measure
I. Was there documentation the member was provided education on the effects of polysubstance use with opioids?	16	6	38%	0	39%	35%

Measure VII — Discharge and Continuing Care Planning Key Findings

There was a significant decline of 29% in documentation that a relapse prevention plan was completed, dropping from 83% in SFY 2023 to 52% in SFY 2024. There was an increase in members being reassessed using ASAM at the time of discharge, from 15% in the previous year to 25% in SFY 2024. Of those reassessed, there was a significant decline in referral to the identified LOC, from 100% in SFY 2023 to 67% in SFY 2024. Continuing care planning may be another area for AzCH to provide technical assistance to providers, as relapse prevention planning and referral are important parts of ongoing stabilization in the recovery process.

Table 5-8: AzCH Discharge and Continuing Care Planning (completed only if member completed treatment or declined further services)

Question	Denominator	# of Yes FY 2024	% of Yes FY 2024	# of N/A FY 2024	% of Yes FY 2023	% of Yes FY 2022
A. Was there documentation present a relapse prevention plan was completed?*	61	32	52%	-	83%	80%
B. Was the individual reassessed at the time of discharge using ASAM criteria to determine an appropriate LOC?*	61	15	25%	-	15%	40%

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Question	Denominator	# of Yes FY 2024	% of Yes FY 2024	# of N/A FY 2024	% of Yes FY 2023	% of Yes FY 2022
C. Was the individual referred to the appropriate LOC based on the ASAM determination?	9	6	67%	18	100%	94%
D. Was there documentation staff offered resources pertaining to community supports, including recovery self-help and/or other individualized support services (e.g., crisis line)?*	61	27	44%	-	43%	84%
E. Was there documentation staff actively coordinated with other involved agencies at the time of discharge?	35	23	66%	26	75%	69%

Measure VIII — Reengagement Key Findings

Reengagement findings also saw a decline, from SFY 2023 to SFY 2024, with telephone outreach dropping from 97% to 60% and follow-up letter contact dropping from 83% to 59%. Other activities taken by providers to make contact include visiting the member's home (57%) and calling the member's emergency contact (57%). Increased reengagement efforts could lead to increased retention, better treatment outcomes, and might be an additional potential area for AzCH to provide technical assistance to providers.

Table 5-9: AzCH Reengagement Key Findings

Question	Denominator	# of Yes FY 2024	% of Yes FY 2024	# of N/A FY 2024	% of Yes FY 2023	% of Yes FY 2022
A. Was the member (or legal guardian, if applicable) contacted by telephone at times when the member was expected to be available (e.g., after work or school)?*	35	21	60%	-	97%	94%
B. If telephone contact was unsuccessful, was a letter mailed requesting contact?	27	16	59%	7	83%	69%
C. Were other attempts made to reengage the individual, such as*:						

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Question	Denominator	# of Yes FY 2024	% of Yes FY 2024	# of N/A FY 2024	% of Yes FY 2023	% of Yes FY 2022
• Home visit?	7	4	57%	-	63%	63%
• Call emergency contact(s)?	7	4	57%	-	11%	25%
• Contacting other involved agencies?	7	0	0%	-	0%	13%
• Street Outreach?	7	0	0%	-	0%	0%

Measure IX — NOMs Key Findings

Each of the six AzCH NOMs for Measure IX are depicted in Table 5-10. Denominators are impacted by missing documentation of status at intake and discharge, if applicable. The graphs below show the members' status for each NOM at intake and discharge. For the NOMs in which data was available at discharge, there was a positive trend in all measures, with 96% of members living in stable housing, 90% participating in social support, and 86% reporting at least 30 days of abstinence. There was also improvement in discharge findings, from SFY 2023 to SFY 2024, with an 8% improvement in employment, a 24% improvement in abstinence, and a 31% improvement in participation in social supports. These numbers may be higher due to a higher volume of available discharge information in SFY 2024, as each measure had more responses.

Table 5-10: 2024 and 2023 AzCH National Outcome Measures

2024	At Intake				At Discharge			
	Denominator	# Yes	% Yes	Missing	Denominator	# Yes	% Yes	Missing
A. Employed?	61	30	49%	0	32	21	66%	29
B. Enrolled in school or vocational educational program?	55	3	5%	6	26	3	12%	35

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2024	At Intake				At Discharge			
C. On disability or retired?	48	6	13%	13	29	5	17%	32
D. Lived in a stable housing environment (e.g., not homeless)?	61	48	79%	0	27	26	96%	34
E. Arrested in the preceding 30 days?**	58	14	24%	3	30	3	10%	31
F. Abstinent from drugs and/or alcohol?	61	32	52%	0	28	24	86%	33
G. Participated in social support recovery in the preceding 30 days?	61	20	33%	12	29	26	90%	32

2023	At Intake				At Discharge			
	Denominator	# Yes	% Yes	Missing	Denominator	# Yes	% Yes	Missing
A. Employed?	50	25	50%	1	24	14	58%	27
B. Enrolled in school or vocational educational program?	44	0	0%	7	24	0	0%	27

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2023	At Intake				At Discharge			
	Denominator	# Yes	% Yes	Missing	Denominator	# Yes	% Yes	Missing
C. On disability or retired?	34	4	12%	17	22	1	5%	29
D. Lived in a stable housing environment (e.g., not homeless)?	51	42	82%	0	24	22	92%	27
E. Arrested in the preceding 30 days?**	49	4	8%	2	25	0	0%	26
F. Abstinent from drugs and/or alcohol?	48	22	46%	3	26	16	62%	25
G. Participated in social support recovery in the preceding 30 days?	51	13	25%	5	22	13	59%	29

Care1st Health Plan

Care1st Health Plan has responsibility for AHCCCS members in the northern region of the state and is part of Arizona Complete Care. Care1st is assigned to members living in Apache, Coconino, Maricopa, Mohave, Navajo, and Yavapai counties. Mercer reviewed provider treatment records from six separate clinics under Care1st's area of responsibility.

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Measure I — Intake/Treatment Planning Key Findings

Initial Behavioral Health Assessment

The initial behavioral health assessment concluded that alcohol was the primary substance of choice, at 46%, followed by amphetamines at 27%. The primary method of ingestion for substances was oral, at 54%, and smoking at 49%.

The behavioral health assessment findings improved for SFY 2024 to 100%, with SFY 2023 and SFY 2022 both being at 95%. The new separate measure of whether the assessment was completed within 45 days of intake was also 100%. There has been a decline in the assessment, including the effect of substance use on personal relationships, which in SFY 2022 and SFY 2023, was 95% and in SFY 2024, the percentage decreased to 89%. A positive finding of note is a significant increase in the number of assessments reflecting a screening for tuberculosis, increasing from 20% in SFY 2023 to 51% in SFY 2024. There was a similar significant increase in the screenings for hepatitis C, HIV, and other infectious diseases, with an increase to 52% in SFY 2024 from 10% in SFY 2023. Regarding the new measure of SDoH in the assessment, unemployment was the highest need identified, at 84%, with both housing and access to medical care being very close to identified needs. Housing was identified at 78%, and access to medical care was close behind, at 76%, as an identified need.

Regulatory Requirements

New measures in the regulatory requirements included HIPAA, informed consent, and ISP completed within 90 days of appointment. Informed consent indicated an 86% compliance, and HIPAA was at 78% compliance. It should be noted that charitable choice was 100% for SFY 2024.

Individual Service Plan

Care1st completed the ISP within 90 days of an appointment, with a result of 97%. As mentioned above, this is a new measure. Completing the ISP for members saw an increase, from 85% for SFY 2023 to 97% for SFY 2024. There was a marked decline in addressing cultural differences for the members, from SFY 2023 (88%) and SFY 2022 (86%) to SFY 2024 (47%). An additional decline in SFY 2024 was seen in family participation in the development of the ISP, from 29% in SFY 2022, to 14% in SFY 2023, to 17% in SFY 2024. Access to medical care was the most identified need addressed in the ISP, at 28%, followed by unemployment, at 19%, for SFY 2024. Other domains include food insecurity, domestic violence, and a new measure of transportation. Transportation was noted in 14% of documentation for SFY 2024.

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Table 5-12: Care1st Health Plan Assessment and ISP

Question	Denominator	# of Yes 2024	% of Yes 2024	# of N/A 2024	# of Yes FY 2023	% of Yes FY 2023
A. What was the primary substance used?*[19]						
• Opioids	37	7	19%	-	7	33%
• Marijuana	37	7	19%	-	4	19%
• Alcohol	37	17	46%	-	12	57%
• Amphetamines	37	10	27%	-	8	38%
• Cocaine	37	0	0%	-	0	0%
• Other (please list)	37	1	3%	-	1	5%
What was the method of ingestion?*						
• Smoking	37	18	49%	-	7	33%
• Oral	37	20	54%	-	12	57%
• Inhalation	37	2	5%	-	2	10%
• Injection	37	2	5%	-	5	24%
• Transdermal	37	0	0%	-	0	0%
• Other (please list)	37	0	0%	-	1	5%

Question	Denominator	# of Yes 2024	% of Yes 2024	# of N/A 2024	% of Yes FY 2023	% of Yes FY 2022
Behavioral Health Assessment						

[19] Substance used and method of ingestion represent information on preferred substances. In some cases, multiple substances were reported as the primary substance for members with polysubstance use conditions because it was hard to discern in the record.

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Question	Denominator	# of Yes 2024	% of Yes 2024	# of N/A 2024	% of Yes FY 2023	% of Yes FY 2022
C. Was a behavioral health assessment completed?*	37	37	100%	-	95%	95%
i. Was the behavioral health assessment completed within 45 days of the initial appointment? [20]	37	37	100%	0	New measure	New measure
D. Did the behavioral health assessment:*						
i. Address substance- related disorder(s)?	37	37	100%	-	100%	100%
ii. Describe the intensity/frequency of substance use?	37	36	97%	-	95%	100%
iii. Include the effect of substance use on daily functioning?	37	35	95%	-	95%	95%
iv. Include the effect of substance use on interpersonal relationships?	37	33	89%	-	95%	95%
v. Was a risk assessment completed?	37	37	100%	-	100%	100%
vi. Document screening for tuberculosis?	37	19	51%	-	20%	38%
vii. Document screening for hepatitis C, HIV, and other infectious diseases?	37	21	57%	-	10%	33%
viii. Document screening for emotional and/or physical abuse/ trauma issues?	37	37	100%	-	100%	86%
ix. Document that review of the PDMP was completed?	37	4	11%	-	5%	11%
Were SDoHs documented as a part of the assessment?*						
i. Access to medical care?	37	28	76%	-	New measure	New measure

[20] Items B and B.i. were split into two questions for the 2024 review due to tool validation.

Question	Denominator	# of Yes 2024	% of Yes 2024	# of N/A 2024	% of Yes FY 2023	% of Yes FY 2022
ii. Housing?	37	29	78%	-	New measure	New measure
iii. Food insecurity?	37	22	59%	-	New measure	New measure
iv. Domestic violence?	37	27	73%	-	New measure	New measure
v. Unemployment?	37	31	84%	-	New measure	New measure
vi. Transportation?	37	26	70%	-	New measure	New measure
vii. Other?	37	3	8%	-	New measure	New measure
Regulatory requirements:						
i. Was there documentation charitable choice requirements were followed, if applicable?	1	1	100%	36	19%	0%
ii. Was there documentation individuals were informed of their HIPAA rights?*	37	29	78%	-	New measure	New measure
iii. Was there documentation individuals were given information on informed consent?*	37	32	86%	-	New measure	New measure
G. Was an ISP completed?*[21]	37	36	97%	-	85%	100%
Was the ISP completed within 90 days of the initial appointment?	37	36	97%	0	New measure	New measure
H. Was the ISP:						

[21] Item G was split into two measures, G and G.i. for the 2024 review due to tool validation.

Question	Denominator	# of Yes 2024	% of Yes 2024	# of N/A 2024	% of Yes FY 2023	% of Yes FY 2022
i. Developed with participation of the family/support network?	36	6	17%	25	12%	29%
ii. Congruent with the diagnosis(es) and presenting concern(s)?*	36	35	97%	-	100%	100%
iii. Measurable objectives and timeframes to address the identified needs?*	36	36	100%	-	100%	95%
iv. Addressing the unique cultural preferences of the individual?*	36	17	47%	-	88%	86%
Were SDoH issues considered part of, and incorporated into, the ISP?	36	17	47%	15	29%	67%
If yes, which domains?*						
• Access to medical care?	36	10	28%	-	24%	10%
• Housing?	36	4	11%	-	6%	24%
• Food insecurity?	36	1	3%	-	0%	0%
• Domestic violence?	36	3	8%	-	0%	10%
• Unemployment?	36	7	19%	-	6%	38%
• Transportation?	36	5	14%	-	0%	New Measure
• Other	36	1	3%	-	2%	3%

Measure II — Placement Criteria/Assessment Key Findings

ASAM criteria was used in determining the appropriate LOC in 86% of cases, an increase from SFY 2023, at 67%, and SFY 2022 at 73%. Level 1 Outpatient Treatment remains the most common LOC, at 63%, followed by Level 2.1 Intensive Outpatient and Level 3 Residential, both at 19%. Members received the LOC indicated in their assessment in 97% of cases, an improvement over last year's result of 86%, and the member was reassessed against ASAM

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criteria during the course of treatment more often, increasing from 57% last year to 59% this year. Additional assessment tools were used in 49% of cases and included:

- PHQ-9, AASE (4 cases)
- GAD-7 (3 cases)
- Columbia Suicide Scale (3 cases)
- CIWA (one case)

Table 5-13: Care1st Placement Criteria/Assessment

Question	Denominator	# of Yes 2024	% of Yes 2024	% of Yes FY 2023	% of Yes FY 2022
A. Was there documentation ASAM dimensions were used to determine the proper level of care at intake?	37	32	86%	67%	73%
If the ASAM Placement Criteria were used, the level of service identified was:					
Level 0.5: Early Intervention	32	0	0%	0%	0%
OMT: Opioid Maintenance Therapy	32	3	9%	0%	0%
Level 1: Outpatient Treatment	32	20	63%	50%	44%
Level 2: Intensive Outpatient Treatment/ Partial Hospitalization	32	6	19%	7%	13%
Level 3: Residential/Inpatient Treatment	32	6	19%	57%	44%
Level 4: Medically Managed Intensive Inpatient Treatment	32	0	0%	0%	0%
B. Did the member receive the level of services identified by the placement criteria/assessment?	32	31	97%	86%	94%

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Question	Denominator	# of Yes 2024	% of Yes 2024	% of Yes FY 2023	% of Yes FY 2022
C. Were the ASAM dimensions reassessed (with documentation) during the course of treatment?	32	19	59%	57%	38%
D. Were additional assessment tools (in addition to ASAM or in lieu of) used during the course of treatment?	37	18	49%	67%	50%

Measure III — Best Practices Key Findings

There was an increase in the use of EBPs in Care1st, increasing from 76% in SFY 2023 to 84% in SFY 2024. Modalities used were reflective of overall state findings, with relapse prevention as the primary EBP used, at 55%, and motivational enhancement/interviewing therapy and cognitive behavior therapy, both at 39%. It is noteworthy that in SFY 2022, cognitive behavior therapy was 74%. Additional interventions used by providers included:

- Living in Balance (3 cases)
- Rational Emotive Behavior Therapy (2 cases)
- Relaxation Therapy (2 cases)

MAT for alcohol was utilized at 19%, despite alcohol being the primary drug of choice for the Care1st cases reviewed. Suboxone remains the primary MAT for OUDs, at 43%, followed by Methadone and Naltrexone, both at 29%. There was one member MAT used for nicotine, although this was a measure reviewed for information purposes only. Peer support services were offered in 51% of cases, an increase from last year's finding of 38%, and 42% of cases utilized peer support services, an increase from last year's result of 25%. Telehealth was offered in 78% of cases, an increase from the previous year's finding of 64%. The findings in the areas of peer support and telehealth services are in alignment with AHCCCS goals for the SUBG.

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Table 5-14: Care1st Best Practices — EBPs

Question	Denominator FY 2024	# of Yes FY 2024	% of Yes FY 2024	% of Yes FY 2023	% of Yes FY 2022
A. Were EBPs used in treatment?	37	31	84%	76%	86%
• Cognitive Behavioral Therapy	31	12	39%	50%	74%
• Dialectal Behavioral Therapy	31	9	29%	6%	11%
• Helping Women Recover	31	0	0%	0%	0%
• Matrix	31	2	6%	6%	16%
• Moral Re-conation Therapy	31	2	6%	0%	0%
• Motivational Enhancement /Interviewing Therapy	31	12	39%	56%	21%
• Relapse Prevention Therapy	31	17	55%	19%	58%
• Seeking Safety	31	1	3%	1%	11%
• SMART Recovery	31	0	0%	0%	5%
• Thinking for a Change	31	0	0%	0%	5%
• Trauma Recovery and Empowerment Model	31	0	0%	0%	9%
• Trauma-Informed Care	31	2	6%	0%	11%
• Wellness Recovery Action Plan	31	0	0%	0%	0%
• Other Practices or Program	31	7	23%	1%	0%

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Table 5-15: Care1st Best Practices — Medication Assisted Treatment, Peer Support, and Telehealth

Question	Denominator FY 2024	# of Yes FY 2024	% of Yes FY 2024	% of Yes FY 2023	% of Yes FY 2022
• MAT [22]	37	7	19%	10%	18%
The following medication was used in treatment:					
Alcohol-Related					
• Acamprosate (Campral)	7	1	14%	0%	0%
• Disulfiram (Antabuse)	7	0	0%	0%	0%
• Oral naltrexone (Vivitrol®, Revia) (naltrexone hydrochloride tablet)	7	1	14%	New measure	New measure
Opioid-Related					
• Buprenorphine and naloxone (Suboxone, Zubsolv®)	7	3	43%	50%	25%
• Subutex (buprenorphine)	7	0	0%	0%	0%
• Methadone/LAAM	7	2	29%	50%	50%
• Naltrexone (Vivitrol®, Revia)	7	2	29%	50%	25%
Nicotine-Related (Information Only)					
• Use of nicotine replacement therapy	7	1	14%	0%	New measure
• Over-the-counter patch, gum, or lozenge	7	1	14%	New measure	New measure
• Prescription inhaler or nasal	7	0	0%	New	New

[22] MAT options updated from 2023 to current evidence-based best practices

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Question	Denominator FY 2024	# of Yes FY 2024	% of Yes FY 2024	% of Yes FY 2023	% of Yes FY 2022
spray				measure	measure
• Varenicline prescription (Chantix®)	7	0	0%	New measure	New measure
• Bupropion prescription (Wellbutrin, Aplezin®, Forfivo®, Zyban®)	7	0	0%	New measure	New measure
B. Was screening for substance use/abuse conducted during the course of treatment?	37	15	41%	14%	41%
C. Was certified peer support offered as part of treatment?	37	19	51%	38%	45%
If yes to C, were certified peer support services used as a part of treatment?	19	8	42%	25%	80%
If peer support services were utilized, were the peer support specialists credentialed?	8	6	75%	New measure	New measure
D. Was telehealth offered as an option to receive treatment?	37	29	78%	64%	New measure

Table 5-16: Care1st Treatment/Support Services/Rehabilitation Services

Question	Denominator	# of Yes FY 2024	% of Yes FY 2024	# of N/A 2024	% of Yes FY 2023	% of Yes FY 2022
The following services were used in treatment:*						
• Individual counseling/ therapy	37	30	81%	-	62%	86%
• Group counseling/ therapy	37	26	70%	-	62%	91%

Question	Denominator	# of Yes FY 2024	% of Yes FY 2024	# of N/A 2024	% of Yes FY 2023	% of Yes FY 2022
• Family counseling/ therapy	37	1	3%	-	0%	5%
• Case management	37	34	92%	-	76%	86%
A. Was there clear documentation of progress or lack of progress towards the identified ISP goals?	37	35	95%	-	90%	91%
The number of completed counseling/therapy sessions during treatment was:*						
• 0–5 sessions	37	13	35%	-	33%	27%
• 6–10 sessions	37	7	19%	-	14%	23%
• 11 sessions or more	37	17	46%	-	52%	50%
B. Was the individual given any education on self-help or recovery groups?	37	22	59%	-	62%	82%
C. Documentation showed the member reported attending self-help or recovery groups the following number of times:*						
• No documentation	37	24	65%	-	57%	27%
• 0 times during treatment	37	4	11%	-	5%	5%
• 1–4 times during treatment	37	4	11%	-	5%	23%
• 5–12 times during treatment	37	2	5%	-	14%	14%
• 13–20 times during treatment	37	2	5%	-	10%	5%
• 21 or more times during treatment	37	1	3%	-	10%	27%
D. If there was evidence of lack of progress towards the identified goal, did the provider revise the treatment approach	22	15	68%	7	44%	64%

Question	Denominator	# of Yes FY 2024	% of Yes FY 2024	# of N/A 2024	% of Yes FY 2023	% of Yes FY 2022
and/or seek consultation to facilitate positive outcomes?						
E. If the member was unemployed during intake, was there evidence the individual's interest in finding employment was explored?	18	12	67%	19	25%	55%
F. If the member was not involved in an educational or vocational training program, was there evidence the individual's interest in becoming involved in such a program was explored?	13	6	46%	24	20%	44%
G. If the member was not involved with a meaningful community activity (e.g., volunteering, caregiving to family or friends, and/or any active community participation), was there evidence the individual's interest in such an activity was explored?	16	11	69%	21	14%	46%
H. Does the documentation reflect that substance abuse services were provided?*	37	36	97%	-	100%	86%
I. Was member's access to a PCP or other medical provider explored?	37	31	84%	4	76%	68%

Measure V — Gender-Specific Key Findings

The total sample size of female members for Care1st was 17. There were seven cases with a history of domestic violence documented, and five cases had a safety plan completed in SFY 2024, for a finding of 71%. There were no pregnant women in the sample. Gender-specific treatment services continue to remain an area of opportunity, with 0% for SFY 2024 and SFY 2023.

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Table 5-17: Care1st Gender-Specific for Women

Question	Denominator	# of Yes FY 2024	% of Yes FY 2024	# of N/A 2024	% of Yes FY 2023	% of Yes FY 2022
A. If there was a history of domestic violence, was there evidence a safety plan was completed?	7	5	71%	10	50%	50%
B. If the female was pregnant, was there documentation of coordination of care efforts with the PCP and/or obstetrician?	N/A	0	-	17	N/A	0%
C. If the female was pregnant, did documentation show evidence of education on the effects of substance use on fetal development?	N/A	0	-	17	N/A	0%
D. If the female had a child less than one year of age, was there evidence a screening was completed for postpartum depression/ psychosis?	N/A	0	-	17	N/A	0%
E. If the female had dependent children, was there documentation to show childcare was addressed?	3	2	67%	14	100%	0%
F. Was there evidence of gender-specific treatment services (e.g., women's-only group therapy sessions)?	13	0	0%	4	0%	14%

Measure VI — Opioid-Specific Key Findings

Care1st saw an increase, from SFY 2023 of 10% to SFY 2024 of 22%, of cases with an opioid use diagnosis. All cases identified as OUD were referred to a MAT provider. This has been consistent since SFY 2022. There were also 100% of all cases that were referred to a provider if withdrawal symptoms were present. There was a positive increase in naloxone education, including overdose and actions to take for an overdose. This increased from 50% in the previous year to 63% in SFY 2024. The measure of natural supports/family members being provided education on how to obtain naloxone and actions to take in case of overdose was

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0%. This would substantiate the information of low incidences of natural supports/family being involved in treatment from earlier than the measure.

Table 5-18: Care1st Opioid-Specific

Question	Denominator	# of Yes 2024	%of Yes FY 2024	# of N/A 2024	% of Yes FY 2023	% of Yes FY 2022
A. Was there documentation of a diagnosed OUD?*	37	8	22%	-	10%	18%
B. Was there documentation the member was provided MAT education as a treatment option?*	8	6	75%	-	50%	100%
If yes, were they referred to a MAT provider?	6	6	100%	1	100%	100%
C. If withdrawal symptoms were present, were they addressed via referral and/or intervention with a medical provider?	4	4	100%	4	100%	100%
D. If a physical health concern related to pain was identified, were alternative pain management options addressed?	4	4	100%	4	N/A	0%
E. If member is a pregnant female, did documentation show evidence of education about the safety of methadone and/or buprenorphine during the course of pregnancy?*	N/A	0	--	-	N/A	N/A
F. Was there documentation the member was provided with relevant information related to overdose, naloxone education, and actions to take in the event of an opioid overdose?*	8	5	63%	-	50%	25%

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Question	Denominator	# of Yes 2024	%of Yes FY 2024	# of N/A 2024	% of Yes FY 2023	% of Yes FY 2022
G. Was the individual provided with naloxone or information on how to obtain naloxone?*	8	6	75%	-	0%	25%
H. Were family members/ natural supports provided information on how to obtain naloxone/provided naloxone, and actions to take in the event of an opioid overdose, if applicable?	8	0	0%	4	0%	New measure
I. Was there documentation the member was provided education on the effects of polysubstance use with opioids?	8	4	50%	0	50%	50%

Measure VII — Discharge and Continuing Care Planning Key Findings

There was a decrease, from SFY 2023 of 56% to 49% in SFY 2024, when a relapse prevention plan was completed. There was a slight increase in members being reassessed using ASAM at the time of discharge, from 31% in the previous year to 34% in SFY 2024. Of those reassessed, there was a slight increase in referral to the identified LOC of 31% in SFY 2023 to 34% in SFY 2024. There was an increase in coordination with other agencies, from 42% in SFY 2023 to 65% in SFY 2024.

Table 5-19: Care1st Discharge and Continuing Care Planning (completed only if member completed treatment or declined further services)

Question	Denominator	# of Yes FY 2024	% of Yes FY 2024	# of N/A FY 2024	% of Yes FY 2023	% of Yes FY 2022
A. Was there documentation present that a relapse prevention plan completed?*	35	17	49%	-	56%	61%

Question	Denominator	# of Yes FY 2024	% of Yes FY 2024	# of N/A FY 2024	% of Yes FY 2023	% of Yes FY 2022
B. Was the individual reassessed at the time of discharge using ASAM criteria to determine an appropriate LOC?*	35	12	34%	-	31%	39%
C. Was the individual referred to the appropriate LOC based on the ASAM determination?	11	9	82%	8	80%	100%
D. Was there documentation staff offered resources pertaining to community supports, including recovery self-help and/or other individualized support services (e.g., crisis line)?*	35	24	69%	-	63%	72%
E. Was there documentation staff actively coordinated with other involved agencies at the time of discharge?	23	15	65%	12	42%	65%

Measure VIII — Reengagement Key Findings

Reengagement findings also saw a decline from SFY 2023 to SFY 2024, with telephone outreach dropping from 80% to 71% and follow-up letter contact dropping from 67% to 56%. Other activities taken by providers to make contact included calling the member's emergency contact (75%). There were no home visits or street outreach. Increased reengagement efforts could lead to increased retention and better treatment outcomes and may be an additional potential area for Care1st to provide technical assistance to providers.

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Table 5-20: Care1st Reengagement (completed only if member declined further services or chose not to appear for scheduled services)

Question	Denominator	# of Yes FY 2024	% of Yes FY 2024	# of N/A FY 2024	% of Yes FY 2023	% of Yes FY 2022
A. Was the member (or legal guardian if applicable) contacted by telephone at times when the member was expected to be available (e.g., after work or school)?*	24	17	71%	-	80%	82%
B. If telephone contact was unsuccessful, was a letter mailed requesting contact?	18	10	56%	6	67%	67%
C. Were there other attempts made to reengage the individual, such as:	D.	E.	F.	G.	H.	I.
• Home visit?	4	0	0%	-	0%	0%
• Call emergency contact(s)?	4	3	75%	-	50%	0%
• Contacting other involved agencies?	4	1	25%	-	0%	100%
• Street Outreach?	4	0	0%	-	0%	0%

Measure IX — NOMs Key Findings

The tables below illustrate both intake and discharge comparisons for NOMs. There was information missing in both categories, reflecting the fluctuations in denominators. Employment information at intake saw a significant decrease, from 75% in SFY 2023 to 47% in SFY 2024. Employment information at discharge also saw a decrease, with SFY 2023 discharge information of 90% while SFY 2024 was 53%. For SFY 2023 documentation of abstinence from drugs and/or alcohol, SFY 2023 was 25%, with SFY 2024 at 30%. The number of members arrested within 30 days at discharge in SFY 2024 was 17%, while SFY 2023 was 22%.

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Table 5-21: 2024 Care1st National Outcome Measures

2024	At Intake				At Discharge			
	Denominator	# Yes	% Yes	Missing	Denominator	# Yes	% Yes	Missing
A. Employed?	36	17	47%	1	19	10	53%	18
B. Enrolled in school or vocational educational program?	33	2	6%	4	14	2	14%	23
C. On disability or retired?	25	5	20%	12	16	3	19%	21
D. Lived in a stable housing environment (e.g., not homeless)?	37	34	92%	0	19	18	95%	18
E. Arrested in the preceding 30 days?**	35	6	17%	2	18	2	11%	19
F. Abstinent from drugs and/or alcohol?	37	11	30%	0	16	12	75%	21
G. Participated in social support recovery in the preceding 30 days?	37	8	22%	5	16	12	75%	21

Table 5-22: 2023 Care1st National Outcome Measures

2023	At Intake				At Discharge			
	Denominator	# Yes	% Yes	Missing	Denominator	# Yes	% Yes	Missing
A. Employed?	20	15	75%	1	10	9	90%	11
B. Enrolled in school or vocational educational program?	18	0	0%	3	11	0	0%	10
C. On disability or retired?	19	2	11%	2	11	1	9%	10
D. Lived in a stable housing environment (e.g., not homeless)?	21	18	86%	0	11	11	100%	10
E. Arrested in the preceding 30 days?**	18	4	22%	3	11	0	0%	10
F. Abstinent from drugs and/or alcohol?	20	5	25%	1	11	11	100%	10
G. Participated in social support recovery in the preceding 30 days?	21	4	19%	6	11	8	73%	10

Mercy Care

Measure I — Intake/Treatment Planning Key Findings

Mercy Care is a not-for-profit health plan having responsibility for AHCCCS members in the central and south-central regions of Arizona. MC is assigned to members living in Gila, Maricopa, and Pinal counties.

Initial Behavioral Health Assessment

Alcohol, opioids, and amphetamines were the top three substances most frequently used during this reporting period, respectively. In the previous reporting period, opioids were the most frequently used substance, followed by alcohol and amphetamines. Use of opioids and marijuana both decreased from SFY 2023; opioid use decreased from 48% to 35%, and marijuana use decreased from 16% to 8%. Amphetamine use increased from 19% in SFY 2023 to 24% in SFY 2024.

The three most used methods of ingestion remained the same from the previous reporting period to this reporting period. Forty-five percent (45%) of members reported smoking as their preference, followed by oral (39%) and inhalation (11%) in SFY 2024.

Ninety-one percent (91%) of the records had a behavioral health assessment completed within 45 days of intake. This metric continued to decline over the last few reporting periods. In SFY 2022, 96% of the records had a completed behavioral health assessment. In SFY 2023, there was a three-point decrease, from 96% to 93%. There was another slight decrease from SFY 2023 (93%) to SFY 2024 (91%).

One hundred percent (100%) of the behavioral health assessments addressed substance-related disorders, showing improvement from the previous year (95%). Describing the intensity and frequency of substance use increased across years (SFY 2022 at 91%, SFY 2023 at 93%, and SFY 2024 at 97%). There was a 38% and 47% increase, respectively, for including the effect of substance use on interpersonal relationships and the completion of a risk assessment. Conversely, there was a 41% and 27% decrease, respectively, in the documentation of tuberculosis and screening for hepatitis C, HIV, and other infectious diseases. Further, there has been a steady decline in the documentation of the PDMP. In SFY 2022, 28% of the charts reviewed the PDMP, followed by 22% in SFY 2023 and 14% in SFY 2024.

A new measure for this reporting period included assessing whether SDoHs were documented as part of the assessment. The top three SDoHs identified in the assessment were:

- Unemployment (85%)
- Housing (78%)
- Access to medical care (73%)

Regulatory Requirements

Regulatory requirements, such as documentation following charitable choice requirements, decreased, from 100% in SFY 2023 to 90% in SFY 2024. There were two additional regulatory metrics added this reporting year related to HIPAA and informed consent. Seventy-one percent (71%) of the records included evidence of members being informed of their HIPAA rights, and 79% included evidence that members were given information on informed consent.

Individual Service Plan

One hundred percent (100%) of the charts reviewed had a completed ISP, and 100% of the ISPs were completed within 90 days of the initial appointment (new measure). All other components of the ISP reflected decreases, with the exception of one metric: "Was the ISP congruent with the diagnosis and presenting concerns?" This metric remained unchanged for SFY 2024, at 100%. All other metrics decreased, with the largest decrease (from 100% to 46%) occurring for addressing the unique cultural preferences of the member.

Table 5-24: MC Assessment and Individual Service Plan

Question	Denominator	# of Yes 2024	% of Yes 2024	# of N/A 2024	# of Yes FY 2023	% of Yes FY 2023
A. What was the primary substance used?*[23]						
• Opioids	102	36	35%	-	61	48%
• Marijuana	102	8	8%	-	21	16%
• Alcohol	102	37	36%	-	43	34%
• Amphetamines	102	24	24%	-	24	19%

[23] [23] Substance used and method of ingestion represent information on preferred substances. In some cases, multiple substances were reported as the primary substance for members with polysubstance use conditions because it was hard to discern in the record.

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Question	Denominator	# of Yes 2024	% of Yes 2024	# of N/A 2024	# of Yes FY 2023	% of Yes FY 2023
• Cocaine	102	8	8%	-	9	7%
• Other (please list)	102	0	0%	-	6	5%
B. What was the method of ingestion?*						
• Smoking	102	46	45%	-	60	47%
• Oral	102	40	39%	-	49	38%
• Inhalation	102	11	11%	-	9	7%
• Injection	102	3	3%	-	6	5%
• Transdermal	102	0	0%	-	0	0%
• Other (please list)	102	1	1%	-	11	9%

Question	Denominator	# of Yes 2024	% of Yes 2024	# of N/A 2024	% of Yes FY 2023	% of Yes FY 2022
Behavioral Health Assessment						
C. Was a behavioral health assessment completed?*	102	93	91%	-	93%	96%
i. Was the behavioral health assessment completed within 45 days of the initial appointment? [24]	102	92	90%	0	New measure	New measure
D. Did the behavioral health assessment:*						
i. Address substance related disorder(s)?	93	93	100%	-	95%	97%
ii. Describe the intensity/ frequency of substance use?	93	90	97%	-	93%	91%

[24] Item C and C.i. was split into two questions for the 2024 review due to tool validation.

Question	Denominator	# of Yes 2024	% of Yes 2024	# of N/A 2024	% of Yes FY 2023	% of Yes FY 2022
iii. Include the effect of substance use on daily functioning?	93	88	95%	-	99%	89%
iv. Include the effect of substance use on interpersonal relationships?	93	84	90%	-	52%	91%
v. Was a risk assessment completed?	93	93	100%	-	53%	91%
vi. Document screening for tuberculosis?	93	51	55%	-	96%	45%
vii. Document screening for hepatitis C, HIV, and other infectious diseases?	93	61	66%	-	93%	58%
viii. Document screening for emotional and/or physical abuse/trauma issues?	93	92	99%	-	95%	93%
ix. Document that review of the PDMP was completed?	85	12	14%	-	22%	28%
E. Were SDoHs documented as a part of the assessment?*						
i. Access to medical care?	97	71	73%	-	New measure	New measure
ii. Housing?	97	76	78%	-	New measure	New measure
iii. Food Insecurity?	97	45	46%	-	New measure	New measure
iv. Domestic Violence?	97	63	65%	-	New measure	New measure
v. Unemployment?	97	82	85%	-	New measure	New measure
vi. Transportation?	97	67	69%	-	New measure	New measure

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Question	Denominator	# of Yes 2024	% of Yes 2024	# of N/A 2024	% of Yes FY 2023	% of Yes FY 2022
vii. Other?	97	5	5%	-	New measure	New measure
F. Regulatory requirements:						
i. Was there documentation charitable choice requirements were followed, if applicable?	20	18	90%	79	100%	73%
ii. Was there documentation individuals were informed of their HIPAA rights?*	99	70	71%	-	New measure	New measure
iii. Was there documentation individuals were given information on informed consent?*	99	78	79%	-	New measure	New measure
G. Was an ISP completed?*[25]	93	93	100%	-	93%	98%
i. Was the ISP completed within 90 days of the initial appointment?	93	93	100%	0	New measure	New measure
H. Was the ISP:						
i. Developed with participation of the family/support network?	93	7	8%	77	13%	9%
ii. Congruent with the diagnosis(es) and presenting concern(s)?*	93	93	100%	-	100%	97%
iii. Showing measurable objectives and timeframes to address the identified needs?*	93	92	99%	-	100%	96%
iv. Addressing the unique cultural preferences of the individual?*	93	43	46%	-	100%	93%
v. Showing SDoH issues were considered as part of, and incorporated into, the ISP?	93	30	32%	34	48%	77%

[25] Item G and G.i. were split into two questions for the 2024 review due to tool validation.

Question	Denominator	# of Yes 2024	% of Yes 2024	# of N/A 2024	% of Yes FY 2023	% of Yes FY 2022
I. If yes, which domains?*						
• Access to medical care?	93	13	14%	-	21%	22%
• Housing?	93	11	12%	-	29%	31%
• Food insecurity?	93	2	2%	-	4%	4%
• Domestic violence?	93	1	1%	-	3%	3%
• Unemployment?	93	17	18%	-	25%	33%
• Transportation?	93	6	6%	-	13%	New Measure
• Other	93	3	2%	-	4%	5%

Measure II — Placement Criteria/Assessment Key Findings

Eighty-two percent (82%) — a 1% decrease from the previous year — of the charts reviewed included documentation that ASAM dimensions were used to determine the proper LOC at intake. Forty-three percent (43%) of members received Level 1 outpatient treatment, and 29% of members received Level 2 intensive outpatient treatment/partial hospitalization. Nineteen percent (19%) of members received opioid maintenance therapy and residential/inpatient treatment. Compared to the previous year, there was a decrease in opioid maintenance therapy (from 34% in SFY 2023 to 19% in SFY 2024) and an increase in intensive outpatient treatment/partial hospitalization (from 16% in SFY 2023 to 29% in SFY 2024). Ninety-eight percent (98%) of members received the level of services identified by the placement criteria/assessment. During the course of treatment, 74% of the ASAM dimensions were reassessed compared to 50% the previous reporting period.

Additional assessment tools were used to identify clinical needs in 61% of the records reviewed. Some of the tools providers used are the following:

- PHQ-9 (22 cases)
- UNCOPE (one case)

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- Columbia Suicide Severity Scale (six cases)
- GAD-7 (27 cases)
- PHQ-2 (two cases)
- PRAPARE (three cases)
- DAST (three cases)
- CRAFFT (three cases)
- ACES (five cases)
- CAGE (two cases)

Table 5-25: MC Placement Criteria/Assessment

Question	Denominator	# of Yes 2024	% of Yes 2024	% of Yes FY 2023	% of Yes FY 2022
A. Was there documentation ASAM dimensions were used to determine the proper level of care at intake?	102	84	82%	83%	80%
If the ASAM Placement Criteria were used, the level of service identified was:					
Level 0.5: Early Intervention	84	1	1%	2%	1%
OMT: Opioid Maintenance Therapy	84	16	19%	34%	21%
Level 1: Outpatient Treatment	84	36	43%	40%	52%
Level 2: Intensive Outpatient Treatment/Partial Hospitalization	84	24	29%	16%	13%
Level 3: Residential/Inpatient Treatment	84	16	19%	20%	32%
Level 4: Medically Managed Intensive Inpatient Treatment	84	1	1%	0%	1%
B. Did the member receive the level of services identified by the placement criteria/ assessment?	84	82	98%	92%	97%

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Question	Denominator	# of Yes 2024	% of Yes 2024	% of Yes FY 2023	% of Yes FY 2022
C. Were the ASAM dimensions reassessed (with documentation) during the course of treatment?	84	62	74%	50%	63%
D. Were additional assessment tools (in addition to ASAM or in lieu of) used during the course of treatment?	102	62	61%	56%	60%

Measure III — Best Practices Key Findings

EBPs were used 81% of the time during treatment; this is an 8% increase from SFY 2023. Relapse prevention therapy was used 70% of the time during treatment, followed by motivational enhancement/interviewing therapy (48%) and cognitive behavioral therapy (36%). Relapse prevention therapy increased 44% in SFY 2024 (from 26% in SFY 2023 to 70% in SFY 2024). Although seeking safety was used 8% in SFY 2024 during treatment, this modality was not used in either SFY 2023 or SFY 2022. Other EBPs included:

- Living in Balance (4 cases)
- Eye Movement Desensitization and Reprocessing (EMDR) (3 cases)
- Rational Emotive Behavior Therapy (2 cases)
- Mindfulness (2 cases)

MAT was used 34% of the time during treatment. There has been a steady decrease in MAT across review years (47% in SFY 2022; 45% in SFY 2023; 34% in SFY 2024). In SFY 2024, 20% of members received oral naltrexone for alcohol-related addiction (which was a new measure this year). Buprenorphine and naloxone, Subutex, methadone, and naltrexone were used by members 29%, 3%, 43%, and 9%, respectively. There was a 27% increase in buprenorphine and naloxone and a 40% decrease in methadone.

Screening for substance use/abuse was conducted during the course of treatment 66% of the time, a 2% increase from the previous year. Since 2022, there has been a steady increase in certified peer support services being offered as part of treatment (36% in SFY 2022; 40% in SFY 2023; 50% in SFY 2024) and deployed as a member of the treatment team (56% in SFY 2022; 63% in SFY 2023; 71% in SFY 2024). Seventy-five percent (75%) of

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peer specialists utilized were credentialed (new measure). Telehealth was offered as an option for treatment 66% of the time in SFY 2024, a 3% increase from the previous year.

Table 5-26: MC Best Practices — EBPs

Questions	Denominator FY 2024	# of Yes FY 2024	% of Yes FY 2024	% of Yes FY 2023	% of Yes FY 2022
Were EBPs used in treatment?	102	83	81%	73%	71%
• Cognitive Behavioral Therapy	83	30	36%	44%	88%
• Dialectal Behavioral Therapy	83	6	7%	14%	8%
• Helping Women Recover	83	0	0%	1%	0%
• Matrix	83	4	5%	9%	12%
• Moral Re-conation Therapy	83	1	1%	0%	0%
• Motivational Enhancement/ Interviewing Therapy	83	40	48%	57%	52%
• Relapse Prevention Therapy	83	58	70%	26%	55%
• Seeking Safety	83	7	8%	0%	0%
• SMART Recovery	83	9	11%	8%	12%
• Thinking for a Change	83	0	0%	0%	0%
• Trauma Recovery and Empowerment Model	83	0	0%	0%	0%
• Trauma-Informed Care	83	4	5%	1%	11%
• Wellness Recovery Action Plan	83	0	0%	0%	0%
• Other Practices or Program	83	10	12%	7%	24%

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Table 5-27: MC Best Practices — Medication Assisted Treatment, Peer Supports, and Telehealth

Questions	Denominator FY 2024	# of Yes FY 2024	% of Yes FY 2024	% of Yes FY 2023	% of Yes FY 2022
MAT[26]	102	35	34%	45%	47%
The following medication was used in treatment:					
Alcohol-Related					
• Acamprosate (Campral)	35	0	0%	2%	0%
• Disulfiram (Antabuse)	35	0	0%	2%	2%
• Oral naltrexone (Vivitrol®, Revia) (naltrexone hydrochloride tablet)	35	7	20%	New measure	New measure
Opioid-Related					
• Buprenorphine and naloxone (Suboxone, Zubsolv®)	35	10	29%	2%	22%
• Subutex (buprenorphine)	35	1	3%	3%	3%
• Methadone/Levo-Alpha-Acetylmethadol (LAAM)	35	15	43%	83%	74%
• Naltrexone (Vivitrol®, Revia)	35	3	9%	3%	5%
Nicotine-Related (Information Only)					
Use of nicotine replacement therapy: •	35	1	3%	3%	New measure
• Over-the-counter patch, gum, or lozenge	35	1	3%	New measure	New measure
• Prescription inhaler or nasal spray	35	0	0%	New measure	New measure

[26] MAT options updated from 2023 to current evidence-based best practices

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Questions	Denominator FY 2024	# of Yes FY 2024	% of Yes FY 2024	% of Yes FY 2023	% of Yes FY 2022
• Varenicline prescription (Chantix®)	35	0	0%	New measure	New measure
• Bupropion prescription (Wellbutrin, Aplezin®, Forfivo®, Zyban®)	35	0	0%	New measure	New measure
H. Was screening for substance use/abuse conducted during the course of treatment?	102	67	66%	64%	65%
I. Was certified peer support offered as part of treatment?	102	51	50%	40%	36%
i. If yes to C, were certified peer support services used as a part of treatment?	51	36	71%	63%	56%
J. If peer support services were utilized, were the peer support specialists credentialed?	36	27	75%	New measure	New measure
K. Was telehealth offered as an option to receive treatment?	102	67	66%	63%	New measure

Measure IV — Treatment/Support Services/Rehabilitation Services Key Findings

Case management services were documented in 90% of records, a slight decrease from 91% in SFY 2023. Eighty-one percent (81%) of members received individual therapy, and 70% of members received group therapy, with a 4% decrease individual services and a 1% drop in group services. Family therapy increased by 1%, from 2% in SFY 2023 to 3% in SFY 2024. There was clear documentation of progress or lack of progress towards the ISP goals in 89% of charts. This is lower than SFY 2023 (91%) but higher than SFY 2022 (85%). Fifty-two percent (52%) of members received 11 sessions or more, compared to 10% of members who received six to 10 sessions and 38% of members who received zero to five sessions.

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Fifty-nine percent (59%) of records had no documentation of members reporting they attended self-help or recovery groups. Sixteen percent (16%) of charts documented members attended zero self-help or recovery groups; a 5% increase from SFY 2023 and 11% increase from SFY 2022. Four percent (4%) of members reported attending self-help groups one to four times during treatment, 7% of members attended five to 12 times during treatment, and 1% attended 13–20 times during treatment.

When there was evidence of lack of progress towards identified goals, providers revised the treatment plan or sought consultation to facilitate positive outcomes 69% of the time. This occurred 68% of the time in SFY 2023 and 54% of the time in SFY 2022. When members were unemployed during intake, 80% of charts showed evidence that finding employment was explored. This is a 3% decline from SFY 2023 and a 10% decline from SFY 2022. Sixty-two percent of charts had evidence that an educational or vocational training program was explored when members were not involved in any such activities, compared to 79% in SFY 2023 and 67% in SFY 2022. Sixty-seven percent (67%) of charts had evidence that meaningful community activities were explored, a 16% decrease from SFY 2023, yet a 9% increase from SFY 2022. The documentation reflected that substance abuse services were provided 99% of the time, an increase from SFY 2023 (97%) and SFY 2022 (90%). Seventy-nine percent (79%) of charts had evidence that a PCP or other medical provider was explored; a 5% decrease from SFY 2023 and 1% increase from SFY 2022.

Table5-28: MC Treatment/Support Services/Rehabilitation Services

Question	Denominator	# of Yes FY 2024	% of Yes FY 2024	# of N/A 2024	% of Yes FY 2023	% of Yes FY 2022
A. The following services were used in treatment:*						
• Individual counseling/ therapy	102	83	81%	-	85%	72%
• Group counseling/ therapy	102	71	70%	-	71%	73%
• Family counseling/ therapy	102	3	3%	-	2%	0%
• Case management	102	92	90%	-	93%	81%
B. Was there clear documentation of progress or lack of progress towards the identified ISP goals?*	102	91	89%	-	91%	85%
C. The number of completed counseling/therapy sessions during treatment was:*						

Question	Denominator	# of Yes FY 2024	% of Yes FY 2024	# of N/A 2024	% of Yes FY 2023	% of Yes FY 2022
• 0–5 sessions	102	39	38%	-	31%	41%
• 6–10 sessions	102	10	10%	-	14%	11%
• 11 sessions or more	102	53	52%	-	55%	48%
D. Was the individual given any education on self-help or recovery groups?*	102	69	68%	-	70%	70%
E. Documentation showed the member reported attending self-help or recovery groups the following number of times:*						
• No documentation	102	60	59%	-	65%	66%
• 0 times during treatment	102	16	16%	-	11%	5%
• 1–4 times during treatment	102	4	4%	-	4%	3%
• 5–12 times during treatment	102	7	7%	-	5%	4%
• 13–20 times during treatment	102	1	1%	-	2%	3%
• 21 or more times during treatment	102	14	14%	-	13%	19%
F. If there was evidence of lack of progress towards the identified goal, did the provider revise the treatment approach and/or seek consultation to facilitate positive outcomes?	48	33	69%	54	68%	54%
G. If the member was unemployed during intake, was there evidence the individual's interest in finding employment was explored?	51	41	80%	51	83%	90%
H. If the member was not involved in an educational or vocational training program, was there evidence the individual's interest in becoming involved in such a program was explored?	34	21	62%	68	79%	67%

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Question	Denominator	# of Yes FY 2024	% of Yes FY 2024	# of N/A 2024	% of Yes FY 2023	% of Yes FY 2022
I. If the member was not involved with a meaningful community activity (e.g., volunteering, caregiving to family or friends, and/or any active community participation), was there evidence the individual's interest in such an activity was explored?	46	31	67%	56	83%	58%
J. Does the documentation reflect substance abuse services were provided?*	102	101	99%	-	97%	90%
K. Was member's access to a PCP or other medical provider explored?	102	81	79%	6	84%	78%

Measure V — Gender-Specific Key Findings

There were 34 members in the MC sample that were women. There were notable increases for three of the gender-specific metrics (domestic violence, coordination of care with PCP/obstetrician, and postpartum depression/psychosis screening). Sixty-seven percent (67%) of MC providers had documentation of a safety plan when there was a history of domestic violence, a 34% increase from SFY 2023 and 29% increase from SFY 2022. For pregnant women, 100% of the charts reflected documentation of coordination of care efforts with PCP and/or obstetricians in SFY 2024 compared to zero percent in SFY 2023 and 50% in SFY 2022. If a female had a child less than one year of age, there was evidence of postpartum depression/psychosis screening 67% of the time, up from 33% in SFY 2023 and 60% in SFY 2022. Childcare was addressed when the female had dependent children 67% of the time in SFY 2024, a decrease from 73% and 86% in SFY 2023 and SFY 2022, respectively.

Table 5-29: MC Gender-Specific for Women

Question	Denominator	# of Yes FY 2024	% of Yes FY 2024	# of N/A 2024	% of Yes FY 2023	% of Yes FY 2022
A. If there was a history of domestic violence, was there evidence a safety	9	6	67%	25	33%	38%

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Question	Denominator	# of Yes FY 2024	% of Yes FY 2024	# of N/A 2024	% of Yes FY 2023	% of Yes FY 2022
plan was completed?						
B. If the female was pregnant, was there documentation of coordination of care efforts with the PCP and/or obstetrician?	1	1	100%	33	0%	50%
C. If the female was pregnant, did documentation show evidence of education on the effects of substance use on fetal development?	1	0	0%	33	0%	50%
D. If the female had a child less than one year of age, was there evidence a screening was completed for postpartum depression/ psychosis?	3	2	67%	31	33%	60%
E. If the female had dependent children, was there documentation to show childcare was addressed?	15	10	67%	19	73%	86%
F. Was there evidence of gender-specific treatment services (e.g., women's only group therapy sessions)?	26	5	19%	8	23%	57%

Measure VI — Opioid-Specific Key Findings

Eighty percent (80%) of charts had documentation of a diagnosed OUD in SFY 2024; this is a 6% decrease from SFY 2023 but a 20% increase from SFY 2022. Ninety-four percent (94%) of charts had documentation that the members were provided with MAT education as a treatment option, and 100% of those members were referred to a MAT provider. Pregnant females were educated about the safety of methadone and/or buprenorphine during the course of pregnancy 50% of the time compared to 33% in SFY 2022. There was documentation the member was provided with relevant information related to overdose, naloxone education, and actions to take in the event of an opioid overdose 50% of the time, a 23% decrease from SFY 2023 and 4% decrease from SFY 2022. Fifty-five percent (55%) of the charts included documentation that family members/natural supports were provided information on how to obtain naloxone/provided naloxone and actions to take in the event of an opioid overdose (new measure). There was documentation (80% of the time) that the

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member was provided education on the effects of polysubstance use with opioids. This is a 4% increase from SFY 2023 and a 21% increase from SFY 2022.

Table 5-30: MC Opioid-Specific

Questions	Denominator	# of Yes 2024	%of Yes FY 2024	# of N/A 2024	% of Yes FY 2023	% of Yes FY 2022
A. Was there documentation of a diagnosed OUD?*	40	32	80%	-	86%	60%
B. Was there documentation the member was provided MAT education as a treatment option?*	32	30	94%	-	97%	85%
If yes to B, were they referred to a MAT provider?	17	17	100%	23	97%	94%
C. If withdrawal symptoms were present, were they addressed via referral and/or intervention with a medical provider?	10	8	80%	30	81%	98%
D. If a physical health concern related to pain was identified, were alternative pain management options addressed?	N/A	0	--	40	86%	79%
E. If member is a pregnant female, did documentation show evidence of education about the safety of methadone and/or buprenorphine during the course of pregnancy?*	40	20	50%	-	N/A	33%
F. Was there documentation the member was provided with relevant information related to overdose, naloxone education, and	40	20	50%	-	73%	54%

Questions	Denominator	# of Yes 2024	%of Yes FY 2024	# of N/A 2024	% of Yes FY 2023	% of Yes FY 2022
actions to take in the event of an opioid overdose?*						
G. Was the individual provided with naloxone or information on how to obtain naloxone?*	40	0	0%	-	73%	54%
H. Were family members/natural supports provided information on how to obtain naloxone/provided naloxone, and actions to take in the event of an opioid overdose, if applicable?	40	22	55%	0	0%	New measure
I. Was there documentation the member was provided education on the effects of polysubstance use with opioids?	40	32	80%	0	76%	59%

Measure VII — Discharge and Continuing Care Planning Key Findings

Case review found that 57% of records contained a relapse prevention plan that was done for members who completed treatment or declined further services. This is a 10% decrease from SFY 2023 (67%) and a 12% decrease from SFY 2022 (69%). Sixty-five percent (65%) of cases had documentation supporting resources for community support, including recovery, self-help, and other services that were offered.

This review found that MC providers referred to the appropriate LOC based on ASAM determination in 93% of cases in which a discharge ASAM assessment was documented (compared to 100% of the cases in SFY 2023). In SFY 2024, there was an increase in the number of members being referred to community resources (65%, up from 63% in SFY 2023, and up from 61% in SFY 2022). Staff are actively coordinating with other relevant agencies (71% in SFY 2024 and SFY 2023, up from 59% in SFY 2022). It should be noted that there was an increase in discharge reassessments using ASAM criteria to determine appropriate LOC (52% in SFY 2024 compared to 33% in SFY 2023).

Table 5-31: MC Discharge and Continuing Care Planning (completed only if member completed treatment or declined further services)

Question	Denominator	# of Yes FY 2024	% of Yes FY 2024	# of N/A FY 2024	% of Yes FY 2023	% of Yes FY 2022
A. Was there documentation present a relapse prevention plan completed?*	81	46	57%	-	67%	69%
B. Was the individual reassessed at the time of discharge using ASAM criteria to determine an appropriate LOC?*	82	43	52%	-	33%	55%
C. Was the individual referred to the appropriate LOC based on the ASAM determination?	40	37	93%	13	100%	94%
D. Was there documentation staff offered resources pertaining to community supports, including recovery self-help and/or other individualized support services (e.g., crisis line)?*	81	53	65%	-	63%	61%
E. Was there documentation staff actively coordinated with other involved agencies at the time of discharge?	52	37	71%	30	71%	59%

Measure VIII — Reengagement Key Findings

Members (or legal guardian if applicable) were contacted by telephone at times when the member was expected to be available (e.g., after work or school) 88% of the time (up from 78% in SFY 2023). When telephone contact was unsuccessful, a letter requesting contact was mailed 61% of the time, up from 55% and 56% in SFY 2023 and SFY 2022, respectively. Other attempts made to reengage members included contacting other involved agencies; this occurred 60% of the time, a 49% increase from SFY 2023.

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Table 5-32: MC Reengagement (completed only if member declined further services or chose not to appear for scheduled services)

Question	Denominator	# of Yes FY 2024	% of Yes FY 2024	# of N/A FY 2024	% of Yes FY 2023	% of Yes FY 2022
A. Was the member (or legal guardian if applicable) contacted by telephone at times when the member was expected to be available (e.g., after work or school)?*	56	49	88%	-	78%	81%
B. If telephone contact was unsuccessful, was a letter mailed requesting contact?	49	30	61%	7	55%	56%
C. Were other attempts made to reengage the individual, such as*:						
• Home visit?	10	1	10%	-	11%	0%
• Call emergency contact(s)?	10	1	10%	-	0%	17%
• Contacting other involved agencies?	10	6	60%	-	11%	33%
• Street outreach?	10	0	0%	-	0%	0%

Measure IX — NOMs Key Findings

Each of the seven MC NOMs for Measure IX is depicted in Tables 5-33 and 5-34. The denominator is determined and compared for both intake and discharge. Denominators are impacted by missing documentation of status at intake and discharge.

The review has shown a 54% increase in the number of members participating in social support recovery at intake versus at discharge. Further, there was also an increase at discharge (76%) compared to the previous year (64%). Abstinence from drugs and/or alcohol also showed an increase, from 61% in SFY 2023 to 84% in SFY 2024. Employment status at discharge showed a slight decrease, from 56% in SFY 2023 to 54% in SFY 2024. The number of members arrested within the past 30 days at discharge decreased, from 3% in SFY 2023 to 0% in SFY 2024.

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Table 5-33: FY 2024 MC National Outcome Measures

2024	At Intake				At Discharge			
	Denominator	# Yes	% Yes	Missing	Denominator	# Yes	% Yes	Missing
A. Employed?	98	44	45%	3	54	29	54%	47
B. Enrolled in school or vocational educational program?	90	4	4%	11	51	3	6%	50
C. On disability or retired?	82	10	12%	19	43	6	14%	58
D. Lived in a stable housing environment (e.g., not homeless)?	96	80	83%	5	52	51	98%	49
E. Arrested in the preceding 30 days?**	89	7	8%	12	46	0	0%	55
F. Abstinent from drugs and/or alcohol?	96	28	29%	5	49	41	84%	52
G. Participated in social support recovery in the preceding 30 days?	100	22	22%	20	50	38	76%	50

Table 5-34: FY 2023 MC National Outcome Measures

2023	At Intake				At Discharge			
	Denominator	# Yes	% Yes	Missing	Denominator	# Yes	% Yes	Missing
Employed?	123	63	51%	5	98	55	56%	30

2023	At Intake				At Discharge			
	Denominator	# Yes	% Yes	Missing	Denominator	# Yes	% Yes	Missing
A. Enrolled in school or vocational educational program?	115	4	3%	13	95	6	6%	33
B. On disability or retired?	108	14	13%	20	93	11	12%	35
C. Lived in a stable housing environment (e.g., not homeless)?	121	94	78%	7	95	78	82%	33
D. Arrested in the preceding 30 days?**	117	7	6%	11	95	3	3%	33
E. Abstinent from drugs and/or alcohol?	121	29	24%	7	82	50	61%	46
F. Participated in social support recovery in the preceding 30 days?	128	25	20%	17	89	57	64%	39

Section 6
Recommendations

Carryover Recommendations from SFY 2022 and SFY 2023 ICRs

- **Consider changes to sampling methodology for future reviews.** As an option in future reviews, AHCCCS should consider increasing validity and reliability by using a more randomized sampling methodology. One method for achieving this would be to have the independent reviewer randomly select the sample cases to be reviewed (from the entire population of files that meet inclusion criteria), and then ask the ACC-RBHAs to supply those specific records. This would add some time to the process (when compared to having the ACC-RBHAs select files to provide), but it would increase confidence in the results and contribute to overall project validity. Mercer used this sampling methodology in support of the Priority Mental Health Services review, which is conducted annually for AHCCCS. An additional benefit of using this sampling methodology is that the independent reviewer would have the opportunity to stratify the sample and increase the number of cases from small subpopulations that are reviewed (e.g., women, older adults, and transition-age youth). For example, this year's review only captured one pregnant woman (versus last year's three). This small representation within the sample makes it difficult to draw conclusions for this group. By using an appropriate sampling methodology, the independent reviewer could increase the representation of subpopulations in the sample while maintaining the randomness necessary for increased validity and reliability.
- **Clinical consideration for improved quality of care includes the following considerations:**
  - **Training and technical assistance on the importance and development of relapse plans at every LOC.** Relapse prevention plans were present in 70% of cases in SFY 2022 and FY 2023 but dropped to 54% in SFY 2024. Relapse prevention plans should be an important part of the member's recovery and be a living document that continues to be updated throughout all treatment levels of care.
  - **Training and technical assistance on the importance of SDoH in treatment planning and care.** The review tool was updated for SFY 2024 to include measurement of SDoH at assessment as well as in the ISP. The findings of the ICR further underscored the gap between identification of a SDoH and a goal for meeting that need in the ISP. For example, housing was identified in 83% of assessments but only addressed as a goal

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in 20% of ISPs. Resources may be limited to address certain SDoH but should still be considered as part of the overall treatment needs.

During focus groups, both providers and members noted ongoing difficulties in resource availability for housing, employment, and transportation. Suggestions to address the lack of resources include seeking donations from the community, working with the Arizona Vocational Rehabilitation Program[27] for members that qualify, and continuing efforts to make connections in the community with food banks and other resources. In addition, it was recommended that staff be trained to address accessing resources in ISPs when identified as a need during the assessment process.

- **Offer training on ASAM criteria**. ASAM criteria are an internationally recognized set of dimensions for assessment of members with substance use as well as a continuum of substance use service settings. Additionally, the ASAM Criteria 4th Edition was released in 2023. Changes include a simplification of LOC, specificity within the dimensions, an increased emphasis on harm reduction, updating standards for co-occurring care, and emphasizing person-centered treatment planning. Although not currently required by any funding agency, such as SAMHSA, training on the new ASAM criteria will assist providers in improving system delivery and in offering the current best practices in substance use treatment, updating terminology, simplifying levels of care, and building specificity within the dimensions.

New Recommendations from SFY 2024 ICR

- **Conduct interim audits of providers in targeted areas such as ASAM utilization and relapse prevention planning.** There has been improvement in some areas from previous years, such as testing for tuberculosis, HIV, hepatitis C, and other infectious diseases, but other areas, such as the use of ASAM, could benefit from more frequent monitoring. Performance improvement projects or corrective action plans should be implemented for providers who consistently underperform, to encourage improvement and better service provision to members.
- **Provide training on cultural competency and person-centered planning.** The incorporation of cultural preferences in the ISP declined significantly this year, from 99% last year to 45% this year. Person-centered treatment has been found to be an important part of member engagement and success in treatment, ensuring the member is engaged in shared decision-making and invested in treatment goals. Cultural humility assists in

[27] Vocational Rehabilitation | Arizona Department of Economic Security

ensuring treatment is effective, incorporating an member's beliefs and preferences in the treatment delivery.[28]

- **Provide gender-specific groups for women.** The overall sample had 65 females, representing 33% of the overall sample population. Only 16% of records demonstrated programs that offered gender-specific groups for women. Women are more likely to have trauma, such as domestic violence, as well as co-occurring disorders. Women also have unique reproductive risks as a result of substance use. Having gender-specific groups could provide a safe space for women to address gender-specific issues and improve outcomes.[29]
- **Increase reengagement efforts for members who leave treatment early.** Reengagement efforts saw a decline in telephone follow up in SFY 2024 from SFY 2023, from 84% to 76%, respectively, and a decline of 65% to 60% for a follow-up letter being sent. The root cause of this decline is not known but could be an opportunity to further increase the use of peer support personnel to perform outreach. They may have more insight into the reason for disengagement as well as a potential opportunity for additional training for providers. Some cases indicated outreach by email and text due to the preferences of the member. Considering alternate outreach methods may be another opportunity to increase engagement. When outreaching members, it may also be an opportunity to survey them about why they have disengaged, even if they do not return to treatment, as a way to improve quality and outcomes long term. Peer support specialists can also provide valuable assistance in connecting members with other resources in the community upon discharge.
- **Ensure education on the use and availability of 12-Step groups.** Documentation of information on 12-Step groups given to members has declined, from 74% in SFY 2022 to 66% in SFY FY 2023 and 63% in SFY 2024. The efficacy of 12-Step groups in recovery, both as a part of formal treatment and independent of a treatment program, has been demonstrated. Encouraging attendance at 12-Step meetings can provide additional support and structure for long-term recovery.[30]
- **Continue to monitor and encourage MAT for alcohol disorder.** There was a decrease in the use of MAT compared to the previous year. Alcohol-specific MAT was used in only 17% of the cases. The benefits of MAT for alcohol addiction include:

[28] Recovery-Oriented, Person-Centered Behavioral Health

[29] Addressing the Specific Needs of Women for Treatment of Substance Use Disorders

[30] Donovan DM, Ingalsbe MH, Benbow J, Daley DC. 12-step interventions and mutual support programs for substance use disorders: an overview. Soc Work Public Health. 2013;28(3-4):313-32. doi: 10.1080/19371918.2013.774663. PMID: 23731422; PMCID: PMC3753023.

- *Reducing cravings and withdrawal symptoms*: MAT medications help alleviate severe withdrawal symptoms, making detoxification safer and more manageable.
- *Supporting long-term sobriety*: MAT provides ongoing support to prevent relapse, with medications, such as naltrexone, blocking the pleasurable effects of alcohol, helping members stay committed to recovery.
- *Enhancing psychological stability*: MAT stabilizes brain chemistry disrupted by chronic alcohol use, improving mood and cognitive function, allowing for better engagement in counseling and behavioral therapies.[31]

[31] https://www.brightviewhealth.com/latest-updates/benefits-of-mat-for-treating-alcohol-dependence/

Appendix A
Case File Review Tool

File Review Tool

Substance Abuse Prevention and Treatment

Case File Review Findings for Measure I–IX

I Intake/Treatment Planning

A. What was the primary substance used?

- Opioids
- Marijuana
- Alcohol
- Amphetamines
- Cocaine
- Other (please list)

B. What was the method of ingestion?

- Smoking
- Oral
- Inhalation
- Injection
- Transdermal
- Other (please list)

C. Was a behavioral health assessment completed?[32]

i. Was the assessment completed within 45 days of the initial appointment?

D. Did the behavioral health assessment:

i. Address substance-related disorder(s)?

ii. Describe the intensity/frequency of substance use?

[32] Assessment - Behavioral Health Definition

Substance Abuse Prevention and Treatment

Case File Review Findings for Measure I–IX

iii. Include the effect of substance use on daily functioning?

iv. Include the effect of substance use on interpersonal relationships?

v. Was a risk assessment completed?

vi. Document screening for tuberculosis (TB)?

vii. Document screening for hepatitis C, HIV, and other infectious diseases?

viii. Document screening for emotional and/or physical abuse/trauma issues?

ix. Documentation that review of the Prescription Drug Monitoring Program (PDMP) was completed?

E. Were social determinants of health issues documented as part of the assessment?

If yes, which domains?

i. Access to Medical Care?

ii. Housing?

iii. Food Insecurity?

iv. Domestic Violence?

v. Unemployment?

vi. Transportation?

vii. Other?

F. Regulatory requirements:

i. Was there documentation that Charitable Choice requirements were followed, if applicable?

ii. Was there documentation that individuals were notified of their HIPAA rights?

iii. Was there documentation that individuals were given information on informed consent?

G. Was an individual service plan (ISP) completed?

i. Was the ISP completed within 90 days of the initial appointment?

H. Was the ISP:

i. Developed with participation of the family/support network?

ii. Congruent with the diagnosis(es) and presenting concern(s)?

iii. Measurable objectives and timeframes to address the identified needs?

Substance Abuse Prevention and Treatment

Case File Review Findings for Measure I–IX

iv. Addressing the unique cultural preferences of the individual?

v. Were social determinants of health issues considered as part of, and incorporated into, the ISP?

If yes, which domains?

- Access to medical care?
- Housing?
- Food insecurity?
- Domestic violence?
- Unemployment?
- Transportation?
- What options were explored if transportation was determined to be a social determinant of health issue?
- Other?

II Placement Criteria/Assessment

A. Was there documentation that the American Society of Addiction Medicine (ASAM) dimensions were used to determine the proper level of care at intake?

1. If the ASAM Patient Placement Criteria were used, the level of service identified was:

Level 0.5: Early Intervention

OMT: Opioid Maintenance Therapy

Level 1: Outpatient Treatment

Level 2: Intensive Outpatient Treatment/Partial Hospitalization

Level 3: Residential/Inpatient Treatment

Level 4: Medically Managed Intensive Inpatient Treatment

B. Did the member receive the level of services identified by the placement criteria/assessment?

C. Were the ASAM dimensions reassessed (with documentation) during the course of treatment?

D. Were additional assessment tools (in addition to ASAM or in lieu of) utilized during the course of treatment? If yes, please list in box below:

III Best Practices

A. Were evidence-based practices used in treatment?

1. The following evidence-based practices were used in treatment:

- Adolescent Community Reinforcement Approach (ACRA)
- Beyond Trauma: A Healing Journey for Women

Substance Abuse Prevention and Treatment

Case File Review Findings for Measure I–IX

- Cognitive Behavioral Therapy (CBT)
- Contingency management
- Dialectal Behavioral Therapy (DBT)
- Helping Women Recover
- Matrix
- Moral Re-conation Therapy (MRT)
- Motivational Enhancement/ Interviewing Therapy (MET/MI)
- Relapse Prevention Therapy (RPT)
- Seeking Safety
- SMART Recovery
- Thinking for a Change
- Trauma Recovery and Empowerment Model (TREM)
- Trauma-Informed Care (TIC)
- Wellness Recovery Action Plan (WRAP)
- Other Practices or Programs (please list in box below):

Medication Assisted Treatment (MAT) and Peer Support

A. The following medication was used in treatment:

- Alcohol-related
- Acamprosate calcium (Campral)
- Disulfiram (Antabuse)
- Oral naltrexone (Vivitrol®, Revia) (naltrexone hydrochloride tablet)
- Opioid-related
- Buprenorphine (Brixadi®, Sublocade®)
- Buprenorphine and naloxone (Suboxone, Zubsolv®)
- Methadone
- Naltrexone (Vivitrol®, Revia)
- Nicotine (For Information Only)

Substance Abuse Prevention and Treatment

Case File Review Findings for Measure I–IX

- Over-the-counter patch, gum, or lozenge
- Prescription inhaler or nasal spray
- Varenicline prescription (Chantix®)
- Bupropion prescription (Wellbutrin, Aplezin®, Forfivo®, Zyban®)

B. Was screening for substance use/abuse conducted during the course of treatment?

C. Was certified peer support offered as part of treatment?

i. If yes, were peer support specialists utilized?
ii. If peer support services were utilized, were the peer support specialists credentialed?

D. Was telehealth offered as an option to receive treatment?

IV Treatment/Support Services/Rehabilitation Services

A. The following services were used in treatment:
- Individual counseling/therapy
- Group counseling/therapy
- Family counseling/therapy
- Case management

B. Was there clear documentation of progress or lack of progress toward the identified ISP goals?

C. The number of completed counseling/therapy sessions during treatment was:
- 0–5 sessions
- 6–10 sessions
- 11 sessions or more

D. Was there documentation that the member was educated on the use of self-help or recovery groups?

E. Documentation showed that the member reported attending self-help or recovery groups (e.g., Alcoholics Anonymous, Narcotics Anonymous, etc.) the following number of times:
- No documentation
- 0 times during treatment
- 1–4 times during treatment
- 5–12 times during treatment
- 13–20 times during treatment

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Case File Review Findings for Measure I–IX

- 21 or more times during treatment

F. If there was evidence of lack of progress towards the identified goal; did the provider revise the treatment approach and/or seek consultation to facilitate positive outcomes?

G. If the member was unemployed during intake, was there evidence that the individual's interest in finding employment was explored?

H. If the member was not involved in an educational or vocational training program, was there evidence that the individual's interest in becoming involved in such a program was explored?

I. If the member was not involved with a meaningful community activity (e.g., volunteering, caregiving to family or friends, and/or any active community participation), was there evidence that the individual's interest in such an activity was explored?

J. Does the documentation reflect that substance abuse services were provided?

K. Was member's access to a primary care physician (PCP) or other medical provider explored?

V Gender-Specific (Female and Female Identified only)

A. If there was a history of domestic violence, was there evidence that a safety plan was completed?

B. If the female was pregnant, was there documentation of coordination of care efforts with the PCP and/or obstetrician?

C. If the female was pregnant, did documentation show evidence of education on the effects of substance use on fetal development?

D. If the female had a child less than one year of age, was there evidence that a screening was completed for postpartum depression/psychosis?

E. If the female had dependent children, was there documentation to show that childcare was addressed?

F. Was there evidence of gender-specific treatment services (e.g., women's-only group therapy sessions)?

VI Opioid-Specific

A. Was there documentation of a diagnosed opioid use disorder (OUD)?

B. Was there documentation that the member was provided MAT education as a treatment option?

i. If yes to VI.B., were they referred to a MAT provider?

C. If withdrawal symptoms were present, were they addressed via referral and/or intervention with a medical provider?

D. If a physical health concern related to pain was identified, were alternative pain management options addressed?

E. If member is a pregnant female, did documentation show evidence of education about the safety of methadone and/or buprenorphine during the course of pregnancy?

F. Was there documentation that the member was provided with relevant information related to overdose, naloxone education, and actions to take in the event of an opioid overdose?

G. Was the member provided with naloxone or information on how to obtain naloxone?

H. Were family members/natural supports provided information on how to obtain naloxone/provided naloxone, and actions to take in the event of an opioid overdose, if applicable?

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Substance Abuse Prevention and Treatment	
Case File Review Findings for Measure I–IX	
	I. Was there documentation that the member was provided education on the effects of polysubstance use with opioids?
VII	**Discharge and Continuing Care Planning (completed only if member completed treatment or declined further services)**
	A. Was there documentation present that a relapse prevention plan completed? B. Was there documentation that ASAM criteria was reassessed at the time of discharge? C. If yes, was the individual referred to the appropriate level of care? D. Was there documentation that staff offered resources pertaining to community supports, including recovery self-help and/or other individualized support services (e.g. crisis line)? E. Was there documentation that staff actively coordinated with other involved agencies at the time of discharge?
VIII	**Reengagement (completed only if member declined further services or chose not to appear for scheduled services**
	The following efforts were documented: A. Was the member (or legal guardian if applicable) contacted by telephone at times when the member was expected to be available (e.g., after work or school)? B. If telephone contact was unsuccessful, was a letter mailed requesting contact? C. Were other attempts made to reengage the individual, such as: • Home visit? • Call emergency contact(s)? • Contacting other involved agencies? • Street Outreach? • Other (please list other identified outreach efforts in the box below)
IX	**National Outcome Measures**

	At Intake			At Discharge		
	Yes	No	Missing	Yes	No	Missing
A. Employed?						
B. Enrolled in school or vocational educational program?						
C. On disability or retired?						
D. Lived in a stable housing environment (e.g., not homeless)?						
E. Arrested in the preceding 30 days?						
F. Abstinent from drugs and/or alcohol?						
G. Participated in social support recovery in the preceding 30 days?						

Appendix B
Case File Review Instructions



AHCCCS Substance Use Prevention and Treatment Block Grant (SUBG)
Fiscal Year 2024 Case File Review Instructions

The items below correspond to the *2024 SUBG Case File Review Tool*. Each case file will contain **one treatment segment.** For the purposes of this review, only supporting documentation falling between the **"date of intake"** and the **"date of closure"** for the selected treatment segment will be reviewed. The date of intake and date of closure are prepopulated on the case file review tool. The length of treatment will range from 30 days to 365 days. There must be at least one episode of care. If there is not at least one episode of care, the case file should be deemed unusable, and a new case file should be requested from the oversample.

I. Intake/Treatment Planning:

A) **Primary substance use —** This is a new question added to the tool to collect/confirm the primary substance used that is the focus of the referral and treatment. Since this is intended to capture the **primary** substance, only choose **one** response for this question. Choose "**Other"** if the primary substance is not listed. List the other substance in the text box provided.

B) **Method of substance ingested —** This is a new question and is intended to be the follow-up to the answer in **I. A)**. Indicate the method of ingestion for the **primary substance only**. If the method of ingestion is not noted or clear in the record, please select "**Unknown." Do not infer the method.**

C) **Assessment —** Review the case file to determine whether a **comprehensive** assessment was completed. Answer **YES** if a comprehensive assessment was completed. Answer **NO** if a comprehensive assessment is not present in the case file.

i. Review the case file to determine whether a comprehensive assessment was completed **within 45 days of the initial appointment**. The addendum sections of the core assessment are

completed based on the needs of the individual; however, a comprehensive assessment allowing for sound clinical formulation and diagnostic impression must be completed within 45 days of the initial appointment. Answer **YES** if a comprehensive assessment was completed within 45 days of the initial appointment. Answer **NO** if a comprehensive assessment is not present in the case file or if the assessment was not completed within 45 days of the initial appointment. Answer **N/A** if there is not a comprehensive assessment present, and the case closed prior to 45 days from the initial appointment.

D) For each component related to the assessment process below (1–9), consider the information contained in the comprehensive initial assessment.

i. Review the assessment to determine whether it addressed substance-related disorder(s). Answer **YES** if the assessment addressed this component. If the assessment did not address a substance related disorder, answer **NO**.

ii. Review the assessment to determine whether the assessment described the intensity/frequency of substance use. Answer **YES** if the assessment addressed this component. If the assessment did not describe the intensity/frequency of substance use, answer **NO**.

iii. Review the assessment to determine whether the assessment included the effect of substance use on daily functioning. Answer **YES** if the assessment addressed this component. If the assessment did not describe the effect of substance use on daily functioning, answer **NO**.

iv. Review the assessment to determine whether the assessment described how substance use affects the interpersonal relationships of the individual. Answer **YES** if the assessment addressed this component. If the assessment did not describe how substance use affects the interpersonal relationships of the individual, answer **NO**.

v. Review the assessment to determine whether a risk assessment was completed. The risk assessment may be contained within the standardized core assessment or may consist of a comparable RBHA- or provider-specific form, but should be completed as part of the comprehensive assessment within 45 days of the initial appointment. Answer **YES** if the assessment

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addressed this component. If the assessment did not address this component, answer **NO**.

vi. Review the assessment to determine whether it contains documentation of screening for tuberculosis (TB). Answer **YES** if the assessment included documentation of screenings for TB. If the assessment did not contain documentation of screenings for TB, answer **NO**. Screening may include testing, education, referrals for screening and services, follow-up counseling that addresses identified services, and an evaluation of history, risk factors, and/or screening tools.

vii. Review the assessment to determine whether it contains documentation of screening for hepatitis C, HIV, and other infectious diseases. Answer **YES** if the assessment included documentation of screenings for hepatitis C, HIV, and other infectious diseases screening. If the assessment did not contain documentation of screenings for hepatitis C, HIV, and other infectious diseases, answer **NO**. Screening may include testing, education, referrals for screening and services, follow-up counseling that addresses identified services, and an evaluation of history, risk factors, and/or screening tools.

viii. Review the assessment to determine whether it contains documentation of screening for emotional and/or physical abuse/trauma issues. Answer **YES** if the assessment included documentation of screening for abuse/trauma issues. If the assessment did not contain evidence, answer **NO**.

ix. Review the assessment to determine whether the State's prescription drug monitoring program (PDMP) was reviewed to determine if the individual is receiving controlled substance prescriptions and addresses potential patient concerns in treatment. Answer **YES** if the assessment contains documentation of review of the PDMP and **NO** if the assessment did not contain evidence.

E) Social Determinants of Health (SDoH) — Review the assessment to determine whether SDoH were documented as part of the assessment. If yes, which domains?

i. Access to Medical Care? Answer **YES** if the assessment addressed this component. If the assessment did not address this component, answer **NO**.

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ii. Housing? Answer **YES** if the assessment addressed this component. If the assessment did not address this component, answer **NO**.

iii. Food Insecurity? Answer **YES** if the assessment addressed this component. If the assessment did not address this component, answer **NO**.

iv. Domestic Violence? Answer **YES** if the assessment addressed this component. If the assessment did not address this component, answer **NO**.

v. Unemployment? Answer **YES** if the assessment addressed this component. If the assessment did not address this component, answer **NO**.

vi. Transportation? Answer **YES** if the assessment addressed this component. If the assessment did not address this component, answer **NO**.

vii. Other? Choose "**Other"** if the SDoH is not listed. List the other SDoH in the text box provided.

F) Regulatory requirements —

Review the assessment to determine whether it contains documentation that charitable choice requirements were followed as outlined in 42 CFR Part 54. Answer **YES** if the assessment included documentation that charitable choice requirements were being followed. If the assessment did not contain evidence, answer **NO**. Answer **N/A** if charitable choice did not apply in this case.

Review the case to determine whether it contains documentation to make sure that members know their HIPPA rights such as the ability to request their own records and have control over their PHI. Answer **YES** if there is documentation that HIPPA rights were included. If the assessment did not contain evidence, answer **NO**.

Review the case to determine whether it contains documentation the member was given information on informed consent, including the sharing of PHI between entities and the risks and benefits of doing so. Answer **YES** if the assessment included documentation that informed consent was discussed. If the assessment did not contain evidence, answer **NO**.

G) **Individual Service Plan (ISP) —** Review the case file to determine whether an ISP was completed. Answer **YES** if an ISP was completed. Answer **NO** if an ISP is not present in the case file.

i. Review the case file to determine whether an ISP was completed within **90 days** of the initial appointment. **The interim service plan should not be considered when responding to this question.** Answer **YES** if an ISP was completed within 90 days of the initial appointment. Answer **NO** if an ISP is not present in the case file or if the service plan was not completed within 90 days of the initial appointment. Answer **N/A** if there is not an ISP, and the case closed prior to 90 days from the initial appointment.

H) For each component related to the ISP process below (i.–iv.), consider the information contained in the completed 90-day ISP. Updates to the service plan should not be considered when responding to the questions below:

i. Review the service plan to determine whether it was developed with the participation of the individual's **family and/or support network,** when appropriate. If there is evidence that staff made efforts to actively engage the involved family members/support network in the treatment planning process, answer **YES**. If there is evidence that these individuals would have an impact on treatment planning, but there is no evidence of staff efforts to engage them, answer **NO**. Answer **N/A** if there is no family/support network or if the individual declined inclusion of others in the service planning process. Evidence of engagement attempts may include verbal or written efforts to solicit their input.

ii. Review the service plan to determine whether the scope, intensity, and duration of services offered was congruent with the diagnosis(es) and presenting concern(s). If the scope, intensity, and duration of services offered were congruent with the diagnosis(es), answer **YES**. If the scope, intensity, and duration of services offered were not congruent with the diagnosis(es), answer **NO**.

iii. Review the service plan to determine whether objectives are measurable and identify timeframes for the identified needs to be met. If the objectives are measurable and identify timeframes for the identified needs to be met, answer **YES**. If the objectives are not measurable and do not identify timeframes, answer **NO**.

iv. Review the service plan to determine whether it addressed the unique cultural preferences of the individual. Cultural preferences may include the influences and background of the individual with regard to language, customs, traditions, family, age, gender, ethnicity, race, sexual orientation, and socioeconomic class. If the unique cultural preferences of the individual were addressed, answer **YES**. If the unique cultural preferences of the individual were not addressed, answer **NO**.

v. Review the service plan to determine whether the earlier identified SDoH (Question I. E) were considered as part of, and incorporated into, the ISP.

If the answer in **Question I. E)** was **YES as being assessed** for a specific SDoH, and **was identified as being issue** and that particular SDoH addressed in the ISP, answer **YES** to the corresponding SDoH in this question. If the SDoH was **identified as an issue but not addressed** in the ISP, answer **NO** in the corresponding SDoH in this question. If the SDoH was not identified in Question I. E as an issue it does not apply to the individual, and the below corresponding SDoH should be marked **N/A**:

a. **Access to medical care** should consider whether the individual has access to a primary care physician and has had a physical within the past year.

b. **Housing** should consider whether the individual has secure housing (i.e., is not sleeping on couches, and has no immediate danger of eviction or homelessness). Housing insecurity should be considered poor housing quality, unstable neighborhoods, overcrowding, and high housing costs relative to income.

c. **Food insecurity** will consider whether the individual does not have access to sufficient food or food of an adequate quality to meet one's needs.

d. **Domestic violence** is a pattern of abusive behavior in any relationship used by one partner to gain or maintain power over another intimate partner. Domestic violence can be physical, sexual, emotional, economic, psychological, or technological.

e. **Unemployment** refers to individuals who are old enough and are physically and mentally able to work but are not in

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paid employment or self-employment.

f. **Transportation** is a condition in which an individual is unable to regularly move from place to place in a safe and timely manner because one lacks the material, economic, or social resources necessary for transportation.

If transportation is selected, provide what type of transportation options were explored in the text box provided.

g. **Other (please list)** should include any domain that might be considered a SDoH not listed above. If indicated as a **YES**, the blank should be filled in with a short description, such as childcare.

II. Placement Criteria/Assessment:

A) Review the case file to determine whether the American Society of Addiction Medicine (ASAM) dimensions were used at intake to determine the criteria to identify the appropriate level of care via the Patient Placement Criteria.

If the ASAM tool was completed, answer **YES**. If the ASAM tool was not completed, answer **NO**. Providers are allowed to create their own ASAM document.

i. If the ASAM tool was completed at intake, select the level of care identified by the tool:

- ☐ Level 0.5: Early Intervention
- ☐ OMT: Opioid Maintenance Therapy
- ☐ Level I: Outpatient Treatment
- ☐ Level II: Intensive Outpatient Treatment/Partial Hospitalization
- ☐ Level III: Residential/Inpatient Treatment
- ☐ Level IV: Medically Managed Intensive Inpatient Treatment

B) Review the case file to determine whether the individual received the level of care identified by the ASAM tool. If the individual received the level of services identified by the placement criteria/assessment, answer **YES**. If not, answer **NO**.

C) Review the case file to determine whether an ASAM tool was completed during the course of treatment at any time subsequent to

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intake/assessment. It is not necessary for the ASAM tool result to change if it is considered an updated tool. If an ASAM tool was completed after intake, answer **YES**. If an ASAM tool was not completed after intake, answer **NO**.

D) Review the case file to determine whether an assessment tool (can include other multi-dimensional placement criteria tools in lieu of ASAM) was utilized **during** the course of treatment at any time subsequent to intake/assessment. If an additional assessment tool was completed after the intake ASAM, answer **YES**. If the answer is **YES**, please list the name of the tool in the box below. If an assessment tool was not completed after the intake ASAM, answer **NO**.

III. Best Practices:

A) Review the case file to determine whether it contains an indication that evidence-based practices were implemented in treatment. Answer **YES** if the case file contains evidence-based practices. If not, answer **NO**. If there is insufficient documentation available to verify that evidence-based practice was utilized (e.g., an evidence-based practice was not mentioned in the treatment progress notes), answer **NO DOCUMENTATION**.

i. Identify **each** type of evidence-based practice documented in the case file:

- ☐ Adolescent Community Reinforcement Approach
- ☐ Beyond Trauma: A Healing Journey for Women
- ☐ Cognitive behavioral therapy
- ☐ Contingency management
- ☐ Dialectal behavioral therapy
- ☐ Helping Women Recover
- ☐ Matrix
- ☐ Moral re-conation therapy
- ☐ Motivational enhancement/Interviewing therapy
- ☐ Relapse prevention therapy
- ☐ Seeking Safety
- ☐ SMART recovery
- ☐ Thinking for a Change
- ☐ Trauma Recovery and Empowerment Model
- ☐ Trauma-informed care
- ☐ Wellness Recovery Action Plan
- ☐ Other: Identify other evidence-based practices utilized (Enter the evidence-based practice in the text box below.)

B) Medication-assisted treatment (MAT) **(for substance use treatment only).** If there was evidence of MAT, answer **YES**. Answer **NO** if there was no documentation of MAT. If **YES** is chosen, identify **each** medication used in the treatment of substance use:

- **Alcohol- related:**
    - Acamprosate (Campral)
    - Disulfiram (Antabuse)
    - Oral naltrexone (Vivitrol®, Revia) (naltrexone hydrochloride tablet)
- **Opioid-related:**
    - Buprenorphine (Brixadi®, Sublocade®)
    - Buprenorphine and naloxone (Suboxone, Zubsolv®)
    - Methadone
    - Naltrexone (Vivitrol®, Revia)
- **Nicotine (informational only[33]):**
    - Over-the-counter patch, gum, or lozenge
    - Prescription inhaler or nasal spray
    - Varenicline prescription (Chantix®)
    - Bupropion prescription (Wellbutrin, Aplezin®, Forfivo®, Zyban®)

C) Review the case file to determine whether it contains evidence that the individual was screened for substance use/abuse during the course of treatment. Answer **YES** if the case file contains evidence that the individual was screened for substance use. Answer **NO** if documentation of screening for substance use was not present in the case file.

D) Review the case file to determine whether certified peer support (e.g., peer worker) was offered as part of the treatment continuum. If

[33] "Informational Only" means we are not scoring the item for provider performance but are collecting the information to inform AHCCCS

evidence is present in the case file, answer **YES**. If evidence is not present in the case file, answer **NO**. Answer **N/A** if the individual declined peer support services:

i. If the answer is **YES to D,** review the case file to determine whether peer support specialists were used as part of the treatment continuum. If evidence is present in the case file, answer **YES**. If evidence is not present in the case file, answer **NO**. If the answer to **D** is **NO**, do not answer this item.

ii. If the answer is **YES** to D) i., review the case file to determine whether peer support specialists were credentialed. If evidence is present in the case file, answer **YES**. If evidence is not present in the case file, answer **NO**. If the answer to D)i. is **NO**, do not answer this item.

E) Review the case file to determine whether telehealth was offered as an option to receive treatment. If evidence is present in the case file, answer **YES**. If evidence is not available in the case file, answer **NO**.

IV. Treatment/Support Services/Rehabilitation Services:

A) Review the case file to identify which services the individual received during the course of treatment. Answer **YES** next to **each** service received. Answer **NO** next to the services that were not received during the course of treatment:

Individual counseling/therapy

Group counseling/therapy

Family counseling/therapy

Case management

B) Review the case file to determine whether documentation (e.g., progress notes) shows evidence of progress or lack of progress toward the identified treatment goals. If the documentation shows progress or lack of progress toward the identified treatment goals, answer **YES**. If the case file does not show evidence of progress or lack of progress toward the identified ISP goals, answer **NO**. Answer **N/A** if there is not an ISP present in the case file. You may also answer **N/A** if services provided are recent
(e.g. three months or less), and there is no change in progress.

C) Review the case file to determine the number of counseling/therapy sessions that the individual attended during the course of treatment. Treatment sessions include individual and group sessions. Select the appropriate response:

0–5 treatment sessions
6–10 treatment sessions
11 sessions or more

D) Review the case file to determine whether the individual was given any education on self-help or recovery groups and how they may be effective in attaining and retaining sobriety. This may include the individual being asked if they would like information but declining. If information is offered, mark this item as **YES**. If there is no documentation of information being provided, mark this item as **NO**.

E) Review the case file to determine how many self-help or recovery group sessions (e.g., Alcoholics Anonymous, Narcotics Anonymous) the individual reported attending during the course of treatment. Select the appropriate response:

No documentation (no evidence of service being offered or attended in the record)

0 times during treatment (includes those individuals who were referred/offered to self-help groups but did not attend)

1–4 times during treatment

5–12 times during treatment

13–20 times during treatment

21 or more times during treatment

F) If there was evidence of lack of progress toward the identified goal, review the case file to determine whether staff revised the treatment approach and/or sought consultation to facilitate symptomatic improvement. Answer **YES** if the provider revised the treatment approach and/or sought consultation. If not, answer **NO**. Answer **N/A** if symptomatic improvement is present in the case file.

G) If the individual was **NOT** employed at the time of intake, review the case file to determine whether the individual's interest in finding employment was explored. Answer **YES** if there is evidence that the individual's interest in finding employment was explored. If not, answer **NO**. **Answer N/A if the individual was employed at the time of intake or employment is not relevant to the individual's situation (e.g., the individual is participating in a vocational program).**

H) If the individual was **NOT** involved in an education or vocational training program at the time of intake, review the case file to determine whether the individual's interest in becoming involved in a program was explored. Answer **YES** if there is evidence that the individual's interest in becoming involved in an educational or vocational training program was explored. If evidence is not present, answer **NO**. **Answer N/A if the individual was involved in an education or vocational training program at the time of intake or it is not relevant to the individual's situation (e.g., the individual was employed).**

I) If the individual was **NOT** involved in a meaningful community activity (volunteering, caregiving to family or friends, and/or any active community participation) at the time of intake, review the case file to determine whether the individual's interest in becoming involved in a community activity was explored. Answer **YES,** if there is evidence that the individual's interest in a community activity was explored. Answer **NO** if the individual's interests were not explored. **Answer N/A if the individual was involved in a community activity at the time of intake or if it is not relevant to the individual's situation (e.g., the individual was participating in a vocational program or employed).**

J) Review the case file to determine whether the documentation reflects that substance use services were rendered. If the documentation in the case file reflects that services were provided for the treatment of substance use, answer **YES**. Answer **NO** if documentation does not reflect that substance use services were rendered.

K) Review the case file to determine whether the documentation reflects that access to a primary care physician (PCP)/other medical provider was explored. If the documentation in the case file reflects the exploration of a PCP, answer **YES**. Answer **NO** if documentation does not reflect exploration of a PCP. Answer **N/A** if medical services were not relevant for the individual treatment (i.e., indication of good health and no medical needs)

V. Gender-Specific (Female and Female-Identified Only):

If the patient is male and identifies as a male, this section of the database will be closed. You will not respond to the following Section V. questions.

A) Review the case file to determine whether it includes a safety plan **in which there are domestic violence issues present**. If the case file contains a safety plan, answer **YES**. If the case file does not contain a safety plan, answer **NO**. Answer **N/A** if there are no domestic violence issues present.

B) **If the individual was pregnant**, review the case file to determine whether there is evidence that staff coordinated care with the PCP and/or obstetrician. If there is evidence in the case file indicating that staff coordinated care, answer **YES**. Answer **NO** if staff did not coordinate with the PCP and/or obstetrician. Answer **N/A** if the service provider does not apply **(e.g., the individual was not pregnant).** Since an adult individual has to give permission for release of information, this should be considered when responding. Coordination of care includes verbal or written efforts to solicit their input or share information.

C) **If the individual was pregnant**, review the case file to determine whether there is evidence that staff provided education pertaining to the effects of substance use on fetal development. Answer **YES** if the case file contains evidence. Answer **NO** if evidence is not present. **Answer N/A if the individual was not pregnant.**

D) **If the individual has a child less than one year of age**, review the case file to determine whether screening was completed for postpartum depression/psychosis. If evidence is present in the case file, answer **YES.** If evidence is not present in the case file, answer **NO**. Answer **N/A** if the individual does not have a child less than one year in age.

E) If the individual has dependent children, review the case file to determine whether childcare was addressed. If evidence is present in the case file, answer **YES.** If evidence is not present in the case file, answer **NO**. Answer **N/A** if the individual does not have dependent children.

F) Review the case file to determine whether gender-specific treatment services were offered and/or provided (e.g., women's-only group therapy sessions, female peer/recovery support/coaches) as part of the treatment continuum. If evidence is present in the case file, answer

YES. If evidence is not present in the case file, answer **NO**. Answer **N/A** if the individual declined gender-specific services.

VI. Opioid Specific (only for records that indicate opioid use):

A) Review the case file to determine whether it contains evidence that the individual has a **diagnosed opioid use disorder (OUD)**. Answer **YES** if the case file contains evidence that the individual has been diagnosed with OUD. Answer **NO** if documentation an OUD was not present in the case file.

B) Review the case file to determine whether it contains documentation that MAT education was a treatment option. If there is documentation that the member was offered MAT education as an option, answer **YES**. Answer **NO** if documentation is not present in the case file.

i. If the answer to **VI. B)** was **YES**, and there is documentation that a referral was made to a MAT provider, answer **YES**. If the answer to **VI. B)** is **YES**, but no referral to a MAT provider was made, answer **NO**. If the answer to **VI. B)** was **NO**, answer **N/A**.

C) Review the case file to determine whether there is evidence that the member had withdrawal symptoms that were addressed via referral and/or intervention with a medical provider. If there is evidence that the withdrawal symptoms were addressed via referral and/or intervention with a medical provider, answer **YES**. Answer **NO** if evidence shows that withdrawal symptoms were not addressed via referral and/or intervention with a medical provider. Answer **NA** if no withdrawal symptoms were documented.

D) Review the case file to determine whether there is documentation that alternative pain management options were addressed if the member reported a physical health concern. Answer **YES** if alternative pain management options were addressed if the member reported a physical health concern. Answer **NO** if the member reported a physical health concern, and there is no evidence that alternative pain management options were addressed. Answer **N/A** if there is no evidence of physical health concerns related to pain.

E) If the **individual is pregnant**, review the case file to determine whether there is evidence that staff provided education pertaining to the safety of methadone and/or buprenorphine during the course of

the pregnancy. Answer **YES** if the case file contains evidence. Answer **NO** if evidence is not present. **Answer N/A if the individual is not pregnant.**

F) Review the case file to determine whether there is evidence that the member was provided relevant information related to overdose, naloxone education, and actions to take in the event of an opioid overdose. Answer **YES** if the case file contains evidence. Answer **NO** if evidence is not present.

G) Review the case file to determine whether the individual was provided with naloxone or information on how to obtain naloxone. Answer **YES,** if the case file contains evidence. Answer **NO** if evidence is not present.

H) Review the case file to determine whether the individual's family members/natural supports were provided with information on overdoses, naloxone education, information on how to obtain naloxone, and actions to take in the event of an opioid overdose. Answer **YES** if the case file contains evidence. Answer **NO** if evidence is not present. Answer, **N/A** if the individual does not have any family involvement or has declined family involvement. *Note: This is a new question added for informational purposes only.*

I) Review the case file to determine whether there is evidence that the member was provided education on the effects of polysubstance use with opioids. Answer **YES,** if the case file contains evidence. Answer **NO** if the evidence is not present.

VII. Discharge and Continuing Care Planning (only completed if the individual completed treatment or declined further services):

A) Review the case file to determine whether a relapse prevention plan was completed. If evidence is present in the case file, answer **YES**. If evidence is not present in the case file, answer **NO**.

B) Review the case file to see whether the individual was reassessed at the time of discharge using ASAM criteria to determine an appropriate level of care. If evidence is present in the case file, answer **YES**. If evidence is not present in the case file, answer **NO.**

C) IF the answer to **VII. B) is YES**, review the case file to see whether the individual was referred to the appropriate level of care based on the ASAM determination. If evidence is present in the case file, answer **YES,** even if the referral is declined. If evidence is not present in the

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case file, answer **NO.** If the answer to **VII. B)** is **NO**, mark the response **N/A.**

D) Review the case file to determine whether there is evidence that staff provided resources pertaining to community supports, including recovery self-help groups and/or other individualized support services. If there is evidence that staff provided resource and/or referral information, answer **YES**. A **YES** response indicates that staff provided information and/or referral regarding at least one resource. If evidence is not present, answer **NO**.

E) Review the case file to determine whether staff actively coordinated with other involved agencies at the time of discharge. If there is evidence in the case file indicating that staff attempted to coordinate/communicate with other involved agencies, answer **YES**. Answer **NO** if staff did not make efforts to coordinate with other involved agencies at the time of discharge. Answer **N/A** if there were no other agencies involved. Since an adult individual must give permission for other involved parties to participate in treatment, this should be considered when responding. Coordination of care includes verbal or written efforts to solicit their input or share information.

VIII. Reengagement (only completed if the individual declined further services or chose not to appear for scheduled services, including closure for loss of contact):

Review the case file to determine whether the following outreach activities were conducted in an effort to reengage the individual prior to closure:

A) **Contacting the individual (or legal guardian if applicable) by telephone at times when the person may be expected to be available (e.g., after work or school) —** Answer **YES** if telephone contact was attempted. Answer **NO** if telephone contact was not attempted.

B) **If telephone contact was unsuccessful, a letter was mailed requesting contact —** Answer **YES** if a letter was sent to the individual. Answer **NO** if a letter was not sent to the individual. Answer **N/A** if attempts to reach the **member** through other means were successful.

C) **Were other attempts made to reengage, such as:**

Home visit

Call emergency contact(s)

Contacting other involved agencies

Street outreach

Other (please enter the type of reengagement in the box below).

Answer **YES** next to each means of outreach attempted to reengage the individual. Answer **NO** next to each action that was not attempted. If other reengagement attempts were made that are not listed, list the other types in the box below. Answer **N/A** if attempts to reach the individual by other means of outreach were successful (e.g., the individual was successfully reached via telephone call). **N/A** may also be used if a particular means of outreach was not applicable to the individual (e.g., answer **N/A** for "contacting other involved agencies" if the individual did not have any other agencies involved).

IX. National Outcome Measures (NOMs) :

For each measure below, answer **YES** or **NO** based on the individual's status at the time of intake and at the time of discharge. Answer **MISSING** if there is no documentation of the NOMs at time of intake and/or discharge. Please note, answers should be based on information actually found in the record, not an assumption or an absence of information.

A) Employed at intake?
Employed at discharge?

B) Enrolled in school or vocational educational program at intake?
Enrolled in school or vocational educational program at discharge?

C) On disability or retired at intake?

On disability or retired at discharge?

D) Lived in a stable housing environment at intake (not homeless)?
Lived in a stable housing environment at discharge (not homeless)?

E) Arrested 30 days prior to treatment?
Arrested 30 days prior to discharge?

F) Was the individual abstinent from alcohol and/or drugs at intake?
Was the individual abstinent from alcohol and/or drugs at discharge?

G) Participated in social support recovery 30 days prior to treatment?
Participated in social support recovery 30 days prior to discharge?

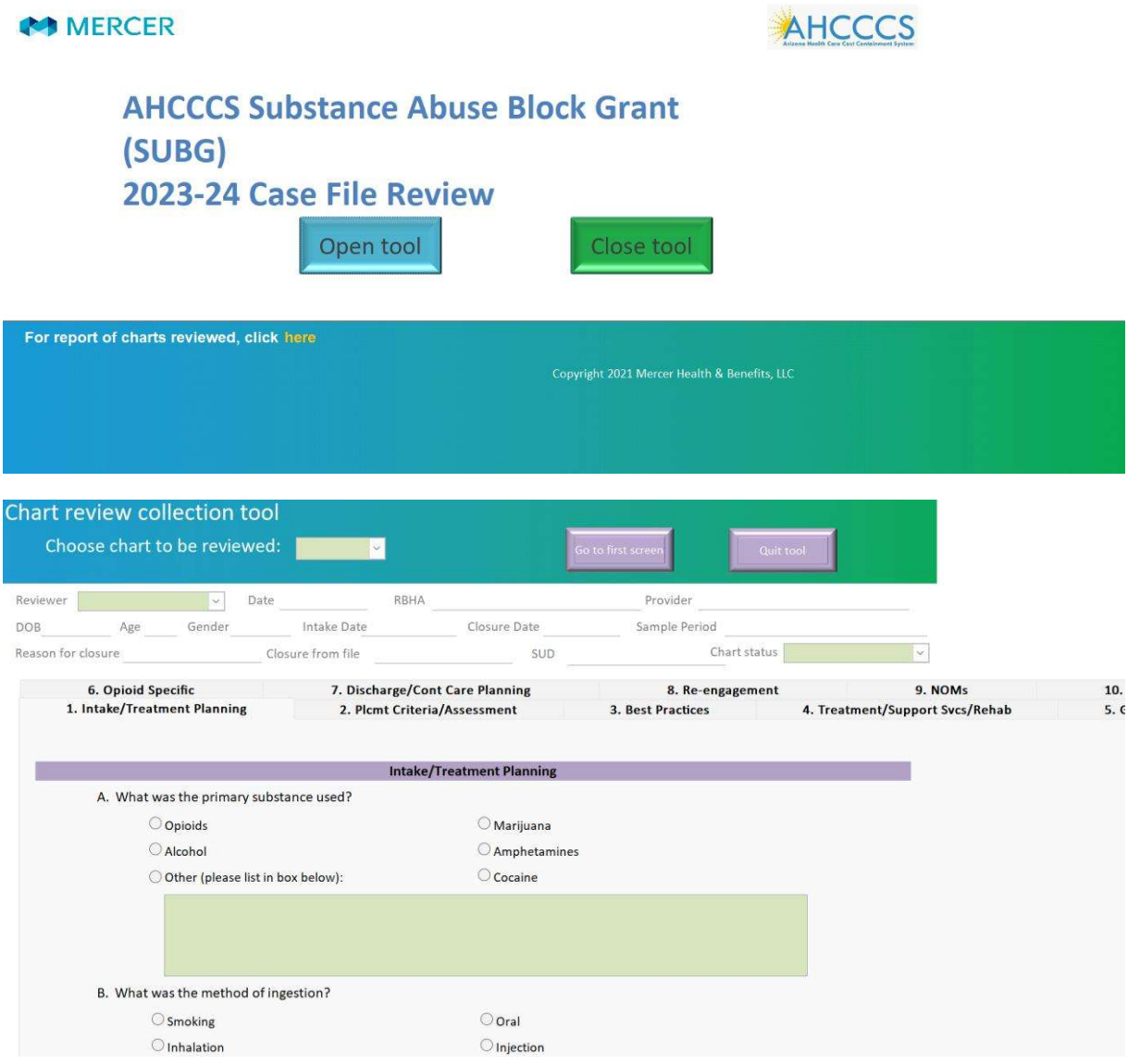
X. Comments:

Include any free text observations, strengths, and opportunities for improvement.

Appendix C

Case File Electronic Review Tool

Reviewers used an Access review tool prepopulated with relevant record data. Below are sample screen shots of the tool.



C. Was a behavioral health assessment completed at intake?

Was the assessment completed within 45 days of the initial appointment?

D. Did the behavioral health assessment:

Address substance-related disorder(s)?

Describe the intensity/frequency of substance use?

Include the effect of substance use on daily functioning?

Include the effect of substance use on interpersonal relationships?

Was a risk assessment completed?

Document screening for tuberculosis (TB)?

Document screening for Hepatitis C, HIV and other infectious diseases?

Document screening for emotional and/or physical abuse/trauma issues

Documentation that review of the Prescription Drug Monitoring Program (PDMP) was completed?

E. Were social determinants of health issues documented as part of the assessmnt?

If yes, choose all domains that apply.

Access to Medical Care

Food insecurity

Housing

Unemployment

Transportation

Domestic Violence

Other (please list in box below):

F. Regulatory requirements:

Was there documentation that charitable choice requirements were followed, if applicable?

Was there documentation demonstrating that individuals were informed of their HIPPA rights?

Was there documentation demonstrating that individuals were given information on informed consent?

G. Was an Individual Service Plan (ISP) completed?

Was the ISP completed within 90 days of the initial appointment?

Appendix D

Arizona Focus Group Findings 2025

Overview

Mercer organized five focus groups, to provide additional qualitative information to the State of AHCCCS, including strengths and opportunities, areas of concern, and follow-up areas from the ICR such as access to community resources. The focus group session for SUD providers was conducted virtually and was open to SUBG providers across the three ACC-RHBAs. The sessions for members were facilitated in person at regional SUBG provider offices. Mercer staff prepared outreach materials to engage interested participants from SUBG providers and members receiving SUBG services. Each focus group had a minimum of at least three participants. Two Mercer consultants facilitated each group and transcribed the comments from group members. The goal of the focus groups was to provide qualitative information to AHCCCS to further enhance the findings of the ICR.

An interview format was used for the focus groups. Each session had a list of questions to prompt discussion, along with a structure that provided the opportunity for feedback on the SUD treatment process and service experience. Additionally, findings and associated questions arising from the ICR were utilized for discussion, clarification, and feedback. Objectives and questions for focus groups were outlined to provide consistency among interviewers for focus groups. After an introduction by Mercer, the following topic areas were posed as questions to each focus group and tailored based on the focus group demographic:

- What are the most significant changes in SUD treatment services that have improved treatment access, treatment completion, and outcomes in the last three (3) years?
- What are opportunities to change/improve the current SUD service system?
- What are new tools and/or services that you think are needed to improve treatment access, assessment, treatment completion, and outcomes?
- What are the most effective tools that are currently being used?
- What successes or barriers have there been with access to medication-assisted treatment (MAT)?
- What specific programming is available for women?
- How is Charitable Choice communicated?

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- What are successes or barriers you have encountered when engaging family or natural supports?
- What are successes or barriers you have encountered in testing for communicable diseases, including tuberculosis, HIV, and other sexually transmitted infections?
- What practices or interventions are the most useful to individualize treatment plans to address the unique needs of each participant and their cultural preferences?
- Were there any tasks or situations that were not addressed due to a lack of resources? How is CommunityCares, the Arizona closed loop referral system,[34] utilized?
- What would you change about the SUD assessment, treatment, and discharge process?
- How can the SUD system work together better to provide SUD services to the uninsured and underinsured?

Member Focus Group Summary

Mercer conducted four focus groups for members on May 13, 14, and 15, 2025. Levels of care included a methadone maintenance program in the southern region (four male and four female participants), a co-ed residential level of care (five male and four female participants) in the northern region, a residential level of care for men (four participants), and a residential level of care for women(twelve participants) in the central region. There was general consensus among members that they felt safe and heard, and treatment was helpful in obtaining and maintaining sobriety. Members described what recovery meant to them, including sobriety as well as reintegrating into the community. There was universal concern that services will be reduced in the future due to changes at the federal level.

Topics discussed included treatment planning, efficacy of treatment, utilization of MAT, and access to resources such as housing and transportation. Resources for employment, housing, and transportation were limited, as was physical health insurance, to provide access to a primary care provider. Family engagement was an area of identified opportunity to assist in long-term support and recovery in the community.

[34] CommunityCares

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Strengths

Treatment Planning

Members generally noted that they were involved in the treatment planning process and developing their goals. Members also described relapse prevention planning as part of the treatment plan process, one member describing it as a contract with themselves that they were able to review and see progress. There was consensus among members that goals were reviewed over time, and updates were made as needed.

Tuberculosis, Hepatitis B, and HIV Testing

Members described how they received testing, although in some cases, it took some time to get results. Some tests were done at clinics or while a member was incarcerated, but the program did review to see whether tests had been done or were needed. There were some concerns about the lack of sufficient quarters for quarantine in residential settings for members who tested positive for conditions such as COVID 19 or the flu.

Peer Supports

Members found that peer support specialists were helpful resources in learning about addiction. One program used peers to train on the use of Narcan. Having direction and interaction with staff that were also in recovery allowed members to discuss coping strategies and lessons learned. Many members also saw value in 12-Step meetings and moving from paid peer supports to having a sponsor and peers in the community.

Group Services

Many members thought that groups were an effective part of their treatment program. Preferred topics noted by members included developing life skills, addressing emotions, and root causes of addiction. Anger management was also thought to be an important group topic. Other effective groups included co-occurring conditions such as anxiety and depression. Members expressed a greater understanding of themselves and have been given tools to help make better choices. Staff were believed to be nonjudgmental and effective in promoting a safe environment.

MAT

Members had positive responses about the efficacy of MAT in treatment.. When members were connected to MAT, they found it helpful in maintaining recovery. Staff discussed MAT options with members, and members believed they were able to discuss their concerns with utilizing MAT. Members who were using pain pills noted that Suboxone was very helpful in

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dealing with withdrawal and has been an important part of their continued recovery. One member found that Vivitrol was effective in addressing alcohol cravings and was helpful. Members expressed concerns with access to other medications for mental and physical health conditions such as depression or diabetes, in part due to lack of insurance to help cover the cost.

Opportunities

Transportation and Housing

Although some resources, such as bus passes, are provided, members believe a need for additional assistance with transportation and housing. One suggestion was for providers to obtain bicycles for members to use to reach bus stops that are too far away to reach on foot. Members also noted in some cases that they have financial issues impacting their ability to find sober housing such as funds for the first month of rent and security deposits. Case managers provide assistance, but in many cases, resources for housing and transportation are not always readily available. It was noted that Oxford House services are effective, if available.

Primary Care Provider Access

Although many members noted their access to a primary care physician was discussed, receiving services was more difficult. In some cases, this was due to a lack of insurance. Some members believed they could use more support from their case managers to coordinate obtaining identification, filling out forms, and addressing out-of-state residency issues, which may be a barrier for members to apply for health insurance.

Employment

Employment was a common theme as an opportunity for improvement, especially for members with a history of justice involvement. The need for assistance in finding employment was noted in all stakeholder groups. Although employment is not the responsibility of the program, it can be a critical part of recovery and a connection between the substance use treatment program and an employment service, such as Arizona's vocational rehabilitation program, could reduce barriers to employment support services.

Family Engagement

For members in residential treatment, there was a concern about limits on time for family engagement, such as having only five minutes for phone contact. Some members suggested using Zoom for meetings with out-of-state family members. Other suggestions included groups to educate family members on addiction and having open Al-Anon or Alateen

meetings available for family to attend. It was noted that psychoeducation for family members could be an important part for returning to the community so that family members can understand addiction and how to provide support to the member. Members expressed that they have ruined relationships with their families due to their behaviors during their active addiction and could use assistance to reengage with them. It was noted that there was a balance to family engagement at the beginning of treatment, with a 14-day period of no visitation for members, to reflect on themselves being helpful. One program noted that family visitation had been limited due to visitors bringing drugs into the facility.

In the residential program for women, additional needs were identified for parenting skills and identifying and addressing the needs of children. It was noted that there was a space for visitation with children, but it was not being used.

Cultural Sensitivity

Members reported that cultural preferences were not always discussed. Additionally, a lack of Spanish-speaking staff was noted in one program with a high Spanish speaking population. Some members stated that they were aware of their right to choose a different provider, including the right to the choice of a program that aligned with their religious beliefs.

Provider Focus Group Summary

Mercer conducted a two-hour provider focus group on May 14, 2025. There were 29 participants in the group, representing 17 different providers from all three geographic service areas. Providers represented multiple levels of care, including MAT, outpatient, intensive outpatient, and residential.

Funding was a primary area of concern noted, with administrative burden, such as prior authorization requirements, increasing due to recent fraud findings in some of Arizona's public system substance use providers. Measures, such as prior authorization, have been put in place to control fraud, waste, and abuse but have also led to higher administrative burden. Additional funding concerns centered around length of time in treatment being limited due to limited funding, leading to ending treatment too early and before members are ready to be sober and self-sufficient. Bridge funding is also lacking for individuals who no longer meet SUBG criteria due to factors, such as income levels, but are working and not eligible for Medicaid, leading to a lack of available support and potential relapse.

Additional areas of discussion included outreach efforts, evidence-based and culturally competent services, MAT, and community resources to assist in recovery. Group participants also reflected on family engagement in treatment and efforts to reengage members who have terminated treatment early. A person-centered approach to treatment was discussed,

as was the importance of a member's integration into the community, to successfully remain sober, and the need to provide education on the science of what is happening in the mind and body as part of the addiction process.

Strengths

Outreach

Providers noted that outreach is not necessarily a reimbursable activity, but efforts made by several providers included utilization of a mobile treatment van to help connect people to services, as well as providers having a co-location with police, jails, and neonatal intensive care units, and regular outreach into areas where homeless members congregate. Providers are also working with their Wellness Recovery Action Plan (WRAP) teams in the central and southern regions to locate homeless camps and assist members who have lost access to their Medicaid benefits.

Gender-Specific Services

Several services for women, including pregnant and parenting women, were discussed as having a positive impact on gender-specific substance use treatment and recovery. One provider discussed the value of sober housing for pregnant and parenting women, noting the value for the identified member, but also, the alleviation of burden on the foster care and Medicaid system by providing a needed resource for the whole family. Another resource noted was a partnership with the local hospital, where registered nurses provide wellness checks on mothers and infants while in supportive housing. Although not covered specifically by SUBG funds, nurse well checks were noted to be a good resource to assist with long-term care and recovery. One provider also described an alumni network for women in recovery who had been in supportive housing. A picnic was held for alumni, with over 300 women and children attending, most of whom had five years of employment and sobriety, serving as a support for newer members still in the program.

Tuberculosis, Hepatitis C, and HIV Testing

Screening for tuberculosis, HIV, hepatitis C, and other infectious diseases has been an area of marked improvement in the 2024 ICR. Several providers noted working with a grant funded program, the Viral Elimination Network, as an extremely effective partner that will come to the substance use program, perform testing, and provide medication in some cases. Grant funding, in general, has contributed to improved outcomes in infectious disease testing. Barriers include members still opting out, as they do not want additional testing or labs if they are not required. There can also be difficulty accessing medication for treatment if a

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member is positive for an infectious disease, as protocols, such as those for hepatitis C, can be very costly. One provider noted they have a small grant that assists with coverage of medication costs. Several providers reported a significant increase in cases of syphilis and are working to address treatment for this concern in the community.

Culturally Competent Resources

Several methods of ensuring cultural competency were discussed. Providers in the Northern Arizona region noted that they serve the Native American population and incorporate cultural programs, such as talking circles, to assist in treatment. Residential programs also noted cultural outings on Sunday, assisting residents in attending a gathering of their choice, such as church. Providers will also accommodate alternate times members would like to worship if Sunday is not their preference. Other methods used to meet the cultural needs of members were having translators, both on-site and through a remote service, and having peer supports to offer services in Spanish. Training for staff on different cultures and their norms was also discussed, such as cultural responses to mental health and substance use issues, which may be considered taboo topics not to be discussed outside of the family. Providers also ask questions on intake for any cultural preferences.

Evidence-Based Practices

Evidence-based practices continue to be an area of focus for providers. Providers discussed increased focus on trauma-informed services, such as utilization of the TREM and expanded use of EMDR. MRT has also been expanded in some areas and, anecdotally, has been showing good results. One provider also noted starting a program designed for users of methamphetamine to include MAT in an intensive outpatient setting: a current promising practice in the field. An additional EBP noted was ACRA. Life coaches for adolescents were also identified as good practice. Contingency management was noted to have good outcomes, although it is currently funded through the SSI/SSDI Outreach, Access, and Recovery program, and not SUBG. The importance of peer supports was also discussed, for example, in addressing stigma regarding admitting to injecting substances. Providers indicated it sometimes takes a few meetings for members to admit to a peer about using drugs intravenously. Having a peer with a similar background was noted to be important to engage members and develop trust. Co-occurring treatment programs and being able to have a fully operational Health Information Exchange to capture whole person care were noted as efforts that are in place but not fully implemented.

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Family Engagement

Providers discussed efforts they have made in the last year and a half to engage family and natural supports in treatment. This appears to have started gaining traction in some residential programs, which are paid with a day rate, allowing family interactions to be included in rates. The group noted that psychoeducation about substance use and family involvement in the process are more effective in residential treatment, with a referral to outpatient family services upon discharge. One residential provider noted that family members will call the unit when the member relapses to see what the family's next steps should be. Outpatient therapists offer family services, as well as co-parenting options, for members sharing children but who are not in a relationship. Time and transportation were noted to be two of the biggest barriers to family engagement.

Opportunities

Charitable Choice

Although the findings of the ICR have been consistently positive in the area of Charitable Choice, many of the providers in the focus group were unfamiliar with Charitable Choice requirements, and a recommendation from the group was for AHCCCS to provide a flyer on Charitable Choice requirements and resources. Another suggestion was to add information on Charitable Choice to the SUBG posters providers currently use. AHCCCS does have a sample notice of requirements as an attachment to AMPM 320T1 available on the AHCCCS website that providers could use as a resource.

Housing and Transportation

Housing and transportation remain two of the largest concerns with resources. Housing was noted as a problem across populations, including pregnant and parenting women. In some cases, housing placements that can be found are not close to the member's support system and resources. Transportation also is a concern, limiting members from attending treatment and limiting family and other social supports from participating in treatment if transportation is not available, as public transportation is not reliable. An additional lack of resources in Northern Arizona were shelters for victims of domestic violence, with only two being available in the area. One provider noted that additional training for staff would be useful to ensure that areas of need identified in the assessment are included in the ISP.

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Many providers noted dissatisfaction with the statewide closed-loop referral system, CommunityCares[35]. In some cases, providers have declined to use the system at all, as the resources that are needed do not utilize the system such as some community food banks. Providers believe resources may not be participating because there is an administrative lift to manage the program and respond to incoming referrals, while smaller programs cannot afford the fee required to participate in the program. Providers described the process flow as an open loop rather than a closed loop, as there are limited resources housed in the CommunityCares system. So, providers require additional staffing to both do the referral and to manually refer and find resources. Some providers have had success in providing vending machines containing items, such as bus passes, Narcan, hygiene kits, and condoms, to ameliorate some social issues.

MAT

Many providers expressed difficulty with funding MAT, especially injectable medications. The majority of providers noted the use of Suboxone and methadone for opioid use disorder, while a few providers also offered MAT for alcohol use disorder. One concern noted for Suboxone was that treatment support is not required, and members seeking Suboxone from a program requiring treatment, as well as MAT, are harder to engage and will seek out a program where counseling or additional treatment support is not required. Some providers reported that members that are incarcerated begin MAT prior to discharge, which is allowing for a smoother transition and stabilization upon release into the community.

Other concerns regarding MAT included retention in services and utilization of harm reduction options. Providers reported many members disengage but are seen as readmissions due to ambivalence to change, with trends in relapse at certain times of the year such as around the holidays. Providers in the southern part of the state also saw trends in members relapsing or using drugs for the first time due to easy availability of substances coming over the border from Mexico. MAT has been a good resource in assisting members in the southern region when they are ready to seek treatment. Providers have taken steps to address some of the retention issues noted, such as providers not titrating methadone as quickly as needed, to maintain a therapeutic dose. This has led to a change in how providers talk to members, beginning treatment with a higher dose and closely monitoring members. The providers use other grant dollars for a virtual application to communicate with members about triggers and geofence, which are areas of high relapse risk. Improvement has also been seen since they have been able to increase take-home dosages due to federal policy changes. Needle exchange programs are in effect, although there have been some negative

[35] CommunityCares

interactions, with law enforcement arresting members with clean needles. Some providers have made efforts to outreach and educate law enforcement on the importance of harm reduction efforts. It was noted that intravenous drug use has had some decline due to a rise in fentanyl use.

Most providers reported screening for smoking and vaping at intake and, at a minimum, offering referrals to the Arizona Quit Line as well as options for MAT for smoking cessation. Concerns noted about smoking cessation focused on vaping, which has been especially normalized among youth, and concerns about the legalization of marijuana. Providers are finding that youth do not see vaping as being as much of a health risk as cigarettes or other tobacco products, and legalization of marijuana has also made marijuana use an acceptable social activity, leading to an increase in use of both products and the need for increased education efforts concerning the risks of use for both.

Reengagement

Providers noted there are opportunities for improvements in the discharge and continuing care process, especially in the transition from inpatient to outpatient services, in which referrals and information can get dropped. Housing also continues to be a barrier for discharge, with some providers discussing how they have successfully managed to develop relationships with community housing resources. An additional best practice providers discussed was ensuring that appointment dates and times, as well as the names of case managers when known, be included in the discharge plan, to ensure better connectivity between providers during discharge. There was also a suggestion for increased access to members' records within the health information system that would include all historical information from providers as well as the treatment received.

Conclusion

There was active participation in all focus groups, both from providers and members. Some common themes included overall feedback that treatment is effective, although most focus group participants had concerns regarding continuing funding and the ability to access additional resources to support long-term recovery. Providers noted efforts to increase family engagement, access to gender-specific treatment, and implementation of EBPs. Members continued to note family engagement as a potential area of opportunity but did note that peer support services have improved treatment experience. Both groups agreed there has been an improvement in treatment planning and in testing for tuberculosis, hepatitis C, HIV, and other infectious diseases. Recommendations include education on Charitable Choice, continued connectivity with natural and community-based resources, and ongoing efforts to improve family engagement and cultural competency, as needed.

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Recommendations

Charitable Choice

Members did express awareness of the ability to choose a program based on religious preference, but providers seemed unfamiliar with the requirement. Suggestions were made to have materials developed explaining the regulation as well as how to access participating providers. Additional education in this area is recommended.

Access to Resources

Providers described efforts to connect members to resources, including the use of vending machines to provide Narcan, hygiene products, and other resources. Both providers and members noted ongoing difficulties in resource availability for housing, employment, and transportation. Suggestions to address the lack of resources include seeking donations from the community, working with the Arizona Vocational Rehabilitation Program[36] for members that qualify, and continuing efforts to make connections in the community with food banks and other resources. In addition, it was recommended that staff be trained to address accessing resources in ISPs when identified as a need during the assessment process.

Family Engagement

There was some discrepancy in the perception of family engagement between providers and members. Providers noted that efforts had been made to increase family education about substance use and how to support the member in recovery as well as making referrals to outpatient providers for family therapy. Members believed that more time with their family while in treatment could be effective and did not think there was enough education provided to their family members on addiction and recovery. It is possible that members voicing concerns were not receiving services from the providers that reported family education was in place. Promoting family psychoeducation on addiction and recovery at all treatment providers is recommended, as are referrals to family counseling when indicated.

Cultural Competency

Cultural competency was identified as an area of concern during the ICR, and members noted that cultural preferences were not always discussed. Providers did note that, in some agencies, there is specific training on culture for staff, including cultural norms regarding addiction and mental illness as well as efforts to address the cultural needs of specific

[36] Vocational Rehabilitation | Arizona Department of Economic Security

populations such as Native Americans. Expanding training to all providers is recommended, to include consideration of culture in the assessment and treatment planning process.

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Mercer Health & Benefits LLC
2325 East Camelback Road, Suite 600
Phoenix, AZ 85016
www.mercer-government.mercer.com

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Environmental Factors and Plan

8. Uniform Reporting System and Mental Health Client-Level Data (MH-CLD)/Mental Health Treatment Episode Data Set (MH-TEDS) – Required for MHBG

Narrative Question

Health surveillance is critical to the federal government's ability to develop new models of care to address substance use and mental illness. Health surveillance data provides decision makers, researchers, and the public with enhanced information about the extent of substance use and mental illness, how systems of care are organized and financed, when and how to seek help, and effective models of care, including the outcomes of treatment engagement and recovery. Title XIX, Part B, Subpart III of the Public Health Services Act **(42 U.S.C. §300x-52(a))**, mandates the Secretary of the Department of Health and Human Services to assess the extent to which states and jurisdictions have implemented the state plan for the preceding fiscal year. The annual report aims to provide information aiding the Secretary in this determination.

42 U.S.C. §300x-53(a) requires states and jurisdictions to provide any data required by the Secretary and cooperate with the Secretary in the development of uniform criteria for data collection. Data collected annually from the 59 MHBG grantees is done through the Uniform Reporting System (URS), Mental Health Client-Level Data (MH-CLD), and Mental Health Treatment Episode Data Set (MH-TEDS) as part of the MHBG Implementation Report. The URS is an initiative to utilize data in decision support and planning in public mental health systems, fostering program accountability. It encompasses 23 data tables collected from states and territories, comprising sociodemographic client characteristics, outcomes of care, utilization of evidence-based practices, client assessment of care, Medicaid funding status, living situation, employment status, crisis response services, readmission to psychiatric hospitals, as well as expenditures data. Currently, data are collected through a standardized Excel data reporting template. The MHBG program uses the URS, which includes the National Outcome Measures (NOMS), offering data on service utilization and outcomes. These data are aggregated by individual states and jurisdictions.

In addition to the aggregate URS data, Mental Health Client-Level Data (MH-CLD) are currently collected. SMHAs are state entities with the primary responsibility for reporting data in accordance with the reporting terms and conditions of the Behavioral Health Services Information System (BHSIS) Agreements funded by the federal government. The BHSIS Agreement stipulates that SMHAs submit data in compliance with the Community Mental Health Services Block Grant (MHBG) reporting requirements. The MH-CLD is a compilation of demographic, clinical attributes, and outcomes that are routinely collected by the SMHAs in monitoring individuals receiving mental health services at the client-level from programs funded or provided by the SMHA.

MH-TEDS is focused on treatment events, such as admissions and discharges from service centers. Admission and discharge records can be linked to track treatment episodes and the treatment services received by individuals. Thus, with MH-TEDS, both the individual client and the treatment episode can serve as a unit of analysis. In contrast, with MH-CLD, the client is the sole unit of analysis. The same set of mental health disorders for National Outcome Measures (NOMs) enumerated under MH-CLD is also supported by MH-TEDS. Thus, while both MH-TEDS and MH-CLD collect similar client-level data, the collection method differs.

Please note: *Efforts are underway to standardize the client level data collection by requiring states to submit client-level data through the MH-CLD system. Currently, over three-quarters of states participate in MH-CLD reporting. Starting in Fiscal Year 2028, MH-CLD reporting will be mandatory for all states. States that currently submit data through MH-TEDS are encouraged to begin transitioning their systems now and may request technical assistance to support this transition process*

This effort reflects the federal commitment to improving data quality and accessibility within the mental health field, facilitating more comprehensive and accurate analyses of mental health service provision, outcomes, and trends. This unified reporting system would promote efficiency in data collection and reporting, enhancing the reliability and usefulness of mental health data for policymakers, researchers, and service providers.

Please respond to the following items:

1. Briefly describe the SMHA 's data collection and reporting system and what level of data are reported currently (e.g., at the client, program, provider, and/or other levels).

   As the State Mental Health Agency (SMHA), AHCCCS utilizes a comprehensive data system that includes multiple subsystems for tracking client eligibility and service encounters. This system feeds into a centralized data warehouse, which supports robust reporting capabilities. AHCCCS is able to collect and report data at various levels, including the client, provider, and program levels, with minimal restrictions. These capabilities enable the agency to monitor service delivery, evaluate outcomes, and support planning and oversight across the behavioral health system.

2. Is the SMHA 's current data collection and reporting system specific to mental health services or it is part of a larger data system? If

the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.).

AHCCCS, serving as Arizona's State Mental Health Agency (SMHA), operates a data collection and reporting system that is part of a larger, integrated Medicaid data system. This system captures a wide range of data beyond mental health services, including physical health, long-term care, and pharmacy services. Data are collected for various populations, including individuals enrolled in Medicaid, members of the Arizona Long Term Care System (ALTCS), and tribal populations served by Tribal Regional Behavioral Health Authorities (TRBHAs). In addition to system-wide data, AHCCCS also receives program-specific data directly from mental health service providers to support targeted reporting and oversight.

3. What is the current capacity of the SMHA in linking data with other state agencies/entities (e.g., Medicaid, criminal/juvenile justice, public health, hospitals, employment, school boards, education, etc.)?

   AHCCCS, as Arizona's State Mental Health Agency (SMHA), has established data sharing agreements with several state agencies, enabling the linkage of member data across systems. This capacity allows AHCCCS to match and integrate data from entities such as Medicaid, the Department of Child Safety, the Department of Corrections, and public health agencies. These linkages support coordinated care, cross-system reporting, and improved service planning for individuals with complex needs, including those involved in the criminal justice system, child welfare, and other public programs.

4. Briefly describe the SMHA 's ability to report evidence-based practices (EBPs) including Early Serious Mental Illness (ESMI and Behavioral Health Crisis Services (BHCS) outcome data at the client-level.

   AHCCCS does not consistently receive data that is explicitly flagged as Evidence-Based Practices (EBPs), Early Serious Mental Illness (ESMI), or Behavioral Health Crisis Services (BHCS). As a result, the agency must define and identify these services using available data sources, primarily through claims data and supplemental information submitted directly by providers. While this approach allows AHCCCS to track service utilization related to EBPs, ESMI, and BHCS, the ability to report client-level outcome data is limited and varies depending on the specificity and completeness of the data received.

5. Briefly describe the limitations of the SMHA 's existing data system.

   One of the primary limitations of AHCCCS's current data system is the inability to consistently link individual services to specific funding sources—such as Medicaid, federal block grants, discretionary grants, or state and local funds—particularly for clients who are not Medicaid-eligible. This makes it challenging to track expenditures and outcomes by funding stream at the client level. Additionally, some data elements not captured in the claims and encounter systems must be obtained directly from health plans or providers, which can limit the completeness and timeliness of reporting.

6. What strategies are being employed by the SMHA to enhance data quality?

   AHCCCS employs a comprehensive set of strategies to enhance data quality, including over 500 automated data edits and audits across its data systems. These checks help ensure accuracy, completeness, and consistency in reported data. In addition, AHCCCS has documented testing procedures and convenes dedicated workgroups that routinely review and validate data. These efforts support continuous improvement and help maintain the integrity of data used for reporting, planning, and oversight.

7. Please describe any barriers (staffing, IT infrastructure, legislative, or regulatory policies, funding, etc.) that would limit your state from collecting and reporting data to the federal government.

   AHCCCS faces several barriers that impact its ability to collect and report data to the federal government. One of the most significant challenges is linking service provision to specific funding streams at the client level, particularly for individuals not covered by Medicaid. This limitation stems from the complexity of the service delivery system and the variety of funding sources involved. Additionally, there are challenges related to IT infrastructure and data availability, as some necessary data elements are not captured in claims or encounter systems and must be obtained directly from providers or health plans. AHCCCS has initiated workgroups to evaluate and improve its reporting capacity, including efforts to enhance the accuracy and completeness of Uniform Reporting System (URS) tables.

8. Please indicate areas of technical assistance needs related to this section.

   AHCCCS is seeking technical assistance specifically focused on optimizing the use of our existing data systems to meet the Uniform Reporting System (URS) reporting requirements. While we have robust infrastructure in place, we would benefit from targeted guidance on how to align our current data elements and reporting processes with federal expectations, particularly in areas where data is not explicitly flagged or categorized. Support in interpreting URS specifications and integrating them into our workflows would significantly improve our reporting accuracy and efficiency.

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Footnotes:

Environmental Factors and Plan

9. Crisis Services – Required for MHBG, Requested for SUPTRS BG

Narrative Question

There is a mandatory 5 percent set-aside within MHBG allocation for each state to support evidence-based crisis systems. The statutory language outlines the following for the 5 percent set-aside:

> *…….to support evidence-based programs that address the crisis care needs of individuals with serious mental illnesses and children with serious emotional disturbances, which may include individuals (including children and adolescents) experiencing mental health crises demonstrating serious mental illness or serious emotional disturbance, as applicable.*
>
> *CORE ELEMENTS: At the discretion of the single State agency responsible for the administration of the program, the funds may be used to fund some or all of the core crisis care service components, as applicable and appropriate, including the following:*
>
> - *Crisis call centers*
> - *24/7 mobile crisis services*
> - *Crisis stabilization programs offering acute care or subacute care in a hospital or appropriately licensed facility, as determined by such State, with referrals to inpatient or outpatient care.*
>
> *STATE FLEXIBILITY: In lieu of expending 5 percent of the amount the State receives pursuant to this section for a fiscal year to support evidence-based programs as required a State may elect to expend not less than 10 percent of such amount to support such programs by the end of two consecutive fiscal years.*

A crisis response system has the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family.The expectation is that states will build on the emerging and growing body of evidence, including guidance developed by the federal government, for effective community-based crisis-intervention and response systems. Given the multi-system involvement of many individuals with M/SUD issues, the crisis system approach provides the infrastructure to improve care coordination, stabilization services to support reducing distress, and the promotion of skill development and outcomes, all towards managing costs and better investment of resources.

Several resources exist to help states. These include **Crisis Services: Meeting Needs, Saving Lives**, which consists of the **National Guidelines for Behavioral Health Coordinated System of Crisis Care** as well as an **Advisory: Peer Support Services in Crisis Care** There is also the **National Guidelines for Child and Youth Behavioral Health Crisis Care** which offers best practices, implementation strategies, and practical guidance for the design and development of services that meet the needs of children, youth, and their families experiencing a behavioral health crisis. Please note that this set aside funding is dedicated for the core set of crisis services as directed by Congress. Nothing precludes states from utilizing more than 5 percent of its MHBG funds for crisis services for individuals with serious mental illness or children with serious emotional disturbances. If states have other investments for crisis services, they are encouraged to coordinate those programs with programs supported by the 5 percent set aside. This coordination will help ensure services for individuals are swiftly identified and are engaged in the core crisis care elements.

When individuals experience a crisis related to mental health, substance use, and/or homelessness (due to mental illness or a co-occurring disorder), a no-wrong door comprehensive crisis system should be put in place. Based on the National Guidelines, there are three major components to a comprehensive crisis system, and each must be in place in order for the system to be optimally effective. These three-core structural or programmatic elements are: Crisis Call Center, Mobile Crisis Response Team, and Crisis Receiving and Stabilization Facilities.

Crisis Contact Center. In times of mental health or substance use crisis, 911 is typically called, which results in police or emergency medical services (EMS) dispatch. A crisis call center (which may provide text and chat services as well) provides an alternative. Crisis call centers should be made available statewide, provide real-time access to a live crisis counselor on a 24/7 basis, meet National Suicide Prevention Lifeline operational guidelines, and serve as "Air Traffic Control" to assess, coordinate, and determine the appropriate response to a crisis. In doing so, these centers should integrate and collaborate with existing 911 and 211 centers, as well as other applicable call centers, to ensure access to the appropriate level of crisis response. 211 centers serve as an entry point to crisis services in many states and provide information and referral to callers on where to obtain assistance from local and national social

services, government agencies, and non-profit organizations.

The public has become accustomed to calling 911 for any emergency because it is an easy number to remember, and they receive a quick response. Many of the crisis systems in the United States continue to use 911 for several reasons such as they are still building their crisis systems or because they have no mechanism to fund a call center separate from 911. However, they recognize that the sure way to minimize the involvement of law enforcement in a behavioral health crisis response is to divert calls from 911. There are basically three diversion models in operation at this time: (1) the 911-based system with dispatchers who forward calls to either law enforcement's responder team (law enforcement officer with a behavioral health professional) or to their Crisis Intervention Team (CIT) with law enforcement officers who have received Crisis Intervention Training, including awareness of mental health and substance use disorders, and related symptoms, de-escalation methods, and how to engage and connect people to supportive services; (2) the 911-based system with well-trained 911 dispatchers who triage calls to state or local crisis call centers for individuals who are not a threat to themselves or others; the call centers may then refer appropriate calls to local mobile response teams (MRTs), also called mobile crisis teams (MCTs); and (3) State or local Crisis Contact Centers with well-trained counselors who receive calls directly (without utilizing 911 at all) on their own toll-free numbers.

Mobile Crisis Response Team. Once a behavioral health crisis has been identified and a crisis line has been called, a mobile response may be required if the crisis cannot be resolved by phone alone. Historically, law enforcement has been dispatched to the location of the individual in crisis. But in an effective crisis system, mobile crisis teams, including a licensed clinician, should be dispatched to the location of the individual in crisis, accompanied by Emergency Medical Services (EMS) or police only as warranted. Ideally, peer support professionals would be integrated into this response. Assessment should take place on site, and the individual should be connected to the appropriate level of care, if needed, as deemed by the clinician and response team.

Crisis Receiving and Stabilization Facilities. In a typical response system, EMS or police would transport the individual in crisis either to an ED or to a jail. Crisis Receiving and Stabilization Facilities provide a cost-effective alternative. These facilities should be available to accept individuals by walk-in or drop-off 24/7 and should have a "no wrong door" policy that supports all individuals, including those who need involuntary services. When anyone arrives, including law enforcement or EMS who are dropping off an individual, the hand-off should be "warm" (welcoming), timely and efficient. These facilities provide assessment for, and treatment of mental health and substance use crisis issues, including initiating medications for opioid use disorder (MOUD), and also provide wrap-around services. The multi-disciplinary team, including peers, at the facility can work with the individual to coordinate next steps in care, to help prevent future mental health crises and repeat contacts with the system, including follow-up care.

Currently, the 988 Suicide and Crisis Lifeline (Lifeline) connects with local call centers throughout the United States. Call center staff is comprised of individuals who are trained to utilize best practices in handling behavioral health calls. Local call centers automatically engage in a safety assessment for every call; if an imminent risk exists and cannot be deescalated, they forward the call to either 911 or to a local mobile crisis team for a response. If there is no imminent risk, the call center will work with the individual (or the person calling on their behalf) for as long as needed or, if necessary, dispatch a local MRT.

988 – 3-Digit behavioral health crisis number. The National Suicide Hotline Designation Act (**P.L. 116-172**) provides an opportunity to support the infrastructure, service and long-term funding for community and state 988 response, a national 3-digit behavioral health crisis number that was approved by the Federal Communications Commission in July 2020. In July 2022, the National Suicide Prevention Lifeline transitioned to 988 Suicide & Crisis Lifeline, but the 1-800-273-TALK is still operational and directs calls to the Lifeline network. The 988 transition has supported and expanded the Lifeline network and will continue utilizing the life-saving behavioral health crisis services that the Lifeline and Veterans Crisis Line centers currently provide.

Building Crisis Services Systems. Most communities across the United States have limited, but growing, crisis services, although some have an organized system of services that provide on-demand behavioral health assessment and stabilization services, coordinate and collaborate to divert from jails, minimize the use of EDs, reduce hospital visits, and reduce the involvement of law enforcement. Those that have such systems did not create them overnight, but it involved dedicated individuals, collaboration, considerable planning, and creative methods of blending sources of funding.

1. Briefly describe your state's crisis system. For all regions/areas of your state, include a description of access to crisis contact centers, availability of mobile crisis and behavioral health first responder services, utilization of crisis receiving and stabilization centers.

Arizona's crisis system, overseen by the Arizona Health Care Cost Containment System (AHCCCS), is built on a comprehensive and integrated continuum of care designed to rapidly stabilize individuals experiencing behavioral health crises and support their return to baseline functioning. This statewide system is accessible to all Arizona residents, regardless of insurance status, and includes a full range of services such as crisis telephone response, mobile crisis team intervention, facility-based stabilization, and other covered supports.

The system is administered through Regional Behavioral Health Agreements (RBHAs), which function as Managed Care Organizations (MCOs)

responsible for delivering crisis services across designated Geographical Service Areas (GSAs). These services are available 24 hours a day, 7 days a week, 365 days a year. At the core of the system are crisis contact centers that provide immediate access to support via phone, text, and chat. These centers are staffed by trained professionals who conduct assessments, offer de-escalation support, and connect individuals to additional services such as mobile crisis teams or crisis stabilization facilities.

Crisis Mobile Teams (CMTs) are a critical component of the system, operating statewide with GPS-enabled dispatch to ensure the fastest possible response. These teams are composed of behavioral health professionals and include at least 25% credentialed peers. They are required to meet strict response time standards: within 30 minutes for law enforcement requests, 60 minutes in urban areas, and 90 minutes in rural regions. When a crisis cannot be resolved in the community, CMTs coordinate directly with crisis stabilization centers to facilitate seamless transitions and ensure continuity of care.

Crisis receiving and stabilization centers, maintained by the RBHAs, provide 24-hour psychiatric and substance use disorder services, including 23-hour observation and access to all FDA-approved Medication Assisted Treatment (MAT) options covered by AHCCCS. These facilities are designed to offer short-term stabilization and operate under a "no wrong door" policy, accepting all referrals and streamlining transfers from law enforcement and other public safety agencies.

Through this coordinated and responsive system, Arizona ensures that individuals in crisis receive timely, effective, and person-centered care, regardless of where they live or their insurance status. The crisis system is a cornerstone of the state's broader behavioral health strategy, promoting recovery, safety, and well-being across all communities.

2. In accordance with the guidelines below, identify the stages where the existing/proposed system will fit in.

*a) The **Exploration** stage: is the stage when states identify their communities' needs, assess organizational capacity, identify how crisis services meet community needs, and understand program requirements and adaptation.*
*b) The **Installation** stage: occurs once the state comes up with a plan and the state begins making the changes necessary to implement the crisis services based on the published guidance. This includes coordination, training and community outreach and education activities.*
*c) **Initial Implementation** stage: occurs when the state has the three-core crisis services implemented and agencies begin to put into practice the published guidelines.*
*d) **Full Implementation** stage: occurs once staffing is complete, services are provided, and funding streams are in place.*
*e) **Program Sustainability** stage: occurs when full implementation has been achieved, and quality assurance mechanisms are in place to assess the effectiveness and quality of the crisis services.*

Check one box for each row indicating state's stage of implementation

	Exploration Planning	Installation	Early Implementation Less than 25% of counties	Partial Implementation About 50% of counties	Majority Implementation At least 75% of counties	Program Sustainment
Someone to contact	☐	☐	☐	☐	☐	☑
Someone to respond	☐	☐	☐	☐	☐	☑
Safe place to be	☐	☐	☐	☐	☐	☑

3. Briefly explain your stages of implementation selections here.

Arizona's crisis system remains in the program sustainment phase, with all components actively maintained and continuously refined to ensure long-term effectiveness. Since the launch and widespread promotion of the national 988 Suicide and Crisis Lifeline, the state has experienced a steady and significant increase in the utilization of crisis services. This upward trend reflects growing public awareness of available supports, a deeper understanding of their value, and a reduction in stigma surrounding behavioral health care.

In response to this rising demand, AHCCCS remains firmly committed to strengthening the crisis system. This includes ongoing efforts to monitor network adequacy, uphold service quality, and evaluate individual outcomes. AHCCCS also continues to strategically invest in innovation and resource allocation to expand access and ensure that Arizona's crisis services remain responsive, and effective for all residents.

4. Based on the National Guidelines for Behavioral Health Crisis Care and the **National Guidelines for Child and Youth Behavioral Health Crisis Care**, explain how the state will develop the crisis system.

In alignment with SAMHSA's National Guidelines for Behavioral Health Crisis Care, Arizona's crisis system remains in the program sustainment phase, with a continued emphasis on maintaining and improving the effectiveness and outcomes of services statewide. During this phase, the state is focused on refining its infrastructure, strengthening service delivery, and ensuring that crisis care remains accessible, responsive, and high-quality for all residents.

To meet the standards outlined in the National Guidelines for Child and Youth Behavioral Health Crisis Care, Arizona is actively expanding access to 24/7 crisis services specifically designed for children and adolescents. This includes the deployment of mobile response teams trained to engage youth in crisis and the development of youth-friendly crisis stabilization centers that provide safe, supportive environments for short-term care. The state is also working to improve coordination across key systems such as education, child welfare, and juvenile justice to ensure that youth receive integrated and timely support.

Special attention is being given to rural and geographically isolated communities, as well as populations with limited access to behavioral health services. Workforce development is a central focus, with increased training for professionals in trauma-informed, youth-centered care and the integration of peer and family support roles to enhance engagement and recovery.

Arizona also maintains a robust data infrastructure to monitor service outcomes and drive continuous quality improvement. This system allows for real-time evaluation of crisis services and supports evidence-based decision-making to ensure that the state's crisis system evolves in step with national best practices and the needs of its communities.

5. Other program implementation data that characterizes crisis services system development.

Someone to contact: Crisis Contact Capacity

a. Number of locally based crisis call Centers in state
   i. In the 988 Suicide and Crisis lifeline network: 1
   ii. Not in the suicide lifeline network: 0

b. Number of Crisis Call Centers with follow up protocols in place
   i. In the 988 Suicide and Crisis lifeline network: 1
   ii. Not in the suicide lifeline network: 0

c. Estimated percent of 911 calls that are coded out as BH related: 0

Someone to respond: Number of communities that have mobile behavioral health crisis mobile capacity (in comparison to the toal number of communities)

a. Independent of public safety first responder structures (police, paramedic, fire): 104
b. Integrated with public safety first responder structures (police, paramedic, fire): 0
c. Number that utilizes peer recovery services as a core component of the model: 0

Safe place to be

a. Number of Emergency Departments: 0
b. Number of Emergency Departments that operate a specialized behavioral health component: 0
c. Number of Crisis Receiving and Stabilization Centers (short term, 23-hour units that can diagnose and stabilize individuals in crisis): 16

6. Briefly describe the proposed/planned activities utilizing the 5% set aside. If applicable, please describe how the state is leveraging the CCBHC model as a part of crisis response systems, including any role in mobile crisis response and crisis follow-up. As a part of this response, please also describe any state-led coordination between the 988 system and CCBHCs.

Arizona plans to utilize the 5% Mental Health Block Grant (MHBG) crisis set-aside to strengthen and expand key components of its behavioral health crisis system. These activities include enhancing access to state-operated crisis hotlines and helplines that offer 24/7 support through phone, text, and chat, ensuring individuals in crisis can immediately connect with trained professionals. The state is also investing in mobile crisis response teams to provide rapid, on-site intervention and de-escalation services in community settings.

To reduce reliance on emergency departments, Arizona is establishing and improving crisis stabilization centers that offer short-term, intensive care for individuals experiencing behavioral health emergencies. These facilities serve as critical alternatives for those needing immediate support. In addition, the State is providing crisis intervention training to first responders, law enforcement, and healthcare professionals to better equip them to recognize and respond to mental health crises.

Peer support programs are another area of focus, with funding directed toward initiatives that engage individuals with lived experience to provide compassionate guidance and support to those currently in crisis. Arizona is also launching outreach and prevention efforts aimed at identifying individuals at risk earlier and connecting them to services before a crisis escalates.

As part of its broader strategy, Arizona is working to improve integration and coordination among crisis services, mental health providers, law enforcement, and social support systems. This includes leveraging the Certified Community Behavioral Health Clinic (CCBHC) model to enhance crisis response capabilities. CCBHCs play a vital role in mobile crisis response and follow-up care, helping to ensure continuity of support after an initial crisis episode. The state is also coordinating efforts between the 988 Suicide and Crisis Lifeline and CCBHCs to streamline referrals, improve service delivery, and ensure that individuals contacting 988 are connected to appropriate local resources for ongoing care. Through these combined efforts, Arizona is building a more responsive, integrated, and person-centered crisis system.

7. Please indicate areas of technical assistance needs related to this section.

Currently, there are no identified areas requiring technical assistance.

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Footnotes:

Environmental Factors and Plan

10. Recovery – Required for MHBG & SUPTRS BG

Narrative Question

Recovery supports and services are essential for providing and maintaining comprehensive, quality behavioral health care. The expansion in access to; and coverage for, health care drives the promotion of the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals. Recovery encompasses the spectrum of individual needs related to those with mental health and substance use disorders.

Recovery is supported through the key components of health (access to quality physical health and M/SUD treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of a recovery- guided approach to person-centered care is inclusive of shared decision-making, culturally welcoming and sensitive to social needs of the individual, their family, and communities. Because mental and substance use disorders can be chronic relapsing conditions, long term systems and services are necessary to facilitate the initiation, stabilization, and management of recovery and personal success over the lifespan.

The following working definition of recovery from mental and/or substance use disorders has stood the test of time:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

In addition, there are 10 identified guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see **Working Definition of Recovery.**

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Technical assistance and training on a variety of such services are available through the several federally supported national technical assistance and training centers. States are strongly encouraged to take proactive steps to implement and expand recovery support services and collaborate with existing RCOs and RCCs. Block Grant guidance is also available at the **Recovery Support Services Table**.

Because recovery is based on the involvement of peers/people in recovery, their family members and caregivers, SMHAs and SSAs should engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing organizations and direct resources for enhancing peer, family, and youth networks such as RCOs and RCCs and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing, and monitoring the state behavioral health treatment system.

1. Does the state support recovery through any of the following:

a) Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care? (●) Yes ( ) No

b) Required peer accreditation or certification? (●) Yes ( ) No

c) Use Block Grant funds for recovery support services? (●) Yes ( ) No

d) Involvement of people with lived experience /peers/family members in planning, implementation, or evaluation of the impact of the state's behavioral health system? (●) Yes ( ) No

2. Does the state measure the impact of your consumer and recovery community outreach activity? (●) Yes ( ) No

3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.

RESPONSE - SAMHSA, defines recovery as "the process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential."

In Arizona, we have Peer-Run Organizations, Family-Run Organizations, and Specialty Providers that provide services to these populations based on the principles of recovery and resiliency. Recovery support services are for all AHCCCS members including adults with a serious mental illness designation. AHCCCS requires all members with a designation of SMI or SED be offered recovery support services during the initial planning process. These services are provided to many specialty populations including members involved in the justice system, dual diagnosis, in tribal communities, and faith- based organizations. These services include peer support and credentialed family support. All individuals providing peer support and/or credentialed family support are credentialed as Peer Recovery Support Specialists (PRSS) through an AHCCCS approved training program.

Credentialed family support training is established in AHCCCS policy including elements for children with SED. Credentialed family support (CFSS) is provided by family members of children with SED who have completed training and credentialing with state approved curricula. This applies the peer principle to family support which traditionally can be provided by individuals without "lived experience." CFSS ensures that those providing the service can relate to those they are serving as peers with shared lived experience of raising children with SED.

AHCCCS Policy AMPM Exhibit 300-3 establishes the 9 Guiding Principles of Adult System of Care and Arizona Vision and 12 Principles for Children's System of Care as outlined below. These principles came directly from members and family members to guide us as the State Medicaid Authority in the fundamental values of recovery in the adult system and resiliency in the children's system.

The ASOC developed the following Nine Guiding Principles to promote recovery in the adult behavioral health system and for engaging with adults who have a serious mental illness:

1. RESPECT: Respect is the cornerstone. Meet the person where they are without judgment, with great patience and compassion.

2. PERSONS IN RECOVERY CHOOSE SERVICES AND ARE INCLUDED IN PROGRAM DECISIONS AND 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.

3. FOCUS ON INDIVIDUAL AS A WHOLE PERSON, WHILE INCLUDING AND/OR DEVELOPING NATURAL SUPPORTS: A person in recovery 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.

4. EMPOWER INDIVIDUALS TAKING STEPS TOWARDS INDEPENDENCE AND ALLOWING RISK TAKING WITHOUT FEAR OF FAILURE: A person in recovery finds 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.

5. INTEGRATION, COLLABORATION, AND PARTICIPATION WITH THE COMMUNITY OF ONE'S CHOICE:
A person in recovery 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.

6. PARTNERSHIP BETWEEN INDIVIDUALS, STAFF, AND FAMILY MEMBERS/NATURAL SUPPORTS FOR SHARED DECISION MAKING WITH A FOUNDATION OF TRUST: A person in recovery, as with any member of a society, finds strength and support through partnerships. Compassion-based alliances with a focus on recovery optimization bolster self-confidence, expand understanding in all participants, and lead to the creation of optimum protocols and outcomes.

7. PERSONS IN RECOVERY DEFINE THEIR OWN SUCCESS: A person in recovery – by their own declaration – discovers success, in part, by quality of life outcomes, which may include an improved sense of well-being, advanced integration into the community,

and greater self-determination. Persons in recovery are the experts on themselves, defining their own goals and desired outcomes.

8. STRENGTHS-BASED, FLEXIBLE, RESPONSIVE SERVICES REFLECTIVE OF AN INDIVIDUAL'S CULTURAL PREFERENCES: A person in recovery 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.

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.
In addition, Arizona/AHCCCS collaborated with the child, family, and others to provide services that are tailored to meet the needs of children with serious emotional disturbances and their caregivers. The goal is to ensure that services are provided to the child and family in the most appropriate setting, in a timely manner, in accordance with the best practices and respecting the child, family and their cultural heritage.

Arizona/AHCCCS developed The Twelve (12) Principles for Children's in the Behavioral Health Service Delivery System:

1. 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.

2. 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.

3. 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, DCS and/or DDD 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.

4. 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.

5. BEST PRACTICES: Competent individuals who are adequately trained and supervised provide behavioral health services. They are delivered in accordance with guidelines adopted by ADHS that incorporate evidence-based "best practice." Behavioral health service plans identify and appropriately address behavioral symptoms that are reactions to death of a family member, abuse or neglect, learning disorders, and other similar traumatic or frightening circumstances, substance abuse problems, the specialized behavioral health needs of children who are developmentally disabled, maladaptive sexual behavior, including abusive conduct and risky behavior, and the need for stability and the need to promote permanency in class member's lives, especially class members in foster care. Behavioral Health Services are continuously evaluated and modified if ineffective in achieving desired outcomes.

6. 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 needs.

7. TIMELINESS: Children identified as needing behavioral health services are assessed and served promptly.

8. 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.

9. STABILITY: Behavioral health service plans strive to minimize multiple placements. Service plans identify whether a class 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.

10. 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.

11. 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 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.

12. 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.

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state. i.e., RCOs, RCCs, peer-run organizations.

RESPONSE - Peer recovery support services are available to all AHCCCS members, including those with substance use disorders, with specialty training and support specifically to members with opioid use disorders. Peer and Recovery Support Specialists (PRSS) serving members with SUD, have substantial representation within Arizona's recovery support workforce. PRSS who serve members with SUD are employed in many settings including within Medication for Opioid Use Disorder (MOUD) programs.

Recovery support services are offered to members in all stages of treatment and all levels of care. Outpatient clinics, residential facilities, inpatient facilities, and MOUD facilities all have necessary recovery support services to help ensure the best chance at recovery. These services are provided both in office and in the community. Recovery support services can help provide support and assistance in gaining and growing a community support system as well as teach important independent living skills.

The AHCCCS Medical Policy Manual (AMPM 310-B) outlines coverage for PRSS Medicaid members including children and adults while the AMPM 300-2B outlines covered services for Non-Medicaid funding such as SUBG, which includes Peer Services. AMPM 963 Peer and Recovery Support Service Provision Requirements such as qualifications for the PRSS, continuing education, supervision of PRSS by a BHT or BHP, training standards, and the approval process, among others.

In addition to the coverage of recovery and peer support through both Title XIX/XXI and Non-Title XIX/XXI funding streams, the SUBG funds additional recovery efforts through the ACC-RBHAs, TRBHAs and the Sonoran Prevention Works harm reduction program. Examples include:
? Oxford House - a democratic, self-run, peer-run sober living environment that provides a housing option with an environment conducive to recovery for members in recovery from SUD
? The Barbell Saves Project - a gym for and by people in recovery from SUD that implements recovery programming around physical fitness and holistic health, highlighting the impacts that the support of peers and health and fitness focus can have on maintaining sobriety
? Supporting to expansion of PRSS through hiring and training additional PRSS across the BH provider network and system, including placement of PRSS in the crisis system
? Community Medical Service's pilot implementation of the Recovery Path application
? Valle Del Sol's implementation of recovery coaches re-engaging member when they no-show to the clinic
? Connie Hillman house implementing programs for supporting parenting individuals in recovery
? Engagement specialists provision of recovery toolbox groups

5. Does the state have any activities that it would like to highlight?

All policies overseeing Recovery services are informed and guided directly by stakeholders including behavioral health service providers, RBHAs/TRBHAs, and members who receive said services and their professional and personal support systems.

6. Please indicate areas of technical assistance needs related to this section.

No technical assistance requested at this time

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Footnotes:

Environmental Factors and Plan

11. Children and Adolescents M/SUD Services – Required for MHBG, Requested for SUPTRS BG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SUPTRS BG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health disorder and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community.[1] Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24.[2] For youth between the ages of 10 and 14 and young adults between the ages of 25 and 34, suicide is the second leading cause of death and for youth and young adults between 15 and 24, the third leading cause of death.[3]

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started using substances the age of 18. Of people who started using substances before the age of 18, one in four will develop a substance use disorder compared to one in 25 who started using substances after age 21.[4]

Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance use, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, states are encouraged to designate a point person for children to assist schools in assuring identified children relate to available prevention services and interventions, mental health and/or substance use screening, treatment, and recovery support services.

Since 1993, the federally funded Children's Mental Health Initiative (CMHI) has been used as an approach to build the system of care model in states and communities around the country. This has been an ongoing program with 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then, states have also received planning and implementation grants for adolescent and transition age youth SUD and MH treatment and infrastructure development. This work has included a focus on formal partnership development across child serving systems and policy change related to financing, workforce development, and implementing evidence-based treatments.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the functioning of children, youth and young adults in home, school, and community settings. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult, and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs.[5]

According to data from the 2017 Report to Congress on systems of care, services reach many children and youth typically underserved by the mental health system.

1. improve emotional and behavioral outcomes for children and youth.
2. enhance family outcomes, such as decreased caregiver stress.
3. decrease suicidal ideation and gestures.
4. expand the availability of effective supports and services; and
5. save money by reducing costs in high-cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

The expectation is that states will build on the well-documented, effective system of care approach. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes:

1. non-residential services (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);
2. supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education

and employment); and

3. residential services (e.g., therapeutic foster care, crisis stabilization services, and inpatient medical withdrawal management).

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[1]Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children - United States, 2005-2011. MMWR 62(2).

[2]Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593-602.

[3]Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from www.cdc.gov/injury/wisqars/index.html.

[4]The National Center on Addiction and Substance use disorder at Columbia University. (June, 2011). Adolescent Substance use disorder: America's #1 Public Health Problem.

[5]Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from **https://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings-Executive-Summary/PEP12-CMHI0608SUM**

Please respond to the following items:

1. Does the state utilize a system of care approach to support:

a) The recovery of children and youth with SED? (●) Yes ( ) No

b) The resilience of children and youth with SED? (●) Yes ( ) No

c) The recovery of children and youth with SUD? (●) Yes ( ) No

d) The resilience of children and youth with SUD? (●) Yes ( ) No

2. Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address M/SUD needs:

a) Child welfare? (●) Yes ( ) No

b) Health care? (●) Yes ( ) No

c) Juvenile justice? (●) Yes ( ) No

d) Education? (●) Yes ( ) No

3. Does the state monitor its progress and effectiveness, around:

a) Service utilization? (●) Yes ( ) No

b) Costs? (●) Yes ( ) No

c) Outcomes for children and youth services? (●) Yes ( ) No

4. Does the state provide training in evidence-based:

a) Substance use prevention, SUD treatment and recovery services for children/adolescents, and their families? (●) Yes ( ) No

b) Mental health treatment and recovery services for children/adolescents and their families? (●) Yes ( ) No

5. Does the state have plans for transitioning children and youth receiving services:

a) to the adult M/SUD system? (●) Yes ( ) No

b) for youth in foster care? (●) Yes ( ) No

c) Is the child serving system connected with the Early Serious Mental Illness (ESMI) services? (●) Yes ( ) No

d) Is the state providing trauma informed care? (●) Yes ( ) No

6. Describe how the state provides integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

Arizona delivers integrated services through its system of care by requiring all AHCCCS health plans to provide coordinated, high-

quality services that span both clinical and non-clinical domains. These services are rooted in evidence-based practices and designed to meet the needs of individuals and families across the state.

Health plans must ensure access to preventive and wellness services, chronic disease management, and transitional care across various settings. This includes discharge planning and the transition from pediatric to adult systems of care. Behavioral health assessments and service planning are guided by the Health Home model, with peer and family-delivered support services incorporated based on individual needs. All services are delivered by licensed or certified providers registered with AHCCCS and must comply with applicable federal and state regulations.

To promote seamless coordination across systems, AHCCCS mandates that all AHCCCS Complete Care (ACC) plans establish formal collaborative protocols with key partners. These include the Administrative Office of the Courts, Juvenile and Adult Probation, the Arizona Department of Corrections and Department of Juvenile Corrections, the Arizona Department of Child Safety, Tribal Nations and providers, the Veterans Administration, and county jails. These written agreements define procedures for joint service delivery and ensure that individuals served by multiple entities receive integrated, comprehensive support.

Additionally, health plans are required to implement health information technology that facilitates communication among treating professionals and caregivers. They must also report performance measures that evaluate system reliability, identify service gaps, and ensure alignment with broader care goals.

Through these coordinated efforts, Arizona's system of care effectively integrates social services, educational services, child welfare, juvenile justice, law enforcement, and substance use disorder treatment into a unified, person-centered framework that supports whole-person health and long-term well-being.

7. Does the state have any activities related to this section that you would like to highlight?

No activities to highlight at this time

8. Please indicate areas of technical assistance needs related to this section.

No technical assistance needed at this time

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Footnotes:

Environmental Factors and Plan

12. Suicide Prevention – Required for MHBG, Requested for SUPTRS BG

Narrative Question

Suicide is a major public health concern, it is a leading cause of death nationally, with over 49,000 people dying by suicide in 2022 in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance use, painful losses, exposure to violence, economic and financial insecurity, and social isolation. Mental illness and substance use are possible factors in 90 percent of deaths by suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, M/SUD agencies are urged to lead in ways that are suitable to this growing area of concern. M/SUD agencies are encouraged to play a leadership role on suicide prevention efforts, including shaping, implementing, monitoring, care, and recovery support services among individuals with SMI/SED.

Please respond to the following items:

1. Have you updated your state's suicide prevention plan since the FY2024-2025 Plan was submitted? (●) Yes ( ) No

2. Describe activities intended to reduce incidents of suicide in your state.

Arizona's statewide suicide prevention efforts are led by the Arizona Department of Health Services (ADHS) in partnership with the Arizona Health Care Cost Containment System (AHCCCS) and other key stakeholders. Together, they implement the Suicide Prevention Action Plan—a dynamic framework updated twice annually to guide strategies that expand access to crisis support, treatment services, and prevention resources for clinicians, communities, families, and survivors.

AHCCCS plays a pivotal role in embedding suicide prevention across the state's behavioral health infrastructure by policies that can be found at the following website- https://www.azahcccs.gov/shared/MedicalPolicyManual/. Through AHCCCS Medical Policy 590, behavioral health crises are clearly defined, and Regional Behavioral Health Authorities (RBHAs) are tasked with delivering essential services such as crisis phone response, mobile crisis teams, and facility-based stabilization.

To streamline access, AHCCCS and the RBHAs contract with Solari—a single provider that manages both the Arizona State Crisis Line and the 988 National Suicide Prevention Lifeline. These integrated lines operate 24/7 and are staffed by trained behavioral health professionals who assess needs, deescalate crises, and connect callers to appropriate services, including mobile teams and stabilization facilities. They also coordinate transportation and ensure warm handoffs to minimize disruption.

For AHCCCS Medicaid members, the crisis call center notifies their health plan within 24 hours to ensure coordinated follow-up. For uninsured or underinsured individuals, RBHAs provide up to 72 hours of continued support, connecting them to community resources such as counseling, peer support, and housing assistance. Call centers follow SAMHSA's National Guidelines for Behavioral Health Crisis Care and participate in Zero Suicide initiatives, with referrals to peer-operated Warm Lines for ongoing support.

Crisis Mobile Teams (CMTs) are a cornerstone of Arizona's response system. Dispatched statewide 24/7 using GPS technology, these teams must include at least 25% credentialed peers and meet strict response time standards—30 minutes for law enforcement, 60 minutes for urban areas, and 90 minutes for rural communities. AHCCCS monitors these metrics monthly. When field resolution isn't possible, CMTs coordinate directly with crisis stabilization facilities to ensure seamless transitions and timely care.

Crisis stabilization facilities provide 24-hour psychiatric and substance use disorder stabilization, 23-hour observation, and access to all FDA-approved medication-assisted treatment (MAT) options covered by AHCCCS.

Tribal Regional Behavioral Health Authorities (TRBHAs) enhance the system through strong partnerships with fire departments, police, EMS, hospitals, tribal entities, and public health providers. They offer regular Crisis Intervention Team (CIT) and Mental Health First Aid training to law enforcement and other stakeholders, fostering collaboration and improving crisis response.

Recognizing that suicide prevention must extend beyond the immediate crisis, AHCCCS requires RBHAs to deliver Post-Crisis Care Plans and tailored follow-up services. AHCCCS Policy 1040 outlines expectations for outreach and engagement, including follow-up within 72 hours of a crisis and within 7 days of inpatient discharge. Providers must address barriers to re-entry into behavioral health services and ensure active participation in treatment planning.

Transportation access is another critical factor in reducing suicide risk. AHCCCS Policy 417 sets standards for appointment availability and transportation timelines, requiring urgent behavioral health appointments within 24 hours, initial assessments within 7 days, and follow-up services within 21–45 days depending on age and urgency. Contractors must maintain robust provider networks and educate providers on these standards to ensure timely care.

Arizona's commitment to youth suicide prevention is reinforced by legislation. The Mitch Warner Act mandates suicide prevention training for all public school staff working with students in grades 6–12. Jake's Law requires schools to establish and publicly post behavioral health referral policies. AHCCCS, in collaboration with the Arizona Department of Education (ADE) and ADHS, provides approved training curricula and resources to schools, with ADE prioritizing staff training and extending opportunities to community members statewide.

To better understand and address suicide trends, the Arizona Legislature established the Suicide Mortality Review (SMR) in 2020. Led by ADHS with AHCCCS participation, this multidisciplinary team evaluates suicide deaths to identify risk and protective factors. The SMR informs policy improvements, enhances service delivery, and supports public education efforts. It also facilitates the formation of local review teams to address county-level needs. AHCCCS uses these insights to refine protocols and strategically invest in closing service gaps and strengthening Arizona's suicide prevention system.

3. Have you incorporated any strategies supportive of the Zero Suicide Initiative? (●) Yes ( ) No

4. Do you have any initiatives focused on improving care transitions for patients with suicidal ideation being discharged from inpatient units or emergency departments? (●) Yes ( ) No

If yes, please describe how barriers are eliminated.

Yes, Arizona has several targeted initiatives focused on improving care transitions for individuals with suicidal ideation who are being discharged from inpatient units or emergency departments. The Arizona Health Care Cost Containment System (AHCCCS) is leading a multifaceted strategy to bridge critical gaps in behavioral health services, particularly for youth and individuals who are uninsured or underinsured.

In Northern Arizona, AHCCCS is working through its Regional Behavioral Health Agreement to establish short-term transitional residential facilities specifically for youth exiting inpatient or emergency settings following a behavioral health crisis. These facilities—currently under renovation in Mohave and Coconino counties—will be dually licensed to provide both crisis stabilization and transitional residential care. The goal is to offer a safe, supportive environment that helps young people stabilize and reintegrate into their communities. To bolster this effort, AHCCCS is also allocating additional funding to local behavioral health home providers to enhance crisis intervention, improve care coordination, and expand high-needs case management services for this vulnerable population.

For uninsured or underinsured individuals recently diagnosed with a Serious Mental Illness (SMI), AHCCCS is revising its policies and NTIX contracts to expand the use of Mental Health Block Grant (MHBG) set-aside funding. These updates will allow for up to 90 days of temporary coverage, during which individuals can access professional assessments, medication management, and case coordination services. This interim support is designed to ensure continuity of care while Medicaid applications and SMI determinations are being processed.

Through these initiatives, AHCCCS aims to reduce immediate suicide risk and promote long-term engagement with the behavioral health system. By responding quickly and effectively during these critical transition periods, the system helps build trust, reduce feelings of isolation and hopelessness, and lay the groundwork for sustained recovery and resilience.

5. Have you begun any prioritized or statewide initiatives since the FFY 2024 - 2025 plan was submitted? (●) Yes ( ) No

If so, please describe the population of focus?

Yes, AHCCCS has initiated several prioritized and statewide efforts since the submission of the FFY 2024–2025 Plan, with a strong focus on population-based suicide prevention strategies. These initiatives target specific high-risk groups, including military service members and their families, individuals at risk of firearm-related suicide, rural communities, and survivors of suicide loss.

In partnership with the Arizona Coalition for Military Families, AHCCCS has expanded the Be Connected Initiative to enhance suicide prevention resources for those who serve or have served in the military and their families.

AHCCCS has also worked closely with the Arizona Department of Health Services to promote the adoption of the Zero Suicide Model (ZSM) across Arizona's hospitals and behavioral health clinics. Internal and external workgroups have been established to build statewide support, and foundational planning is underway to integrate ZSM into Arizona's medical infrastructure as a priority within the 2023–2025 Suicide Prevention Action Plan.

To further reduce access to lethal means, AHCCCS has supported a statewide initiative that includes sharing medication take-back information on the ADHS Suicide Prevention website and launching community-level listening sessions aimed at developing recommendations to reduce firearm-related suicides.

Public awareness of crisis services has also been prioritized. AHCCCS partnered with ADHS to fund a statewide media campaign promoting the availability of 988 crisis services. This campaign is currently rolling out across Arizona to ensure residents are informed about how to access immediate support during a behavioral health crisis.

Additionally, AHCCCS collaborated with the American Foundation for Suicide Prevention to expand the distribution of Local Outreach to Survivors of Suicide (LOSS) materials to all counties in Arizona. This initiative is designed to raise community

awareness and provide support to individuals who have lost someone to suicide. Volunteers have been identified in high-priority rural counties to lead LOSS activities, including counseling and outreach, ensuring that survivors receive compassionate and timely assistance.

These initiatives reflect AHCCCS's commitment to advancing suicide prevention through targeted outreach, system-level integration, and community engagement, with a clear focus on populations most at risk.

6. Please indicate areas of technical assistance needs related to this section.

No technical assistance requested at this time

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Environmental Factors and Plan

13. Support of State Partners – Required for MHBG & SUPTRS BG

Narrative Question

The success of a state's MHBG and SUPTRS BG programs will rely heavily on the strategic partnerships that SMHAs and SSAs have or will develop with other health, social services, community-based organizations, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The State Medicaid Authority agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations.
- The state justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with M/SUD who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment.
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that prioritize risk and protective factors for mental and substance use disorders, and, for those youth with or at-risk of M/SUD, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;
- The state public housing agencies which can be critical for the implementation of Olmstead.
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and
- The state's emergency management agency and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in M/SUD needs and/or impact persons with M/SUD and their families and caregivers, providers of M/SUD services, and the state's ability to provide M/SUD services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in M/SUD.
- The state's agency on aging which provides chronic disease self-management and social services critical for supporting recovery of older adults with M/SUD.
- The state's intellectual and developmental disabilities agency to ensure critical coordination for individuals with ID/DD and co-occurring M/SUD.
- Strong partnerships between SMHAs and SSAs and their counterparts in physical health, public health, and Medicaid, Medicare, state, and area agencies on aging and educational authorities are essential for successful coordinated care initiatives. While the State Medicaid Authority (SMA) is often the lead on a variety of care coordination initiatives, SMHAs and SSAs are essential partners in designing, implementing, monitoring, and evaluating these efforts. SMHAs and SSAs are in the best position to offer state partners information regarding the most effective care coordination models, connect current providers that have effective models, and assist with training or retraining staff to provide care coordination across prevention, treatment, and recovery activities.
- SMHAs and SSAs can also assist the state partner agencies in messaging the importance of the various coordinated care initiatives and the system changes that may be needed for success with their integration efforts. The collaborations will be critical among M/SUD entities and comprehensive primary care provider organizations, such as maternal and child health clinics, community health centers, Ryan White HIV/AIDS CARE Act providers, and rural health organizations. SMHAs and SSAs can assist SMAs with identifying principles, safeguards, and enhancements that will ensure that this integration supports key recovery principles and activities such as person-centered planning and self-direction. Specialty, emergency and rehabilitative care services, and systems addressing chronic health conditions such as diabetes or heart disease, long-term or post-acute care, and hospital emergency department care will see numerous M/SUD issues among the persons served. SMHAs and SSAs should be collaborating to educate, consult, and serve patients, practitioners, and families seen in these systems. The full integration of community prevention activities is equally important. Other public health issues are impacted by M/SUD issues and vice versa. States should assure that the M/SUD system is actively engaged in these public health efforts.
- Enhancing the abilities of SMHAs and SSAs to be full partners in implementing and enforcing MHPAEA and delivery of health system improvement in their states is crucial to optimal outcomes. In many respects, successful implementation is dependent on leadership and

collaboration among multiple stakeholders. The relationships among the SMHAs, SSAs, and the state Medicaid directors, state housing authorities, insurance commissioners, prevention agencies, child-serving agencies, education authorities, justice authorities, public health authorities, and HIT authorities are integral to the effective and efficient delivery of services. These collaborations will be particularly important in the areas of Medicaid, data and information management and technology, professional licensing and credentialing, consumer protection, and workforce development.

Please respond to the following items:

1. Has your state added any new partners or partnerships since the last planning period? (●) Yes ( ) No

2. Has your state identified the need to develop new partnerships that you did not have in place? (●) Yes ( ) No

If yes, with whom?

Yes, Arizona continues to prioritize and strengthen collaboration among State Mental Health Authorities (SMHAs), Single State Agencies (SSAs), State Medicaid directors, State housing authorities, insurance commissioners, prevention agencies, child-serving agencies, education authorities, justice authorities, public health authorities, and Health Information Technology (HIT) authorities. These partnerships support the development and implementation of new initiatives and projects focused on meaningful collaboration. Alongside ongoing efforts within these partnerships, Arizona has also pursued additional collaborations to enhance service delivery and increase educational awareness.

3. Describe the manner in which your state and local entities will coordinate services to maximize the efficiency, effectiveness, quality and cost-effectiveness of services and programs to produce the best possible outcomes with other agencies to enable consumers to function outside of inpatient or residential institutions, including services to be provided by local school systems under the Individuals with Disabilities Education Act.

Arizona's behavioral health system, led by the Arizona Health Care Cost Containment System (AHCCCS), is built on a foundation of coordinated service delivery across state and local entities to maximize efficiency, effectiveness, quality, and cost-effectiveness. This coordination is designed to produce the best possible outcomes and support individuals in functioning successfully outside of inpatient or residential institutions.

AHCCCS requires all Medicaid health plans—including AHCCCS Complete Care plans, ACC-RBHAs, and TRBHAs—to establish formal Memoranda of Understanding (MOUs) and Collaborative Protocols with other agencies and system partners. These agreements ensure shared procedures for service coordination, problem resolution, data sharing, resource commitments, joint training, and co-location of providers in settings such as jails, prisons, and detention centers.

Coordination extends beyond Medicaid-funded services to include Non-Title XIX/XXI supports, which address continuity of care for individuals in court-ordered treatment, early intervention, and integration with health, social, justice, education, and employment systems. AHCCCS policies (AMPM 310-B and 300-2B) promote a "no wrong door" approach to substance use disorder treatment, ensuring broad access and consistent monitoring of provider interventions.

To further enhance care coordination, AHCCCS launched the Closed Loop Referral System (CLRS), branded as CommunityCares, in late 2022. This electronic platform allows providers to screen for health-related social needs using tools like Protocol for Responding to & Assessing Patients' Assets, Risks & Experiences (PRAPARE) and connect members to community-based organizations. By bridging healthcare and social services, CommunityCares helps address critical needs that impact both physical and mental health.

Case management services are available to all AHCCCS members, with additional requirements for those receiving tuberculosis and HIV/AIDS services under SUBG funding.

In the criminal justice system, AHCCCS supports behavioral health services for voluntary juvenile justice-involved members. These services are delivered by qualified professionals using evidence-based practices, guided by individualized service plans, and include relapse prevention strategies. Telehealth is used to expand access and improve service delivery efficiency.

Coordination with local school systems under the Individuals with Disabilities Education Act (IDEA) is embedded within Arizona's broader integration strategy. Through MOUs and collaborative protocols, AHCCCS works with educational institutions to ensure that children and youth with disabilities receive appropriate behavioral health supports that complement their educational plans. This includes early identification, service planning, and transition supports that enable students to thrive in community and school settings.

Arizona's integrated approach reflects a strong commitment to recovery, independence, and community reintegration, ensuring that individuals receive the right services at the right time in the most appropriate setting.

4. Please indicate areas of technical assistance needs related to this section.

No technical assistance needed at this time.

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Footnotes:

Environmental Factors and Plan

14. State Planning/Advisory Council and Input on the Mental Health/Substance Use Block Grant Application – Required for MHBG, Requested for SUPTRS BG

Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council to carry out the statutory functions as described in **42 U.S.C. §300x-3** for adults with SMI and children with SED. To assist with implementing and improving the Planning Council, states should consult the **State Behavioral Health Planning Councils: An Introductory Manual.**

Planning Councils are required by statute to review state plans and annual reports; and submit any recommended modifications to the state. Planning councils monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state. They also serve as advocates for individuals with M/SUD. States should include any recommendations for modifications to the application or comments to the annual report that were received from the Planning Council as part of their application, regardless of whether the state has accepted the recommendations. States should also submit documentation, preferably a letter signed by the Chair of the Planning Council, stating that the Planning Council reviewed the application and annual report. States should transmit these documents as application attachments.

Please respond to the following items:

1. How was the Council involved in the development and review of the state plan and report? Attach supporting documentation (e.g., meeting minutes, letters of support, letter from the Council Chair etc.)

The Arizona Behavioral Health Planning Council is mandated by Public Law 103-321 to review Arizona's Mental Health and SUPTRS BG Services Plan for Children and Adults for the 2026-2027 period. This review is required prior to submission to the U.S. Department of Health and Human Services (DHHS) in order for Arizona to be eligible for the Federal Mental Health Block Grant and the Federal SUPTRS BG for 2026. In support of transparency and effective communication with the Council, AHCCCS notified members during the June 20, 2025 meeting that the combined block grant application would be released soon and that detailed instructions would follow.

On July 7, 2025, the Council received the application instructions and review timeline via email. These instructions were subsequently reviewed during the July 18, 2025 council meeting, where AHCCCS provided an overview of changes to the application and Council members volunteered to review specific sections. On August 15, 2025, AHCCCS met with the Council to discuss their feedback, questions, and recommendations pertaining to the draft application. The Council will have until August 22, 2025 to submit further comments. Within the constraints of applicable law and policy, we are committed to ensuring the Council's concerns and suggestions are reflected in the final application submitted by Arizona.

2. Has the state received any recommendations on the State Plan or comments on the previous year's State Report?

a. State Plan — (●) Yes ( ) No

b. State Report — (●) Yes ( ) No

Attach the recommendations /comments that the state received from the Council (without regard to whether the State has made the recommended modifications).

3. What mechanism does the state use to plan and implement community mental health treatment, substance use prevention, SUD treatment, and recovery support services?

Within AHCCCS, multiple divisions collaborate to ensure grant programs and services are implemented in full compliance with block grant responsibilities and that allocated funding is consistently aligned with the priorities, goals, and objectives outlined in the application and plan. The Division of Behavioral Health and Housing (DBHH) holds primary oversight and management responsibility for evidence-based, person-centered programming and service delivery, as well as fiscal stewardship of MHBG and SUPTRS grant funds. Additional support is provided by the Division of Managed Care (DMC), the Office of the Director (OOD), the Division of Public Policy & Strategic Planning (DPPSP), Office of Individual & Family Affairs (OIFA) and the Division of Fee for Service Management (DFSM), all of which contribute to ongoing program monitoring and compliance, including ensuring appropriate utilization of block grant resources, enhancing adherence to block grant requirements, and demonstrating effective use of grant funds.

ACC-RBHAs and TRBHAs are expected to ensure both they and their subcontractors meet all reporting obligations and deliverables specified in their contracts or IGAs. These contracts and IGAs are regularly updated and amended, both on a scheduled basis and as needed, to address evolving reporting, monitoring, evaluation, and compliance standards. Non-Title XIX/XXI contracts with ACC-RBHAs are reviewed annually, with amendments executed by October 1 each year. This amendment process is managed by the

AHCCCS Division of Health Care Services, Contracts Unit, and involves review and revision by relevant AHCCCS divisions and subject matter experts. Upon completion, proposed contract changes are posted for public comment, and feedback is thoroughly considered and addressed before final contract execution. IGAs are updated every five years through negotiations between the DFSM and TRBHAs.

All decision-making is informed by comprehensive analysis of contractor reports and deliverables, financial data, needs and fidelity assessments, community feedback, and topics raised during meetings with RBHAs, TRBHAs, and the BHPC, ensuring continuous improvement and accountability.

4. Has the Council successfully integrated substance use prevention and SUD treatment recovery or co-occurring disorder issues, concerns, and activities into its work? (●) Yes ( ) No

5. Is the membership representative of the service area population (e.g., rural, suburban, urban, older adults, families of young children?) (●) Yes ( ) No

6. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.

The Planning Council has the responsibility to review plans and submit recommendations for modification to the State. It advocates for adults experiencing serious mental illness and children who are seriously emotionally disturbed, including individuals with mental illnesses or emotional concerns. The Council monitors, reviews, and evaluates, at least annually, the allocation and adequacy of mental health services in the State, and participates in efforts to improve these services.

The Arizona Behavioral Health Planning Council holds regular monthly meetings, along with meetings of its executive committee made up of elected members of the Council who oversee key initiatives and subcommittees. These subcommittees include the Legislation and Advocacy Committee, which tracks behavioral health-related legislation and reports findings to the Council. The council collects information through formal data requests to AHCCCS, collaboration with community partners and members, stakeholder presentations, and provider or member listening sessions. Advocacy efforts are conducted via official letters of support, participation in oversight committees across multiple sectors, and organized demonstrations.

In July 2019, the Arizona Behavioral Health Planning Council (BHPC) agreed to record each of their meetings in lieu of written minutes. The BHPC follows the Arizona Open Meeting Law and minutes are uploaded to AHCCCS' website within 3 working days after the meeting. These recordings are available on AHCCCS' website at https://www.azahcccs.gov/Resources/Grants/CMHS/.

7. Please indicate areas of technical assistance needs related to this section.

No technical assistance needs at this time.

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Footnotes:

ARIZONA BEHAVIORAL HEALTH PLANNING COUNCIL
150 N. 18th Ave.
Phoenix, AZ 85007

August 21, 2025

Substance Abuse and Mental Health Services Administration (SAMHSA)
Center for Mental Health Services (CMHS)
Division of State and Community Systems Development (DSCSD)
5600 Fishers Lane
Station 14E26C
Rockville, MD 20857

Dear Sir or Madam,

Each year, the Arizona Behavioral Health Planning Council plays a vital role in shaping the future of behavioral health care in our state. Following Public Law 103-321, the Council is reviewing Arizona's Mental Health and Substance Abuse Block Grant (SABG) Services Plan for Children and Adults for Fiscal Year 2026–2027 before it is submitted to the U.S. Department of Health and Human Services (DHHS). Over the summer of 2025, the Council received the draft plan from the Arizona Health Care Cost Containment System (AHCCCS), reviewed the document, and provided comments and recommendations. The Planning Council is submitting this letter to the Center for Mental Health Services to provide information regarding our role and activities.

Since its inception, the Planning Council has included recipients and family members of individuals receiving behavioral health services, those with lived experience, professionals in the field, and representatives from state agencies. The Council's membership reflects Arizona's diversity, and it continues to work diligently to ensure broad representation from across the state and from different communities.

The Council remains committed to its statutory mission to:

- Review state plans and submit recommendations for modification.
- Serve as an advocate for adults with serious mental illness (SMI) and children with serious emotional disturbance (SED).
- Monitor, review, and evaluate the adequacy of mental health and substance use services in the State.
- Participate in strengthening and improving behavioral health services.

Over the past year, the Council has addressed several issues, including access to care in rural areas, the expansion of the 988 crisis system, parity in behavioral health services, utilization of peer and family support services, and barriers to culturally responsive care. Council members also participated in reviews of system redesigns, block grant funding allocations, and reports on youth, older adults, and tribal community needs.

"…to advise, review, monitor, and evaluate all aspects of the development of the State Plan"
(Public Laws 99-660, 100-639, and 102-321)

Looking ahead, the Council plans to expand its efforts to **address co-occurring disorders and strengthen integrated service delivery.** We recognize that many individuals in Arizona experience both mental health and substance use challenges, and that better coordination of services is essential for recovery and wellness. Enhancing integration will remain a Council priority as we advise, monitor, and advocate for improvements in the behavioral health system.

We are encouraged by ongoing collaboration with AHCCCS, including improvements to the block grant review process that allow for earlier engagement and meaningful input from the Council. This reflects a stronger partnership that will benefit individuals and families across Arizona.

Thank you for the opportunity to provide input on the State Mental Health and SABG Plan. The Council remains committed to reviewing, monitoring, and evaluating all aspects of the development of this plan and of the overall Arizona Behavioral Health System.

Respectfully,
Arizona Behavioral Health Planning Council

"…to advise, review, monitor, and evaluate all aspects of the development of the State Plan"
(Public Laws 99-660, 100-639, and 102-321)

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

MEETING AGENDA

Topic: Behavioral Health Planning Council

Date: August 15, 2025

Time: 9:00 a.m. - 12:00 p.m.

Facilitator: Pamala Sacks-Lawlar, Co-Chair

Note Taker: Blair Bernal

AHCCCS Virtual Meeting

For meeting access please contact bhpc-connect@azahcccs.gov.

AGENDA ITEMS	PRESENTER
Welcome • Roll Call • Ensure a Quorum • Call Meeting to Order • Approve Minutes/Recording	**Pamala Sacks-Lawlar** **BHPC Co-Chair**
FFY 2026-2027 MHBG/SUBG Application Review (council members comments for environmental factors and plan)	**Council Members**
Council Updates	**Council Members**
State Agency Updates	**State Agencies**
Committee Updates: • Advocacy • Membership • Data & Evaluation • Youth • SMI • Seniors	**Kathy Bashor, Council Member** **Karen Resseguie, Council Member**
Call to the Public	**Pamala Sacks-Lawlar** **BHPC Co-Chair**
Adjourn	**Pamala Sacks-Lawlar** **BHPC Co-Chair**

Next meeting: September 19 ,2025

To review the state's annual block grant application and the state's implementation report of the previous year and make formal recommendations
• To advocate for persons with mental illness
• To monitor and review the adequacy of mental health services statewide
(42 U.S. Code § 300x–3(b))

DATE: August 29, 2025

TO: Substance Abuse and Mental Health Services (SAMHSA)

FROM: Jennifer Gonzales, Mental Health Block Grant Administrator

SUBJECT: Arizona Behavioral Health Planning Council Minutes

In July 2019, the Arizona Behavioral Health Planning Council (BHPC) agreed to record each of their meetings in lieu of written minutes. The BHPC follows the Arizona Open Meeting Law and minutes are uploaded to AHCCCS' website within 3 working days after the meeting.

These recordings are available on AHCCCS' website at https://www.azahcccs.gov/Resources/Grants/CMHS/

If you have any questions or concerns regarding these recordings, please contact me at 602-417-4933 or Jennifer.Gonzales@azahcccs.gov.

Thank you,

Jennifer Gonzales

Environmental Factors and Plan

Advisory Council Members

For the Mental Health Block Grant, **there are specific agency representation requirements** for the State representatives. States MUST identify the individuals who are representing these state agencies.

State Mental Health Agency
State Education Agency
State Vocational Rehabilitation Agency
State Criminal Justice Agency
State Housing Agency
State Social Services Agency
State Medicaid Agency

Start Year: 2026 End Year: 2027

Name	Type of Membership*	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
Loree Adams	State Employees			
Monica Amaya	State Employees			
Gwen Bailey	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)			
Kathy Bashor	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)			
Kathryn Blair	Advocates/representatives who are not state employees or providers			
Lauren Blocher	State Employees			
David Bridge	State Employees			
Damien Browning	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)			
Lilla DeLuca	Providers			
Robert Devries	Providers			
Samantha Diaz	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)			
Pamela Dotson	Advocates/representatives who are not state employees or providers			
Andrew Ecker	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)			
William French	Persons in Recovery from or providing treatment for or advocating for SUD services			
Lauren Friend	State Employees			

Jessie Gillam	Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)			
April Greer	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)			
Daniel Haley	Providers			
Christina Hedges	State Employees			
Shasa Jackson	Providers			
Vicki Johnson	Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)			
Jane Kallal	Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)			
Susan Kennard	State Employees			
Tania Long-Gervais	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)			
Andrea Lustfield	State Employees			
Jennifer Milham	Parents of children with SED			
Taylor Miranda	Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)			
Chussette Oden	Parents of children with SED			
Stacy Paul	State Employees			
Nicole Reesman	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)			
Karen Resseguie	Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)			
Pamala Sacks-Lawlar	Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)			
Amrita Sethi	Providers			
Yoendry Torres	Representatives from Federally Recognized Tribes			
Mary Ward	State Employees			

*Council members should be listed only once by type of membership and Agency/organization represented.

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Footnotes:

Environmental Factors and Plan

Advisory Council Composition by Member Type

Start Year: 2026 End Year: 2027

Type of Membership	Number	Percentage of Total Membership
1. Individuals in recovery (including adults with SMI who are receiving or have received mental health services)	8	
2. Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)	6	
3. Parents of children with SED	2	
4. Vacancies (individuals and family members)	0	
5. Total individuals in recovery, family members, and parents of children with SED	**16**	**45.71%**
6. State Employees	10	
7. Providers	5	
8. Vacancies (state employees and providers)	0	
9. Total State Employees & Providers	**15**	**42.86%**
10. Persons in Recovery from or providing treatment for or advocating for SUD services	1	
11. Representatives from Federally Recognized Tribes	1	
12. Youth/adolescent representative (or member from an organization serving young people)	0	
13. Advocates/representatives who are not state employees or providers	2	
14. Other vacancies (who are not individuals in recovery/family members or state employees/providers)	0	
15. Total non-required but encouraged members	**4**	**11.43%**
16. Total membership (all members of the council)	**35**	

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Footnotes:

Environmental Factors and Plan

15. Public Comment on the State Plan – Required for MHBG & SUPTRS BG

Narrative Question

Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. §300x-51) requires, as a condition of the funding agreement for the grant, that states will provide an opportunity for the public to comment on the state Block Grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to the federal government.

Please respond to the following items:

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?

a) Public meetings or hearings? (●) Yes ( ) No

b) Posting of the plan on the web for public comment? (●) Yes ( ) No

If yes, provide URL:

https://www.azahcccs.gov/AHCCCS/PublicNotices/SA-MHBG.html

If yes for the previous plan year, was the final version posted for the previous year? Please provide that URL:

public comment https://www.azahcccs.gov/AHCCCS/Downloads/PublicNotices/FY2024_2025_BlockGrantApplication.pdf
final version https://www.azahcccs.gov/AHCCCS/Downloads/PublicNotices/FY2024_2025_BlockGrantApplication.pdf

c) Other (e.g. public service announcements, print media) (●) Yes ( ) No

d) Please indicate areas of technical assistance needs related to this section.

None at this time

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Environmental Factors and Plan

16. Syringe Services Program (SSP) – Required for SUPTRS BG if Planning for Approval of SSP

Planning Period Start Date: 10/1/2025 Planning Period End Date: 9/30/2026

Narrative Question:
Use of SUPTRS BG funds to support syringe service programs (SSP) is authorized through appropriation acts which provide authority for federal programs or agencies to incur obligations and make payment, and therefore are subject to annual review. The following guidance for the application to budget SUPTRS BG funds for SSPs is therefore contingent upon authorizing language during the fiscal year for which the state is applying to the SUPTRS BG.

A state experiencing, or at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, (as determined by CDC), may propose to use SUPTRS BG to fund elements of an SSP other than to purchase sterile needles or syringes for the purpose of illicit drug use. States interested in directing SUPTRS BG funds to SSPs must provide the information requested below and receive approval from the State Project Officer.

States may consider making SUPTRS BG funds available to either one or more entities to establish elements of a SSP or to establish a relationship with an existing SSP. States should keep in mind the related PWID SUPTRS BG authorizing legislation and implementing regulation requirements when developing its Plan, specifically, requirements to provide outreach to persons who inject drugs (PWID), SUD treatment and recovery services for PWID, and to routinely collaborate with other healthcare providers, which may include HIV/STD clinics, public health providers, emergency departments, and mental health centers. Federal funds cannot be supplanted, or in other words, used to fund an existing SSP so that state or other non-federal funds can then be used for another program.

The federal government released three guidance documents regarding SSPs, These documents can be found on the **HIV.gov website.**

Please refer to guidance documents provided by the federal government on SSPs to inform the state's plan for use of SUPTRS BG funds for SSPs, if determined to be eligible. The state must follow the steps below when requesting to direct SUPTRS BG funds to SSPs during the award year for which the state is eligible and applying:

Step 1 - Request a **Determination of Need** from the CDC

Step 2 - Include request in the SUPTRS BG Application Plan to expend the funds for the award year which the state is planning support an existing SSP or establish a new SSP. Items to include in the request:

- Proposed protocols, timeline for implementation, and overall budget
- Submit planned expenditures and agency information on Table 16a listed below

Step 3 - Obtain SUPTRS BG State Project Officer Approval

Use of SUPTRS BG funds for SSPs future years are subject to authorizing language in appropriations bills, and must be re-applied for on an annual basis.

Additional Notes:

1. Section 1931(a(1)(F) of Title XIX, Part B, Subpart II of the Public Health Service (PHS) Act (**42 U.S.C.§ 300x-31(a)(1)(F)**) and **45 CFR § 96.135(a)(6)** explicitly prohibits the use of SUPTRS BG funds to provide PWID with hypodermic needles or syringes so that such persons may inject illegal drugs unless the Surgeon General of the United States determines that a demonstration needle exchange program would be effective in reducing injection drug use and the risk of HIV transmission to others. On February 23, 2011, the Secretary of the U.S. Department of Health and Human Services published a notice in the Federal Register (76 FR 10038) indicating that the Surgeon General of the United States had made a determination that syringe services programs, when part of a comprehensive HIV prevention strategy, play a critical role in preventing HIV among PWID, facilitate entry into SUD treatment and primary care, and do not increase the illicit use of drugs.

2. Section 1924(a) of Title XIX, Part B, Subpart II of the PHS Act (**42 U.S.C. § 300x-24(a)**) and **45 CFR § 96.127** requires entities that receives SUPTRS BG funds to routinely make available, directly or through other public or nonprofit private entities, tuberculosis services as described in section 1924(b)(2) of the PHS Act to each person receiving SUD treatment and recovery services.

3. Section 1924(b) of Title XIX, Part B, Subpart II of the PHS Act (**42 U.S.C. § 300x-24(b)**) and **45 CFR 96.128** requires "designated states" as defined in Section 1924(b)(2) of the PHS Act to set- aside SUPTRS BG funds to carry out 1 or more projects to make available early intervention services for HIV as defined in section 1924(b)(7)(B) at the sites at which persons are receiving SUD treatment and recovery services.

Section 1928(a) of Title XXI, Part B, Subpart II of the PHS Act (**42 U.S.C. 300x-28(c)**) and **45 CFR 96.132(c)** requires states to ensure that substance use prevention and SUD treatment and recovery services providers coordinate such services with the provision of other services including, but not limited to health services.

Syringe Services Program (SSP) Agency Name	Main Address of SSP	Planned Budget of SUPTRS BG for SSP	SUD Treatment Provider (Yes or No)	# of locations (include any mobile location)	Naloxone or other Opioid Overdose Reversal Medication Provider (Yes or No)
Sonoran Prevention Works (Contractor)	2211 S 48th St STE B, Tempe, AZ - 85282	$553,580.00	No	7	Yes
Totals:		$553,580.00		7	

Arizona Health Care Cost Containment System (AHCCCS) and Sonoran Prevention Works (SPW) Syringe Services Program (SSP) Plan

Substance Use Prevention Treatment and Recovery Services Block Grant (SUPTRS BG)

FFY26-27 Combined Application – Environmental Factors Table 16.

1. BACKGROUND

In 2021, Sonoran Prevention Works (SPW) responded to a Request for Proposals (RFP) released by AHCCCS to procure statewide services for overdose prevention and infectious disease prevention. This resulted in a contract between AHCCCS and SPW that was effective for an initial 3-year term of January 1, 2022 – December 31, 2024 with 2 optional 1-year extensions (Calendar year 2025 and calendar year 2026).

Prior to utilizing SUPTRS BG (herein referred to as SUBG) funds to support SPW's syringe services program (SSP), AHCCCS received approval to do so from SAMHSA in the FFY2022-2023 application. AHCCCS work closely with SPW to ensure the use of federal funds are within federal and state law, including Presidential Executive Orders (EOs) (e.g. EO on Ending Crime and Disorder on America's Streets).

This workplan reflects the 2025 updated version of the contractually agreed upon workplan.

2. WORKPLAN

AHCCCS, through the statewide contractor, SPW, has developed and is implementing a comprehensive, evidence-based program for the State of Arizona to meet the needs of the most vulnerable to overdose and other drug-related harms. *Figure 1* below displays the conceptual model developed for this project, illustrating the relationship between the interventions, immediate outcomes, and long-term outcomes.

Figure 1. Conceptual Model

Intervention	Immediate Outcomes	Long-term Outcomes
1) Naloxone distribution, education, and training 2) Syringe Services Program 3) Education and training 4) Peer support and wraparound services 5) Fentanyl and xylazine testing strip distribution, education, and training 6) Tailored programming and services for women 7) Community appropriate services and resources 8) Expanded network of key community stakeholders	• Increased initiation, continuation, and coordination of evidence-based treatment for individuals who use drugs • Increased overdose and infectious disease prevention behaviors such as reduced or safer use through education, supply testing, and overdose prevention kits • Increased proper disposal of used syringes • Increased public awareness and community engagement	• Reduced rates of overdose, drug-related deaths and injuries, and transmission of infectious diseases • Improved health and wellness of people who use drugs • Reduced costs and burden associated with substance use/misuse on public systems

To achieve the listed outcomes, our strategy consists of eight (8) overarching strategies/interventions:

1) **Naloxone distribution, education, and training:** Expand a comprehensive, statewide naloxone distribution, education, and training initiative for people who use drugs (PWUD), prescribers,

pharmacists, AHCCCS members and the public. Through the subcontracted provider, we aim to achieve the following objectives:

- **a.** Distribute naloxone doses via kits to communities across Arizona through targeted street and community outreach.
- **b.** Conduct in-person and web-based training sessions for prescribers, pharmacists, AHCCCS members, and the public, emphasizing evidence-based responses to opioid overdose and post-overdose support.
- **c.** *SPW reports that the following objectives have been eliminated since CY2022:*
    - i. Provide naloxone training and technical assistance to the correctional system to at least 50 percent of Arizona jails and 75 percent of state prisons distributing naloxone upon release.
        1. *Efforts were made towards this objective during CY2022, but SPW's subcontracted service provider (Community Medical Services) was not making significant progress & a similarly appropriate service provider could not be identified. With AHCCCS' permission, the objective was eliminated as a result.*
    - ii. Train 10 percent of Arizona group homes for transition-age youth on overdose prevention, recognition, and response.
        1. *Efforts were made towards this objective during CY2022, but SPW's subcontracted service provider (Community Medical Services) was not making significant progress & a similarly appropriate service provider could not be identified. With AHCCCS' permission, the objective was eliminated as a result.*

2) **A statewide SSP:** Through SPW, AHCCCS aims to implement the following elements for a statewide SSP:

- **a.** Develop and expand needle and hypodermic syringe disposal education and options for the State of Arizona to reach at least 5,640 individuals who inject drugs. In order to maximize our reach among our target population, we have developed three strategies to deliver supplies to PWUD: 1) fixed sites, 2) mobile units, and 3) mail order programs. Supplies include syringes (NOT funded by federal dollars), safe disposal containers, hygiene and wound care kits, internal and external condoms, rapid home HIV tests, and other associated supplies.
    - i. *SPW reports that the following strategy was also employed from CY2022 – CY2024: Supply distribution kiosks. For CY2025 and CY2026, the future of this effort is unknown, as SPW is awaiting input from SPW's subcontracted service provider (Community Medical Services) about its capacity to continue with the kiosk strategy.*
- **b.** Implement a statewide SSP with sites in Cochise, Coconino, Maricopa, Mohave, Pima, Santa Cruz, & Yuma Counties (in partnership with Southwest Recovery Alliance and Cochise partners). The statewide provider will also create new and expanded mobile and delivery based SSP services to reach PWUD across Arizona. In this project period, we aim to reach at least 5,640 Arizonans who inject drugs.

i. *SPW reports that the following additional counties also had SSP sites prior to CY2025: Graham, Navajo, Pinal, and Yavapai. If the kiosk strategy currently paused ultimately moves forward, it is possible that could reinstate implementation in some or all of these counties.*

c. Coordinate navigation services and treatment referrals for mental illness, substance use disorder, and other co-occurring disorders for SSP participants, as appropriate. SSPs provide an excellent opportunity to engage PWUD in a community setting with peer support from people with lived experience with substance use. Individuals seeking sterile needles or other supplies may also be offered referrals to navigation services, treatment referrals, or additional services as appropriate.

d. Develop and disseminate educational materials to at least 5,640 individuals through the SSP. Educational material may include the following topics: Overdose prevention, peer support services, infectious disease and transmission prevention, education, referrals, and treatment referrals for mental illness, SUD, and co-occurring disorders.

e. Develop and distribute evidence-based standards for distributing and disposing of needles and hypodermic syringes.

Acquiring Syringes, Needles, and any other supplies used in the facilitation or promotion of drug usage through Non-Federal Funds: *The statewide contractor, SPW, understands they will not utilize federal funds to purchase syringes/needles. SPW also understands that they will not use federal funds to purchase any supplies that are used in the facilitation or promotion of drug use. AHCCCS will continue to ensure compliance with state and federal regulations. SPW is dedicated to ensuring that participants have access to all the supplies they need to stay as safe and healthy as possible, including syringes and needles. In support of this project, SPW will continue to fund the purchase of syringes and needles through a combination of grassroots fundraising methods as well as grant funding from a diverse range of private and public funders. SPW has a long history of utilizing grassroots fundraising methods, including one-time and monthly sustaining donations and program service revenue to support the work and help to fund the purchase of program supplies. SPW is committed to seeking out a diverse range of funders who share our values, and can support the purchasing of lifesaving supplies, such as syringes and needles, for participants. For years, SPW has worked to build and maintain relationships with funders dedicated to supporting health and overdose and infectious disease prevention services to people impacted by substance use, including Broadway Cares, the Gilead Foundation, AIDS United, and more. SPW has also received funding from county health departments, hospital systems, and foundations across Arizona. Additionally, SPW proactively seeks out and applies to new funding opportunities that can further support the purchase of syringes and needles.*

a. ***Applicable MOUs with SSP Providers who can supply needles:*** SPW is the acquirer of the syringes and needles needed for the program, and therefore no MOU is needed for supplying needles. In lieu of an MOU, SPW has an executed contract that may be submitted if required

3) **Training for professionals and the broader community;** Through SPW, AHCCCS aims to implement the following stigma reduction trainings for professionals and the broader community:
    - **a.** Develop and distribute educational material to at least 30,000 people through print and electronic distribution. With AHCCCS guidance, SPW will review and adapt existing educational material targeted at PWUD, the general public, providers, pharmacists, AHCCCS members, and other specific populations as appropriate.
    - **b.** Provide at least 20 free training sessions for community members and the broader public. SPW's training sessions are typically geared toward community members, resource organizations, and medical/behavioral health professionals, with specialized curricula for numerous populations and professions. In coordination with AHCCCS and the program officer, SPW will review and update all training curricula and materials for free general training sessions geared toward community members. Current training topics include overdose prevention and naloxone use, opioid use disorder, stimulant use disorder, stigma, injection-related complications, and other relevant issues. These general trainings are offered in-person or virtually, including virtual video workshops or self-paced online courses.
    - **c.** Provide at least 15 training sessions to medical, behavioral health, and social service providers. SPW will develop or enhance trainings on overdose prevention, fentanyl testing strip use, stimulants, and other emerging topics and deliver to drug treatment providers, substance use prevention coalitions, health care providers, AHCCCS members, SUBG priority populations, organizations who serve women who use drugs, and other groups who engage with PWUD.
    - **d.** *SPW reports that the following objectives have been eliminated since CY2022:*
        - i. Conduct at least three trainings each year in each Geographic Service Area (GSA) in Arizona to the Department of Child Safety regional offices on overdose and infectious disease prevention. SPW will adapt existing curriculum to specifically address the unique needs of transition-age youth struggling with substance use/misuse.
            1. *Efforts were made towards this objective during CY2022, but SPW's subcontracted service provider (Community Medical Services) was not making significant progress & a similarly appropriate service provider could not be identified. With AHCCCS' permission, the objective was eliminated as a result.*
        - ii. Provide training to at least 50 percent of Community Corrections offices on overdose prevention. Due to the disproportionate impact of opioid overdoses on criminal-justice involved individuals, we will make a concerted effort to train those that work in the criminal justice system with specialized content for this population.
            1. *Efforts were made towards this objective during CY2022, but SPW's subcontracted service provider (Community Medical Services) was not making significant progress & a similarly appropriate service provider could not be identified. With AHCCCS' permission, the objective was eliminated as a result.*

4) **Peer support program to facilitate linkages to treatment and wrap-around supports;** Through SPW, AHCCCS aims to implement the following peer support program through the following strategies:
    a. Develop and implement a network of at least 75 provider organizations to facilitate linkages to evidence-based care navigation services for individuals requiring a higher level of care. Peer support staff at SPW work at SSPs and conduct street outreach in order to identify new clients and facilitate referrals to organizations which provide the additional services they seek.
    b. Provide at least 1,500 referrals to treatment through peer support staff for individuals requiring a higher level of care. Referrals may include treatment for: SUD, mental illness, mental health and overdose and infectious disease prevention-based counseling, screening and treatment for HIV, viral hepatitis, and STIs, medical treatment and basic wound care. SPW's outreach staff are peer support-certified and specially trained to provide support around drug treatment, medical care, mental health, housing, criminal justice involvement, identification replacement, and other services.
    c. Disseminate risk reduction material through peer support staff to 5,640 individuals. Supply kits may include condoms, hygiene products, naloxone kits, fentanyl test strips, and other necessities.
    d. Promote awareness through in-depth training for 2,700 individuals about the relationship between injection drug use and communicable diseases, recommended steps for disease transmission prevention, and options for treatment. Through syringe services and rapid HIV/HCV screening, outreach specialists will provide education on prevention, risk mitigation, and treatment for HIV, HCV, and other communicable diseases including hepatitis A and B, COVID-19, and STIs.
5) **Fentanyl testing strip distribution, education, and training;** Through SPW, AHCCCS aims to implement the following strategies:
    a. Distribute 120,000 rapid fentanyl testing strips (FTS) to communities across the State of Arizona by the end of Year 3 (2024). Distribution will be prioritized to people who use drugs (all drugs, including heroin, stimulants, and pills), their friends and family, and organizations who can effectively distribute testing strips to people at risk for overdose. SPW maintains the lowest available cost-effective pricing agreement with pharmaceutical companies for FTS in Arizona and will continue to do so for this project. Our budget for this proposal includes resources to purchase 120,000 FTS for statewide distribution.
    b. Develop and distribute FTS training materials and modules. FTS educational material will include content such as the use of FTS; alleviating fears and stigma; education on overdose and infectious disease prevention and how it relates to using the testing strips to test for the presence of fentanyl; and information regarding use and/or disposal of substances that test positive for fentanyl. This content will be made available to PWUD, families, AHCCCS members, community-based organizations, and the general public.
6) **Tailored programming and services for women, especially pregnant and parenting women (SUBG Priority Population);** Through SPW, AHCCCS aims to implement the following strategies for this SUBG Priority Population:

a. Provide outreach and care coordination services to at least 200 women who use drugs, prioritizing pregnant and parenting women. Tailored programming and services for women who use drugs may include pediatric medical treatment and care, child welfare, Arizona Department of Child Safety (DCS) coordination, legal assistance, early childhood education, family counseling, and other services needed by all PWUD. We aim to serve a minimum of 30 women in each region.

b. Staff the statewide SSP with at least one staff member who specializes in supporting women who use drugs, particularly pregnant and parenting women. The staff member will travel throughout the state to provide services, as well as training and education for project staff and partners.

c. Prioritize the delivery of services and training to SUBG priority populations. In compliance with SAMHSA and AHCCCS regulations for the use of SUBG funds, all services provided through the resources requested for this project will prioritize the following SUBG populations: 1) pregnant women/teenagers who use drugs by injection, 2) pregnant women/teenagers with a SUD, 3) other persons who use drugs by injection, 4) women/teenagers with a SUD, with dependent children and their families, including women who are attempting to regain custody of their children, and 5) all other individuals with a SUD, regardless of gender or route of use. With respect to naloxone distribution, education and training, we aim to increase the utilization of SPW services among SUBG priority populations by at least 10 percent during the three-year project period (2022-2024).

d. Participate in statewide groups to conduct provider education on decreasing stigma and utilization of evidence-based practices for pregnant and parenting women who use drugs. Along with Objective 3E, we will make concerted efforts to train providers who treat women who use drugs.

7) Community appropriate services and resources; Through SPW, AHCCCS aims to implement the following:

a. Provide Spanish translations and community sensitive versions of services and resources. SPW has provided Spanish translations of educational and outreach materials, as well as offered peer support services in Spanish since 2019. SPW currently has Spanish-speaking outreach staff in five Arizona counties. All printed educational materials will be available in English and Spanish, and additional materials will be revised for consideration of communities when working with tribal nations.

i. *SPW reports that in CY2022, we offered a telephone translation service to our outreach staff, but it was never used, so we eliminated it to reduce program costs.*

ii. *SPW reports that during CY2024, one of our SSP staff enrolled in additional training to become more proficient in the Navajo/Diné language to assist him in working more effectively with tribal participants.*

b. Host at least 20 training sessions in Spanish and distribute materials to at least 1,000 Spanish-speaking clients.

8) Stakeholder relationship and capacity building to ensure long-term program sustainability. Through SPW, AHCCCS aims to implement the following:

a. Convene a Community Advisory Board (CAB) consisting of impacted individuals from across the state of Arizona. Through regular meetings, the CAB provides SPW with critical feedback and insights into program efficacy & accessibility, builds community capacity to prevent overdoses and overdose deaths, & mitigates stigma. SPW utilizes successes & lessons learned from the CAB to build, train, & sustain a statewide network of professional partners, including SSPs, state and local government agencies, Substance Use Disorder and behavioral health treatment providers, health departments, health clinics and systems, correctional health, first responders, community-based organizations, mutual aid groups, local businesses, schools, colleges and universities, and neighborhood associations.
b. Evaluate and continuously improve the services provided through our program through regular data monitoring, performance reports, and quality improvement methods. A critical part of this project is collecting reliable data to assess performance, evaluate progress, and continuously improve services and internal control systems. Additionally, we will maintain and expand SPW's inventory tracking system to monitor the supply and distribution of naloxone, FTS, and related outreach supplies purchased with SUBG funds.
    i. *In CY2022, SPW subcontracted ASU CHS for evaluation services. Due to high costs associated with this subcontractor and no evaluations completed beyond those which SPW itself is capable of completing via SUBG-supported staff, the subcontract did not continue after CY2022. Instead, SPW continues to collect and report to AHCCCS program implementation data (e.g. reach, referrals, trainings completed, syringes collected, distributed, etc.)*
c. Identify and disseminate best practices and recommendations for sustaining and expanding the program. All project processes, protocols, tools, evaluations, publications, and reports will be documented for dissemination to sustain and expand our collective efforts.

3. TIMELINE FOR IMPLEMENTATION

Please refer to **Attachment A** at the end of this document for the timeline for implementation.

4. COPY OF EXISTING SSP PROTOCOLS OR GUIDELINES

AHCCCS, in consultation with SPW, will utilize the following protocols/guidelines, and applicable state law such as:

a) Arizona Revised Statutes (ARS) Title 36, Chapter 6, Article 15: *Title 36, chapter 6, Arizona Revised Statutes. ARTICLE 15. OVERDOSE AND DISEASE PREVENTION. 36-798.51. Overdose and disease prevention programs; requirements; standards*
b) Centers for Disease Control and Prevention: *Syringe Service Programs, A Technical Package of Effective Strategies and Approaches for Planning, Design, and Implementation (published 2020)*
c) NASTAD: *Syringe Services Program (SSP) Development and Implementation Guidelines for State and Local Health Departments (published 2012)*
d) SAMHSA Dear Colleague Letter 7.30.2025
e) SAMHSA Overdose Prevention and Response Toolkit

5. BUDGET, BUDGET JUSTIFICATION, AND PROPOSED ACTIVITIES, INCLUDING A PLAN FOR DISPOSAL OF INJECTION EQUIPMENT

Category	2025 SUBG annual and ARPA
Personnel	$971,572
Fringe	$257,952
Travel	$42,607
Equipment	$0
Supplies	$429,759
Contractual	$74,300
Other	$42,383
Total Direct Charges	$1,818,573
Indirect Charges or Administration	$381,876
Total Project Costs	**$2,091,359**

**Footnote: This is based on level funding from CY25 budget subject to change based on funding availability and has not yet been approved or obligated to the contractor.*

Proposed Activities:

1) Naloxone distribution, education, and training;
2) A statewide SSP;
3) Trainings for professionals and the broader community;
4) Peer support program to facilitate linkages to treatment and wrap-around supports;
5) Fentanyl testing strip distribution, education, and training;
6) Tailored programming and services for women, especially pregnant and parenting women (SUBG Priority Population);
7) Community appropriate services and resources; and
8) Stakeholder relationship and capacity building to ensure long-term program sustainability.

SPW aims to follow applicable Arizona law regarding the disposal of injection equipment *(SB 1250: Article 15: 36-798.51. Overdose and disease prevention programs; requirements; standards):*

> *"A program established pursuant to this section shall develop standards for distributing and disposing of needles and hypodermic syringes based on scientific evidence and best practices. the number of needles and hypodermic syringes disposed of through a program shall be at least equivalent to the number of needles and hypodermic syringes distributed through the program."*

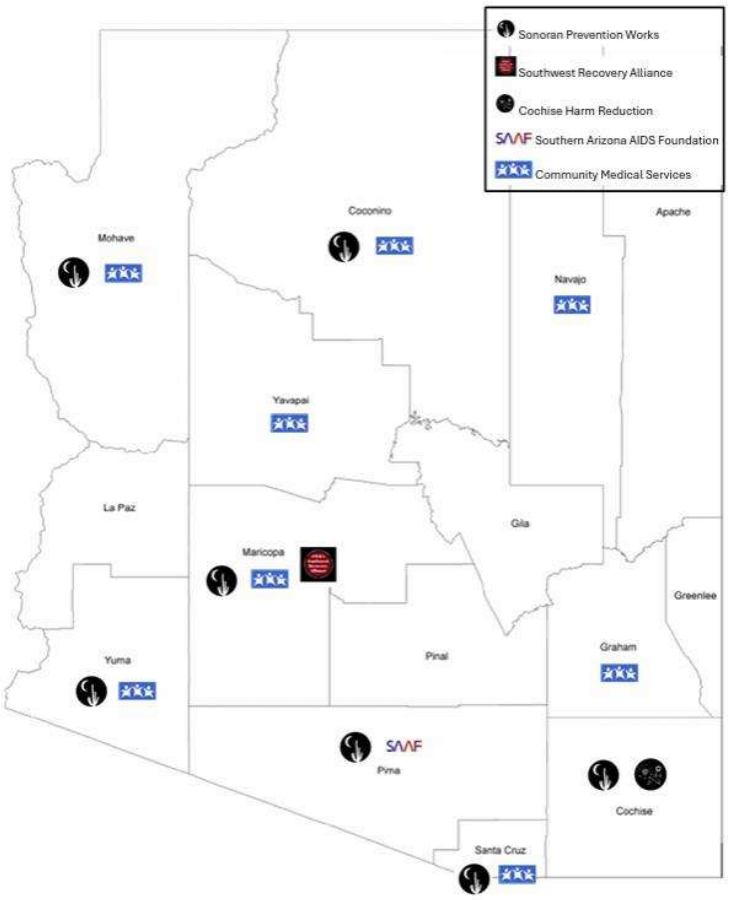
6. DESCRIPTION OF CURRENT TRAINING AND TECHNICAL ASSISTANCE NEEDS

Training/Technical Assistance Item	Description	Resource
None at this time		

7. LOCATION OF SSP RELATED ACTIVITIES TO BE SUPPORTED WITH FEDERAL FUNDS

AHCCCS will implement a statewide SSP to adequately address the needs of PWUD across the Arizona community. *Figure 2* (below) shows the statewide reach of our program, with SPW and its partners having a presence in a combined 10 of Arizona's 15 counties.

Figure 2.



8. SIGNED STATEMENT (I.E., ANNUAL CERTIFICATION)

Signed and included as part of this request **(Attachment B)**.

9. SSP METRIC INFORMATION

SUBG sub-recipients (i.e., community-based organizations), implementing new or expanding existing SSPs will need to collect basic SSP metrics information (e.g., number of syringes distributed, estimated number of syringes returned for safe disposal, number of persons tested for HIV or viral hepatitis, and referrals to HIV, viral hepatitis and substance use disorder treatment).

AHCCCS developed an evaluation design into the method of approach to measure project performance, identify best practices, and facilitate continuous program improvement. Using the RE-AIM framework, the contracted provider, SPW, will gather data from program staff and participants through monthly programmatic reports. The data will track all measurable objectives, required reports, and reports for use by the advisory committee and executive team. All data collection methods will take into consideration the language, norms and values of the focus populations.

In compliance with SAMHSA guidance for State Block Grants, AHCCCS will collect the following information related to SSPs:

- Number of syringes distributed,
- Estimated number of syringes returned for safe disposal,
- Number of persons tested for HIV or viral hepatitis,
- Referrals to HIV/Viral Hepatitis testing and treatment, and
- Referrals to substance use disorder treatment.

AZ SSP Plan Attachment A_SPW Timeline

Milestones	Lead	Year 0 (Administrative)				Year 1 (2022)				Year 2 (2023)				Year 3 (2024)				Year 4 (2025)				Year 5 (2026)			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q3	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Develop SUBG RFP	AHCCCS																								
RFP out for Bid	AHCCCS																								
RFP Proposal Evaluation & Contractor Selection	AHCCCS																								
Receive Determination of Need for SSP in AZ (Obtained Oct-21)	AHCCCS																								
Contract Executed (December 1)	AHCCCS																								
Develop SUBG-SSP Metrics for Contractor	AHCCCS																								
Receive Approval for SUBG Funds for SSP Activities	AHCCCS																								
Naloxone Distribution, Education, and Testing (ongoing)	Contractor																								
Syringe Service Program (Approved by SAMHSA March 16, 2022)	Contractor																								
Fentanyl Testing Strip Distribution, Education, and Testing	Contractor																								
Programming for Pregnant and Parenting Women (SUBG)	Contractor																								
Contract Close-Out for Statewide Vendor	Contractor																								
Final Deliverable for Statewide Vendor	Contractor																								

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

150 N. 18th Avenue
Phoenix, AZ 85007
602.417.4000

KATIE HOBBS
GOVERNOR

KRISTEN CHALLACOMBE
INTERIM DIRECTOR

Attachment B: Signed statement (i.e., Annual Certification) AZ Syringe Service Program Plan

August 29, 2025

Theresa Mitchell Hampton, DrPH, M.Ed.
Public Health Advisor/State Project Officer / COR II / FAC-P\PM
HHS Region VIII (MT and UT), and IX (AZ; HI; and NV), and (CNMI, FSM, GU, and PU)
U.S. Department of Health and Human Services (DHHS)
Substance Abuse and Mental Health Services Administration (SAMHSA)
Center for Substance Abuse Treatment (CSAT)
Division of State and Community Assistance (DSCA)
Performance Partnership Grant Branch (PPGB)
5600 Fishers Lane, Station 13N16–E
Rockville, MD 20857 (courier/overnight use 29000)
O: (240) 276-1365
E: theresa.mitchell@samhsa.hhs.gov

Dear Dr. Theresa Mitchell-Hampton:

In accordance with the Consolidated Appropriations Act, 2016, Division H, the Arizona Health Care Cost Containment System (AHCCCS) respectfully submits the following attestation.

> *SEC. 520. Notwithstanding any other provision of this Act, no funds appropriated in this Act shall be used to purchase sterile needles or syringes for the hypodermic injection of any illegal drug: Provided, That such limitation does not apply to the use of funds for elements of a program other than making such purchases if the relevant State or local health department, in consultation with the Centers for Disease Control and Prevention, determines that the State or local jurisdiction, as applicable, is experiencing, or is at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, and such program is operating in accordance with State and local law.*

For programmatic questions, please contact Emma Hefton at (602) 417-4748 or Emma.Hefton@azahcccs.gov.

Sincerely,

Alisa Randall, Assistant Deputy Director

CC:
CJ Loiselle, AHCCCS
Nereyda Ramirez, AHCCCS
Emma Hefton, AHCCCS
Albert Swanson, AHCCCS
Heather Torrez, AHCCCS
Sara Lippitt, AHCCCS

Footnotes:

The planned budget for SUPTRS BG for SSP is assuming level funding of the SPW contract between calendar year 2025 and 2026. AHCCCS is awaiting the FFY2026 final allocation in order to finalize SPW's budget allocation for the time period of January 1, 2026 – December 31, 2026. There are no 2027 spend projections at this time.

Arizona Health Care Cost Containment System (AHCCCS) and Sonoran Prevention Works (SPW) Syringe Services Program (SSP) Plan

Substance Use Prevention Treatment and Recovery Services Block Grant (SUPTRS BG)

FFY26-27 Combined Application – Environmental Factors Table 16.

1. BACKGROUND

In 2021, Sonoran Prevention Works (SPW) responded to a Request for Proposals (RFP) released by AHCCCS to procure statewide services for overdose prevention and infectious disease prevention. This resulted in a contract between AHCCCS and SPW that was effective for an initial 3-year term of January 1, 2022 – December 31, 2024 with 2 optional 1-year extensions (Calendar year 2025 and calendar year 2026).

Prior to utilizing SUPTRS BG (herein referred to as SUBG) funds to support SPW's syringe services program (SSP), AHCCCS received approval to do so from SAMHSA in the FFY2022-2023 application. AHCCCS work closely with SPW to ensure the use of federal funds are within federal and state law, including Presidential Executive Orders (EOs) (e.g. EO on Ending Crime and Disorder on America's Streets).

This workplan reflects the 2025 updated version of the contractually agreed upon workplan.

2. WORKPLAN

AHCCCS, through the statewide contractor, SPW, has developed and is implementing a comprehensive, evidence-based program for the State of Arizona to meet the needs of the most vulnerable to overdose and other drug-related harms. *Figure 1* below displays the conceptual model developed for this project, illustrating the relationship between the interventions, immediate outcomes, and long-term outcomes.

Figure 1. Conceptual Model

Intervention	Immediate Outcomes	Long-term Outcomes
1) Naloxone distribution, education, and training 2) Syringe Services Program 3) Education and training 4) Peer support and wraparound services 5) Fentanyl and xylazine testing strip distribution, education, and training 6) Tailored programming and services for women 7) Community appropriate services and resources 8) Expanded network of key community stakeholders	• Increased initiation, continuation, and coordination of evidence-based treatment for individuals who use drugs • Increased overdose and infectious disease prevention behaviors such as reduced or safer use through education, supply testing, and overdose prevention kits • Increased proper disposal of used syringes • Increased public awareness and community engagement	• Reduced rates of overdose, drug-related deaths and injuries, and transmission of infectious diseases • Improved health and wellness of people who use drugs • Reduced costs and burden associated with substance use/misuse on public systems

To achieve the listed outcomes, our strategy consists of eight (8) overarching strategies/interventions:

1) **Naloxone distribution, education, and training:** Expand a comprehensive, statewide naloxone distribution, education, and training initiative for people who use drugs (PWUD), prescribers,

pharmacists, AHCCCS members and the public. Through the subcontracted provider, we aim to achieve the following objectives:

- **a.** Distribute naloxone doses via kits to communities across Arizona through targeted street and community outreach.
- **b.** Conduct in-person and web-based training sessions for prescribers, pharmacists, AHCCCS members, and the public, emphasizing evidence-based responses to opioid overdose and post-overdose support.
- **c.** *SPW reports that the following objectives have been eliminated since CY2022:*
    - i. Provide naloxone training and technical assistance to the correctional system to at least 50 percent of Arizona jails and 75 percent of state prisons distributing naloxone upon release.
        1. *Efforts were made towards this objective during CY2022, but SPW's subcontracted service provider (Community Medical Services) was not making significant progress & a similarly appropriate service provider could not be identified. With AHCCCS' permission, the objective was eliminated as a result.*
    - ii. Train 10 percent of Arizona group homes for transition-age youth on overdose prevention, recognition, and response.
        1. *Efforts were made towards this objective during CY2022, but SPW's subcontracted service provider (Community Medical Services) was not making significant progress & a similarly appropriate service provider could not be identified. With AHCCCS' permission, the objective was eliminated as a result.*

2) **A statewide SSP:** Through SPW, AHCCCS aims to implement the following elements for a statewide SSP:

- **a.** Develop and expand needle and hypodermic syringe disposal education and options for the State of Arizona to reach at least 5,640 individuals who inject drugs. In order to maximize our reach among our target population, we have developed three strategies to deliver supplies to PWUD: 1) fixed sites, 2) mobile units, and 3) mail order programs. Supplies include syringes (NOT funded by federal dollars), safe disposal containers, hygiene and wound care kits, internal and external condoms, rapid home HIV tests, and other associated supplies.
    - i. *SPW reports that the following strategy was also employed from CY2022 – CY2024: Supply distribution kiosks. For CY2025 and CY2026, the future of this effort is unknown, as SPW is awaiting input from SPW's subcontracted service provider (Community Medical Services) about its capacity to continue with the kiosk strategy.*
- **b.** Implement a statewide SSP with sites in Cochise, Coconino, Maricopa, Mohave, Pima, Santa Cruz, & Yuma Counties (in partnership with Southwest Recovery Alliance and Cochise partners). The statewide provider will also create new and expanded mobile and delivery based SSP services to reach PWUD across Arizona. In this project period, we aim to reach at least 5,640 Arizonans who inject drugs.

i. *SPW reports that the following additional counties also had SSP sites prior to CY2025: Graham, Navajo, Pinal, and Yavapai. If the kiosk strategy currently paused ultimately moves forward, it is possible that could reinstate implementation in some or all of these counties.*

c. Coordinate navigation services and treatment referrals for mental illness, substance use disorder, and other co-occurring disorders for SSP participants, as appropriate. SSPs provide an excellent opportunity to engage PWUD in a community setting with peer support from people with lived experience with substance use. Individuals seeking sterile needles or other supplies may also be offered referrals to navigation services, treatment referrals, or additional services as appropriate.

d. Develop and disseminate educational materials to at least 5,640 individuals through the SSP. Educational material may include the following topics: Overdose prevention, peer support services, infectious disease and transmission prevention, education, referrals, and treatment referrals for mental illness, SUD, and co-occurring disorders.

e. Develop and distribute evidence-based standards for distributing and disposing of needles and hypodermic syringes.

Acquiring Syringes, Needles, and any other supplies used in the facilitation or promotion of drug usage through Non-Federal Funds: *The statewide contractor, SPW, understands they will not utilize federal funds to purchase syringes/needles. SPW also understands that they will not use federal funds to purchase any supplies that are used in the facilitation or promotion of drug use. AHCCCS will continue to ensure compliance with state and federal regulations. SPW is dedicated to ensuring that participants have access to all the supplies they need to stay as safe and healthy as possible, including syringes and needles. In support of this project, SPW will continue to fund the purchase of syringes and needles through a combination of grassroots fundraising methods as well as grant funding from a diverse range of private and public funders. SPW has a long history of utilizing grassroots fundraising methods, including one-time and monthly sustaining donations and program service revenue to support the work and help to fund the purchase of program supplies. SPW is committed to seeking out a diverse range of funders who share our values, and can support the purchasing of lifesaving supplies, such as syringes and needles, for participants. For years, SPW has worked to build and maintain relationships with funders dedicated to supporting health and overdose and infectious disease prevention services to people impacted by substance use, including Broadway Cares, the Gilead Foundation, AIDS United, and more. SPW has also received funding from county health departments, hospital systems, and foundations across Arizona. Additionally, SPW proactively seeks out and applies to new funding opportunities that can further support the purchase of syringes and needles.*

a. ***Applicable MOUs with SSP Providers who can supply needles:*** SPW is the acquirer of the syringes and needles needed for the program, and therefore no MOU is needed for supplying needles. In lieu of an MOU, SPW has an executed contract that may be submitted if required

3) **Training for professionals and the broader community;** Through SPW, AHCCCS aims to implement the following stigma reduction trainings for professionals and the broader community:
    - **a.** Develop and distribute educational material to at least 30,000 people through print and electronic distribution. With AHCCCS guidance, SPW will review and adapt existing educational material targeted at PWUD, the general public, providers, pharmacists, AHCCCS members, and other specific populations as appropriate.
    - **b.** Provide at least 20 free training sessions for community members and the broader public. SPW's training sessions are typically geared toward community members, resource organizations, and medical/behavioral health professionals, with specialized curricula for numerous populations and professions. In coordination with AHCCCS and the program officer, SPW will review and update all training curricula and materials for free general training sessions geared toward community members. Current training topics include overdose prevention and naloxone use, opioid use disorder, stimulant use disorder, stigma, injection-related complications, and other relevant issues. These general trainings are offered in-person or virtually, including virtual video workshops or self-paced online courses.
    - **c.** Provide at least 15 training sessions to medical, behavioral health, and social service providers. SPW will develop or enhance trainings on overdose prevention, fentanyl testing strip use, stimulants, and other emerging topics and deliver to drug treatment providers, substance use prevention coalitions, health care providers, AHCCCS members, SUBG priority populations, organizations who serve women who use drugs, and other groups who engage with PWUD.
    - **d.** *SPW reports that the following objectives have been eliminated since CY2022:*
        - i. Conduct at least three trainings each year in each Geographic Service Area (GSA) in Arizona to the Department of Child Safety regional offices on overdose and infectious disease prevention. SPW will adapt existing curriculum to specifically address the unique needs of transition-age youth struggling with substance use/misuse.
            1. *Efforts were made towards this objective during CY2022, but SPW's subcontracted service provider (Community Medical Services) was not making significant progress & a similarly appropriate service provider could not be identified. With AHCCCS' permission, the objective was eliminated as a result.*
        - ii. Provide training to at least 50 percent of Community Corrections offices on overdose prevention. Due to the disproportionate impact of opioid overdoses on criminal-justice involved individuals, we will make a concerted effort to train those that work in the criminal justice system with specialized content for this population.
            1. *Efforts were made towards this objective during CY2022, but SPW's subcontracted service provider (Community Medical Services) was not making significant progress & a similarly appropriate service provider could not be identified. With AHCCCS' permission, the objective was eliminated as a result.*

4) **Peer support program to facilitate linkages to treatment and wrap-around supports;** Through SPW, AHCCCS aims to implement the following peer support program through the following strategies:
    a. Develop and implement a network of at least 75 provider organizations to facilitate linkages to evidence-based care navigation services for individuals requiring a higher level of care. Peer support staff at SPW work at SSPs and conduct street outreach in order to identify new clients and facilitate referrals to organizations which provide the additional services they seek.
    b. Provide at least 1,500 referrals to treatment through peer support staff for individuals requiring a higher level of care. Referrals may include treatment for: SUD, mental illness, mental health and overdose and infectious disease prevention-based counseling, screening and treatment for HIV, viral hepatitis, and STIs, medical treatment and basic wound care. SPW's outreach staff are peer support-certified and specially trained to provide support around drug treatment, medical care, mental health, housing, criminal justice involvement, identification replacement, and other services.
    c. Disseminate risk reduction material through peer support staff to 5,640 individuals. Supply kits may include condoms, hygiene products, naloxone kits, fentanyl test strips, and other necessities.
    d. Promote awareness through in-depth training for 2,700 individuals about the relationship between injection drug use and communicable diseases, recommended steps for disease transmission prevention, and options for treatment. Through syringe services and rapid HIV/HCV screening, outreach specialists will provide education on prevention, risk mitigation, and treatment for HIV, HCV, and other communicable diseases including hepatitis A and B, COVID-19, and STIs.
5) **Fentanyl testing strip distribution, education, and training;** Through SPW, AHCCCS aims to implement the following strategies:
    a. Distribute 120,000 rapid fentanyl testing strips (FTS) to communities across the State of Arizona by the end of Year 3 (2024). Distribution will be prioritized to people who use drugs (all drugs, including heroin, stimulants, and pills), their friends and family, and organizations who can effectively distribute testing strips to people at risk for overdose. SPW maintains the lowest available cost-effective pricing agreement with pharmaceutical companies for FTS in Arizona and will continue to do so for this project. Our budget for this proposal includes resources to purchase 120,000 FTS for statewide distribution.
    b. Develop and distribute FTS training materials and modules. FTS educational material will include content such as the use of FTS; alleviating fears and stigma; education on overdose and infectious disease prevention and how it relates to using the testing strips to test for the presence of fentanyl; and information regarding use and/or disposal of substances that test positive for fentanyl. This content will be made available to PWUD, families, AHCCCS members, community-based organizations, and the general public.
6) **Tailored programming and services for women, especially pregnant and parenting women (SUBG Priority Population);** Through SPW, AHCCCS aims to implement the following strategies for this SUBG Priority Population:

a. Provide outreach and care coordination services to at least 200 women who use drugs, prioritizing pregnant and parenting women. Tailored programming and services for women who use drugs may include pediatric medical treatment and care, child welfare, Arizona Department of Child Safety (DCS) coordination, legal assistance, early childhood education, family counseling, and other services needed by all PWUD. We aim to serve a minimum of 30 women in each region.

b. Staff the statewide SSP with at least one staff member who specializes in supporting women who use drugs, particularly pregnant and parenting women. The staff member will travel throughout the state to provide services, as well as training and education for project staff and partners.

c. Prioritize the delivery of services and training to SUBG priority populations. In compliance with SAMHSA and AHCCCS regulations for the use of SUBG funds, all services provided through the resources requested for this project will prioritize the following SUBG populations: 1) pregnant women/teenagers who use drugs by injection, 2) pregnant women/teenagers with a SUD, 3) other persons who use drugs by injection, 4) women/teenagers with a SUD, with dependent children and their families, including women who are attempting to regain custody of their children, and 5) all other individuals with a SUD, regardless of gender or route of use. With respect to naloxone distribution, education and training, we aim to increase the utilization of SPW services among SUBG priority populations by at least 10 percent during the three-year project period (2022-2024).

d. Participate in statewide groups to conduct provider education on decreasing stigma and utilization of evidence-based practices for pregnant and parenting women who use drugs. Along with Objective 3E, we will make concerted efforts to train providers who treat women who use drugs.

7) Community appropriate services and resources; Through SPW, AHCCCS aims to implement the following:

a. Provide Spanish translations and community sensitive versions of services and resources. SPW has provided Spanish translations of educational and outreach materials, as well as offered peer support services in Spanish since 2019. SPW currently has Spanish-speaking outreach staff in five Arizona counties. All printed educational materials will be available in English and Spanish, and additional materials will be revised for consideration of communities when working with tribal nations.

i. *SPW reports that in CY2022, we offered a telephone translation service to our outreach staff, but it was never used, so we eliminated it to reduce program costs.*

ii. *SPW reports that during CY2024, one of our SSP staff enrolled in additional training to become more proficient in the Navajo/Diné language to assist him in working more effectively with tribal participants.*

b. Host at least 20 training sessions in Spanish and distribute materials to at least 1,000 Spanish-speaking clients.

8) Stakeholder relationship and capacity building to ensure long-term program sustainability. Through SPW, AHCCCS aims to implement the following:

a. Convene a Community Advisory Board (CAB) consisting of impacted individuals from across the state of Arizona. Through regular meetings, the CAB provides SPW with critical feedback and insights into program efficacy & accessibility, builds community capacity to prevent overdoses and overdose deaths, & mitigates stigma. SPW utilizes successes & lessons learned from the CAB to build, train, & sustain a statewide network of professional partners, including SSPs, state and local government agencies, Substance Use Disorder and behavioral health treatment providers, health departments, health clinics and systems, correctional health, first responders, community-based organizations, mutual aid groups, local businesses, schools, colleges and universities, and neighborhood associations.
b. Evaluate and continuously improve the services provided through our program through regular data monitoring, performance reports, and quality improvement methods. A critical part of this project is collecting reliable data to assess performance, evaluate progress, and continuously improve services and internal control systems. Additionally, we will maintain and expand SPW's inventory tracking system to monitor the supply and distribution of naloxone, FTS, and related outreach supplies purchased with SUBG funds.
    i. *In CY2022, SPW subcontracted ASU CHS for evaluation services. Due to high costs associated with this subcontractor and no evaluations completed beyond those which SPW itself is capable of completing via SUBG-supported staff, the subcontract did not continue after CY2022. Instead, SPW continues to collect and report to AHCCCS program implementation data (e.g. reach, referrals, trainings completed, syringes collected, distributed, etc.)*
c. Identify and disseminate best practices and recommendations for sustaining and expanding the program. All project processes, protocols, tools, evaluations, publications, and reports will be documented for dissemination to sustain and expand our collective efforts.

3. TIMELINE FOR IMPLEMENTATION

Please refer to **Attachment A** at the end of this document for the timeline for implementation.

4. COPY OF EXISTING SSP PROTOCOLS OR GUIDELINES

AHCCCS, in consultation with SPW, will utilize the following protocols/guidelines, and applicable state law such as:

a) Arizona Revised Statutes (ARS) Title 36, Chapter 6, Article 15: *Title 36, chapter 6, Arizona Revised Statutes. ARTICLE 15. OVERDOSE AND DISEASE PREVENTION. 36-798.51. Overdose and disease prevention programs; requirements; standards*
b) Centers for Disease Control and Prevention: *Syringe Service Programs, A Technical Package of Effective Strategies and Approaches for Planning, Design, and Implementation (published 2020)*
c) NASTAD: *Syringe Services Program (SSP) Development and Implementation Guidelines for State and Local Health Departments (published 2012)*
d) SAMHSA Dear Colleague Letter 7.30.2025
e) SAMHSA Overdose Prevention and Response Toolkit

5. BUDGET, BUDGET JUSTIFICATION, AND PROPOSED ACTIVITIES, INCLUDING A PLAN FOR DISPOSAL OF INJECTION EQUIPMENT

Category	2025 SUBG annual and ARPA
Personnel	$971,572
Fringe	$257,952
Travel	$42,607
Equipment	$0
Supplies	$429,759
Contractual	$74,300
Other	$42,383
Total Direct Charges	$1,818,573
Indirect Charges or Administration	$381,876
Total Project Costs	**$2,091,359**

**Footnote: This is based on level funding from CY25 budget subject to change based on funding availability and has not yet been approved or obligated to the contractor.*

Proposed Activities:

1) Naloxone distribution, education, and training;
2) A statewide SSP;
3) Trainings for professionals and the broader community;
4) Peer support program to facilitate linkages to treatment and wrap-around supports;
5) Fentanyl testing strip distribution, education, and training;
6) Tailored programming and services for women, especially pregnant and parenting women (SUBG Priority Population);
7) Community appropriate services and resources; and
8) Stakeholder relationship and capacity building to ensure long-term program sustainability.

SPW aims to follow applicable Arizona law regarding the disposal of injection equipment *(SB 1250: Article 15: 36-798.51. Overdose and disease prevention programs; requirements; standards):*

> *"A program established pursuant to this section shall develop standards for distributing and disposing of needles and hypodermic syringes based on scientific evidence and best practices. the number of needles and hypodermic syringes disposed of through a program shall be at least equivalent to the number of needles and hypodermic syringes distributed through the program."*

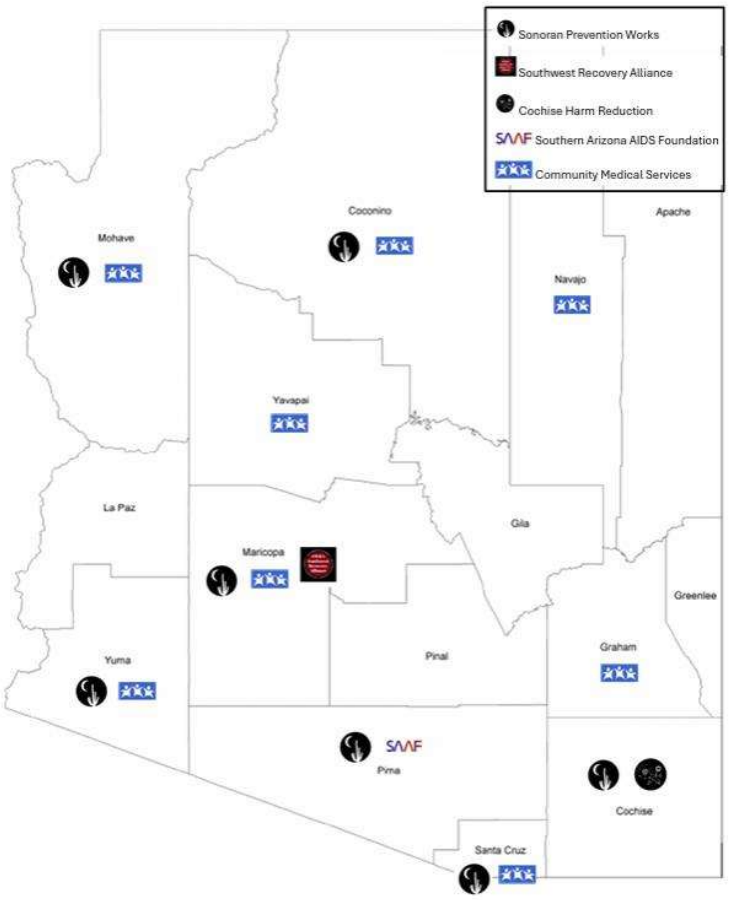
6. DESCRIPTION OF CURRENT TRAINING AND TECHNICAL ASSISTANCE NEEDS

Training/Technical Assistance Item	Description	Resource
None at this time		

7. LOCATION OF SSP RELATED ACTIVITIES TO BE SUPPORTED WITH FEDERAL FUNDS

AHCCCS will implement a statewide SSP to adequately address the needs of PWUD across the Arizona community. *Figure 2* (below) shows the statewide reach of our program, with SPW and its partners having a presence in a combined 10 of Arizona's 15 counties.

Figure 2.



8. SIGNED STATEMENT (I.E., ANNUAL CERTIFICATION)

Signed and included as part of this request **(Attachment B)**.

9. SSP METRIC INFORMATION

SUBG sub-recipients (i.e., community-based organizations), implementing new or expanding existing SSPs will need to collect basic SSP metrics information (e.g., number of syringes distributed, estimated number of syringes returned for safe disposal, number of persons tested for HIV or viral hepatitis, and referrals to HIV, viral hepatitis and substance use disorder treatment).

AHCCCS developed an evaluation design into the method of approach to measure project performance, identify best practices, and facilitate continuous program improvement. Using the RE-AIM framework, the contracted provider, SPW, will gather data from program staff and participants through monthly programmatic reports. The data will track all measurable objectives, required reports, and reports for use by the advisory committee and executive team. All data collection methods will take into consideration the language, norms and values of the focus populations.

In compliance with SAMHSA guidance for State Block Grants, AHCCCS will collect the following information related to SSPs:

- Number of syringes distributed,
- Estimated number of syringes returned for safe disposal,
- Number of persons tested for HIV or viral hepatitis,
- Referrals to HIV/Viral Hepatitis testing and treatment, and
- Referrals to substance use disorder treatment.

AZ SSP Plan Attachment A_SPW Timeline

Milestones	Lead	Year 0 (Administrative)				Year 1 (2022)				Year 2 (2023)				Year 3 (2024)				Year 4 (2025)				Year 5 (2026)			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q3	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Develop SUBG RFP	AHCCCS																								
RFP out for Bid	AHCCCS																								
RFP Proposal Evaluation & Contractor Selection	AHCCCS																								
Receive Determination of Need for SSP in AZ (Obtained Oct-21)	AHCCCS																								
Contract Executed (December 1)	AHCCCS																								
Develop SUBG-SSP Metrics for Contractor	AHCCCS																								
Receive Approval for SUBG Funds for SSP Activities	AHCCCS																								
Naloxone Distribution, Education, and Testing (ongoing)	Contractor																								
Syringe Service Program (Approved by SAMHSA March 16, 2022)	Contractor																								
Fentanyl Testing Strip Distribution, Education, and Testing	Contractor																								
Programming for Pregnant and Parenting Women (SUBG)	Contractor																								
Contract Close-Out for Statewide Vendor	Contractor																								
Final Deliverable for Statewide Vendor	Contractor																								

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

150 N. 18th Avenue
Phoenix, AZ 85007
602.417.4000

KATIE HOBBS
GOVERNOR

KRISTEN CHALLACOMBE
INTERIM DIRECTOR

Attachment B: Signed statement (i.e., Annual Certification) AZ Syringe Service Program Plan

August 29, 2025

Theresa Mitchell Hampton, DrPH, M.Ed.
Public Health Advisor/State Project Officer / COR II / FAC-P\PM
HHS Region VIII (MT and UT), and IX (AZ; HI; and NV), and (CNMI, FSM, GU, and PU)
U.S. Department of Health and Human Services (DHHS)
Substance Abuse and Mental Health Services Administration (SAMHSA)
Center for Substance Abuse Treatment (CSAT)
Division of State and Community Assistance (DSCA)
Performance Partnership Grant Branch (PPGB)
5600 Fishers Lane, Station 13N16–E
Rockville, MD 20857 (courier/overnight use 29000)
O: (240) 276-1365
E: theresa.mitchell@samhsa.hhs.gov

Dear Dr. Theresa Mitchell-Hampton:

In accordance with the Consolidated Appropriations Act, 2016, Division H, the Arizona Health Care Cost Containment System (AHCCCS) respectfully submits the following attestation.

> *SEC. 520. Notwithstanding any other provision of this Act, no funds appropriated in this Act shall be used to purchase sterile needles or syringes for the hypodermic injection of any illegal drug: Provided, That such limitation does not apply to the use of funds for elements of a program other than making such purchases if the relevant State or local health department, in consultation with the Centers for Disease Control and Prevention, determines that the State or local jurisdiction, as applicable, is experiencing, or is at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, and such program is operating in accordance with State and local law.*

For programmatic questions, please contact Emma Hefton at (602) 417-4748 or Emma.Hefton@azahcccs.gov.

Sincerely,

Alisa Randall, Assistant Deputy Director

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