Tribal Regional Behavioral Health Authority (TRBHA) & Division of Fee-for-Service Management (DFSM) Provider Training FAQ

1. Understanding TRBHAs and Related Programs

Q1. What is the difference between TRBHA and Tribal ALTCS?

Answer: A Tribal Regional Behavioral Health Authority (TRBHA) and Tribal Arizona Long Term Care System (Tribal ALTCS) serve different roles within the AHCCCS system. A TRBHA is a tribal entity that has an Intergovernmental Agreement (IGA) with AHCCCS to coordinate the delivery of behavioral health services for eligible members assigned to the TRBHA. TRBHAs are responsible for behavioral health care coordination and case management activities as outlined in their IGA with AHCCCS.

Tribal ALTCS serves members who meet nursing facility level of care criteria and require long-term services and support due to age, physical disability, or developmental disability. Tribal ALTCS provides case management and coordinates long-term care services and supports for eligible members.

Some members may be enrolled with both a TRBHA and Tribal ALTCS. In those situations, providers are expected to coordinate care with all entities involved in the member's care, including the TRBHA, Tribal ALTCS, and other treating providers, as applicable.

For additional information on Tribal ALTCS and their contact information, please refer to the following link:
https://www.azahcccs.gov/AmericanIndians/LongTermCareCaseManagement/

For additional information on TRBHAs and their contact information, please refer to the following link:
https://www.azahcccs.gov/AmericanIndians/Downloads/TRBHAContacts.pdf

Q2. Is an AHCCCS provider required to coordinate care with the American Indian Medical Home (AIMH)?

Answer: The American Indian Medical Home (AIMH) Program is a care management model available to members enrolled in the American Indian Health Program (AIHP). AIHP members can voluntarily select empanelment with an AIMH for care coordination and case management.
Per AMPM 320-O, providers serving FFS members are responsible for coordinating care across all levels with any individuals or entities involved in the member's

treatment, including TRBHAs, DDD-THP, Tribal ALTCS, AIMH, PCPs, inpatient and outpatient providers, Indian Health Services, Tribal 638 Facilities, and Urban Health Clinics (I/T/U facilities), and physical health providers. While a formal Child Family Team (CFT) or Adult Recovery Team (ART) is not required, an equivalent team-based approach must be used to support care coordination and inclusion of TRBHA representatives, as applicable.

For additional information on the American Indian Medical Home (AIMH) please go to the following link:
https://www.azahcccs.gov/AmericanIndians/AmericanIndianMedicalHome/

Q3. What settings does TRBHA care coordination apply to?

Answer: TRBHA care coordination applies across the continuum of behavioral health care and is not limited to a specific level of care. This includes, but is not limited to, crisis services, including crisis observation, inpatient psychiatric settings, outpatient treatment, Intensive Outpatient Programs (IOP), Behavioral Health Residential Facilities (BHRFs), and other behavioral health treatment settings. Care coordination is intended to support continuity of care, communication among treatment team members, and safe transitions between levels of care. The TRBHA should be incorporated into the assessment process, treatment planning, ongoing service delivery, and discharge planning, as applicable.

Q4. What are the TRBHAs contact information for care coordination?

Answer:
Gila River TRBHA
- Email: BHSCC@GRHC.ORG

Navajo Nation TRBHA
- Phone: (928) 871-6235

Pascua Yaqui TRBHA
- Phone: (520) 879-6060 [Tucson]
- Phone: (480) 755-2500 [Guadalupe]

White Mountain Apache TRBHA
- Phone: (928) 338-4811
- Email: TRBHACC@WMABHS.ORG

2. Care Coordination Requirements and Expectations

Q5. What are the care coordination requirements, case management responsibilities, and authorization processes for members receiving care in a BHRF?

Answer: Care coordination requirements – AMPM 320-O establishes the requirements for care coordination across the behavioral health system. It requires providers serving FFS members to coordinate care across all levels of care and with all involved entities, including TRBHAs, primary care providers, and other treatment team members.

AMPM 320-V further reinforces these expectations within the BHRF setting emphasizing ongoing collaboration among treatment team members, including the TRBHA and other involved providers, throughout admission, continued stay, transition, and discharge planning.

Case management responsibilities – Per AMPM 570, case management for FFS members may be provided either by a TRBHA case manager or by a behavioral health provider, as applicable. When provider case management is in place, providers are required to work collaboratively with the TRBHA to ensure care coordination occurs.

Authorization process – AMPM 820 requires prior authorization for BHRF services. Initial and continued stay requests must include documentation demonstrating active care coordination with the assigned TRBHA and all involved treatment team members. Additional prior authorization requirements can be found in the Fee-for-Service Billing Manual, Chapter 8 – Prior Authorization and AMPM 320-V for BHRF requirements.

Q6. What are the provider's ongoing care coordination responsibilities, and what documentation may be requested by AHCCCS Prior Authorization?

Answer: The Fee- for- Service (FFS) Behavioral Health Prior Authorization (PA) team looks for documentation confirming active care coordination with an American Indian Health Program (AIHP) member's outpatient treatment team when reviewing all BH services that are subject to PA, regardless of whether the member is enrolled with a TRBHA for BH care coordination. The provider maintains an ongoing responsibility to coordinate care with all members of the individual's outpatient treatment team, including TRBHA case management, regardless of whether a case manager is actively involved. This includes collaboration, communication, and documentation demonstrating attempts to coordinate services with any treating providers or entities involved in the member's care. Please refer to AMPM 320-O.

Q7. What records must be maintained to demonstrate that care coordination requirements have been met?

Answer: Providers are responsible for documenting care coordination activities within the member's health record. Evidence of care coordination may be documented in assessments, treatment plans and treatment plan updates, ART/CFT meetings or equivalent treatment team meetings, progress notes, case management notes, discharge planning records, referral documentation, and communications with other providers or entities involved in the member's care. Documentation should demonstrate the provider's efforts to coordinate services, share relevant clinical information, and support continuity of care. Providers must maintain records in accordance with applicable federal and state requirements, as well as AHCCCS record retention requirements outlined in AMPM 940.

Q8. What are the expectations for BHRFs when a member is referred to an organization that does not offer case management services?

Answer: Not every member will have a case manager. Per AMPM 570, case management for FFS members may be provided by either a TRBHA case manager, if enrolled with a TRBHA, or a behavioral health provider, as applicable. However, regardless of whether case management services are available, providers remain responsible for conducting care coordination for every member.
When a member is referred to an organization that does not provide case management services, the BHRF is expected to continue coordinating with all involved parties, including the assigned TRBHA, primary care providers, behavioral health providers, and other treatment team members, as applicable. Providers should document their care coordination efforts and ensure communication occurs to support continuity of care, treatment planning, transitions of care, and discharge planning.

The absence of a designated case manager does not eliminate the expectation for ongoing care coordination among providers involved in the member's care.

Q9. If a member is not enrolled with a TRBHA and does not currently have any other providers, entities, or care team members involved in their care, what care coordination is required?

Answer: Per AMPM 320-O, providers serving FFS American Indian Health Program (AIHP) members are responsible for coordinating care across all levels of care with applicable treating providers and entities involved in the member's care. This may include, but is not limited to, a TRBHA, Tribal ALTCS, American Indian Medical Home (AIMH), primary care provider (PCP), I/T/U, outpatient treatment providers,

inpatient providers, and other physical or behavioral health providers.

If an AIHP member does not currently have any identified providers, entities, or care team members involved in their care, the provider should document the efforts made to identify potential treatment team participants and the member's response. However, care coordination responsibilities do not end there. Providers remain responsible for coordinating care across the healthcare delivery system, including making referrals and facilitating access to medically necessary physical and behavioral health services that are beyond the provider's scope of practice. Any outreach, referrals, and care coordination efforts should be documented in the member's medical record.

A Child and Family Team (CFT) or Adult Recovery Team (ART) is not required for FFS members. However, an equivalent outpatient treatment team process is required when other providers or entities become involved in the member's care. If providers conduct treatment team meetings or case conferences for TRBHA members, the TRBHA should be included and given the opportunity to participate in care coordination activities.

3. Working with TRBHAs

Q10. What should a provider do if a member refuses TRBHA involvement?

Answer: The provider should assist in educating the member on the TRBHA's role and how the TRBHA can support the member in coordinating their behavioral health needs. If the member has questions about working with the TRBHA, the provider should encourage the member to discuss those concerns with the TRBHA and assist with connecting the member to a TRBHA representative when appropriate.

If a member wishes to change health plans, they may contact AHCCCS Member Services or work directly with their TRBHA Case Manager to request a change in health plan enrollment. However, until the change is completed and reflected in the AHCCCS eligibility system, the provider remains responsible for coordinating care with the member's assigned TRBHA. While TRBHA enrollment remains active, both the provider and the TRBHA are expected to participate in care coordination activities for the shared member.

Per the Provider Participation Agreement (PPA), providers shall not steer members to change their health plan. All health plan decisions are at the sole discretion of the member and according to their voice and choice and not the provider's health plan preference. Steering members to make changes to health

plan constitutes a violation of the PPA and may be grounds for termination of AHCCCS provider status. If the member needs assistance in selecting a health plan, the member may call a Beneficiary Support Specialist at (602) 417-7100 or 1-(800)-334-5283 or email your question and contact information to BeneficiarySupportSpecialist@azahcccs.gov.

If the member remains enrolled with the TRBHA, the TRBHA must remain involved in case management and care coordination activities. As long as the member's AHCCCS eligibility record reflects TRBHA enrollment, the expectation is that the provider and TRBHA will work collaboratively to coordinate services and support the member's treatment needs.

Q11. If a TRBHA does not respond to a provider's request for care coordination, how long should providers hold a member before discharge?

Answer: Providers are expected to continue making reasonable care coordination and discharge planning efforts and to document all outreach attempts and responses received.

In the event a provider is experiencing barriers in communication with the TRBHA, the provider should submit a ticket via AHCCCS Solutions Center. Select Tribal Services then the TRBHA Support Form. This will connect you with the AHCCCS Integrated Services team for assistance with resolving communication barriers. Providers should continue to document all care coordination activities, discharge planning efforts, and actions taken to support continuity of care.

Q12. What is the TRBHA's scope of authority when working with AHCCCS registered providers, including when they may request facility or personnel records, review facility operations or compliance activities, and how these activities remain distinct from formal AHCCCS or AZDHS regulatory inspections?

Answer: TRBHAs and Tribal ALTCS programs are AHCCCS Fee-for-Service (FFS) health programs responsible for monitoring quality of care and ensuring members receive medically necessary services. Similar to AHCCCS managed care health plans, they may review Incident, Accident, and Death (IAD) reports, investigate Quality of Care (QOC) concerns involving their enrolled members, and request records relevant to those activities.

Each TRBHA or Tribal ALTCS program determines the staff responsible for conducting these reviews and investigations. Depending on the applicable TRBHA or Tribal ALTCS Intergovernmental Agreement (IGA), individuals performing quality management functions may also have other responsibilities, such as case management. When acting in a quality

management or investigative capacity, those individuals may request records and information necessary to review concerns involving TRBHA- or Tribal ALTCS-enrolled members.

TRBHAs and Tribal ALTCS programs may also refer concerns to AHCCCS DFSM Quality Management for further review or investigation. In some circumstances, multiple entities, divisions, or regulatory agencies may be reviewing the same concern simultaneously. Providers are responsible for complying with applicable reporting requirements and responding to requests from the appropriate oversight entities.

These activities are distinct from formal licensing inspections conducted by agencies such as the Arizona Department of Health Services (AZDHS), and are focused on quality oversight, quality-of-care investigations, care coordination, member safety, and compliance with AHCCCS program requirements.

4. Discharge Planning and Community Placement

Q13. If a member is ready to transition to a lower level of care but does not wish to return to their reservation, home community, or previous living environment, what resources and support are available to assist with discharge planning and placement?

Answer: When a member is clinically ready for discharge to a lower level of care but does not wish to return to their prior environment, discharge planning must be individualized and member-centered. Providers should collaborate with the TRBHA case manager, if enrolled with a TRBHA, to identify appropriate placement options that support the member's clinical needs, safety, and preferences. This may include supportive housing programs, alternative community placements, or other behavioral health service settings. The expectation is that discharge planning occurs collaboratively and begins as early as possible to allow time to explore all viable options.

Q14. Who is responsible for identifying alternative housing, treatment, or supportive living options?

Answer: Treatment team members should work collaboratively to identify available community resources, housing programs, supportive living settings, Tribal resources, grant-funded programs, and other local supports that may be available to assist the member. For more information on AHCCCS Housing Program requirements, please visit the following link: https://www.azahcccs.gov/housing.

TRBHAs and providers share responsibility for making sure members receive appropriate services in the least restrictive and most cost-effective setting that meets their needs. It is the expectation that providers collaborate with the TRBHAS in the care coordination and discharge planning of the member to most

effectively meet the member's specific, identified needs. This shared approach ensures the members have meaningful choice and access to services.

5. Treatment Planning and Service Coordination

Q15. How is duplication of services determined for AIHP members with an SMI designation who reside in a BHRF and also receive outpatient SMI services? If the outpatient services are medically necessary, documented in the treatment plan, and provided by a separate provider, why would the BHRF's authorization be impacted, and what responsibility does the BHRF have for billing practices of providers outside of its control?

Answer: AMPM 320-O requires that the members' service plan serve as the central document that directs care. The service plan must outline all services being provided, the providers responsible for delivering those services, and care coordination strategies to ensure services are medically necessary, integrated, and not duplicative. All behavioral health services should be delivered in accordance with the current service plan and coordinated among involved providers.

For members designated with an SMI, AMPM 320-R requires involvement of the Adult Recovery Team (ART) and, when applicable, a designated representative or individual providing Special Assistance. Through the service planning process, the treatment team should discuss and coordinate services provided by multiple organizations to ensure each service has a distinct purpose and supports the member's identified treatment goals. Coordination among providers is expected regardless of the setting in which services are delivered.

Providers participating in a member's treatment team are expected to communicate, coordinate services, and ensure that the services reflected in the treatment plan are clinically appropriate, medically necessary, and clearly differentiated in scope and purpose. When multiple providers are rendering similar services, documentation should clearly reflect the need for each service and how it supports the member's overall treatment goals.

6. Privacy, Consent, and Information Sharing

Q16. Is an authorization or other signed consent required before sharing information for care coordination, treatment planning, or discharge planning when a member has an SUD diagnosis or SUD-related information in the record?

Answer: Consent for treatment and authorization to disclose protected health information are separate concepts and may be subject to different requirements. Providers should evaluate whether the information being shared is subject to 42 CFR Part 2 and determine what consent or authorization requirements apply to

their organization and the services they provide. Requirements may vary based on whether the provider is a Part 2 program, the purpose of the disclosure, and the type of information being shared. Aside from information that is subject to 42 CFR Part 2, a separate ROI is not needed for coordinating care with TRBHAs.

AHCCCS does not make determinations regarding the applicability of 42 CFR Part 2 for individual providers. Each provider is responsible for reviewing federal requirements and ensuring appropriate consents and authorizations are obtained when required. Providers should review the most current guidance issued by the U.S. Department of Health and Human Services (HHS) regarding 42 CFR Part 2 and HIPAA alignment. 42 CFR Part 2 Guidance

Please refer to HHS guidance for additional information on the difference between consent and authorization. . https://www.hhs.gov/hipaa/for-professionals/faq/264/what-is-the-difference-between-consent-and-auth…

Q17. If a member has an SUD, should providers coordinate care if an ROI is not established?

Answer: