# 320-V - BEHAVIORAL HEALTH RESIDENTIAL FACILITIES

EFFECTIVE DATES: 02/08/19, 10/01/19, 10/01/20, 10/01/21, 10/01/22, 01/14/25, 10/01/26

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## I. PURPOSE

This Policy applies to ACC, ACC-RBHA, ALTCS E/PD, DCS CHP (CHP), DES DDD (DDD) Contractors, and Behavioral Health Residential Facility (BHRF) Providers serving Fee-For-Service (FFS) Programs including: American Indian Health Program (AIHP), DES DDD Tribal Health Program (DDD THP), Tribal ALTCS, TRBHA; and all FFS populations, excluding Federal Emergency Services Program (FESP). (For FESP, refer to AMPM Chapter 1100). This Policy establishes requirements for the provision of care and services in a BHRF.

Throughout this Policy, all references to outpatient treatment team can indicate Child and Family Team (CFT), Adult Recovery Team (ART), American Indian Medical Home (AIMH), Indian Health Services, Tribally operated 638 Facility, Urban Indian Health (I/T/U), TRBHA, Tribal ALTCS, and/or DDD. A CFT/ART is not required in order for FFS members to receive services. However, an equivalent team process through the outpatient treatment team is required for care coordination for FFS members.

## II. DEFINITIONS

Refer to the AHCCCS ACOM and AMPM Policy Dictionary for common terms found in this Policy.

For purposes of this Policy, the following terms are defined as:

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| **BEHAVIORAL HEALTH RESIDENTIAL FACILITY STAFF ([BHRF] STAFF)** | Any employee of the agency providing the BHRF service including but not limited to administrators, Behavioral Health Professionals (BHPs), and Behavioral Health Technicians (BHTs). |
| **CO-OCCURRING** | The coexistence of both a Behavioral Health (BH) and a Substance Use Disorder (SUD). |
| **SUPERVISION** | Directly overseeing and inspecting the act of accomplishing a function or activity. |

## III. POLICY

The care and services provided in a BHRF are based on a per-diem rate (24-hour day), require prior and continued authorization and do not include room and board. A BHRF is considered a level of care that is inclusive of all treatment that is within the scope of BHRF services, and that is provided by the BHRF, in accordance with the treatment plan created by the treatment team. Behavioral health services that are determined to be medically necessary for the member but are not services that can be provided by the BHRF staff or BHRF Behavioral Health Professional (BHP) (e.g. Specialty counseling, Assertive Community Treatment [ACT], step down services or programs as a part of a formal discharge plan to support transition into a lower level of care) are subject to separate prior and continued authorization. Documentation requirements from medically necessary services that are outside of the BHRF scope of work are as outlined in this policy must be included in the member's record. The BHRF provider shall ensure that information for associated BHPs is updated and current in the AHCCCS Provider Enrollment Portal (APEP).

The BHRF providers shall be Arizona Department of Health Services (ADHS) licensed facilities in accordance with AAC Title 9, Chapter 10. All IHS/638 facilities are subject to Centers for Medicare and Medicaid Services (CMS) certification requirements. The BHRF providers who have an ADHS approved supplemental application and scope of work to provide respite services as specified in AAC R9-10-702 (A)(5) shall refer to AMPM Policy 1250-D and AMPM Policy 310-B for limitations and requirements. For requirements and procedures in the event that an Out-of-State placement for behavioral health treatment that is clinically necessary and supported by the CFT, ART, or an equivalent team process through the outpatient treatment team for FFS members, refer to AMPM Policy 450. Operationalization of the use of CFT Practice in BHRFs for youth in out-of-home placements shall refer to AMPM Policy 586. For all other supplemental or partial day BHRF services approved under AAC R9-10-702, for billing limitations and additional guidance, providers shall refer to the Medical Coding Resources page of the AHCCCS website.

The Contractor shall refer to ACOM Policy 414 for the requirements for service authorization decision and adverse benefit determination timeframes and required notifications. Contractors shall treat all authorization requests for BHRF services as expedited requests.

For information on PA requirements for FFS members, refer to AMPM Policy 820.

The Contractor and BHRF Providers shall ensure appropriate notification is sent to the Primary Care Provider (PCP) and Behavioral Health Provider/ Outpatient Treatment Provider/Agency/TRBHA/Tribal ALTCS program upon intake to and discharge from the BHRF. Members shall not be required to change PCP, Behavioral Health Provider/Outpatient Treatment Provider/Agency/TRBHA/Tribal ALTCS program as a condition of admission or continued stay.

The sections applicable to Secured BHRF will not be effective until such time that these facilities are developed and subsequently enrolled with AHCCCS as a provider.

## A. BEHAVIORAL HEALTH RESIDENTIAL FACILITY (BHRF) OVERVIEW AND REQUIREMENTS

1. The BHRF is a level of care available to members diagnosed with a behavioral health condition (inclusive of substance use conditions), which is causing significant functional and/or psychosocial impairment, leading to at least one area of significant risk of harm. This impairment and risk of harm warrants the need for 24-hour supervision and support while the member engages in treatment interventions to address behavioral health condition(s) that will allow the member to live safely in the community.

2. The Behavioral Health services deemed medically necessary through the assessment and/or outpatient treatment team which are not offered at the BHRF, shall be documented in the member's comprehensive service plan and BHRF treatment plan. Documentation of medically necessary behavioral health services that are outside of the scope of the BHRF shall include:
   a. A description of the need,
   b. Identified goals,
   c. Frequency and duration of services to be provided,
   d. Identification of provider meeting the need,
   e. Documentation shall also include why the BHRF and current BHP are unable to provide these services for the member, and
   f. Why the outpatient treatment team must provide them separately.

3. The following services shall be made available and provided by the BHRF and cannot be billed separately unless otherwise noted below:
   a. Counseling and therapy (group and individual). Behavioral health counseling and therapy.
   b. Behavioral health prevention/promotion education and medication training and support services including but not limited to:
      i. Symptom management (e.g., including identification of early warning signs and crisis planning/use of crisis plan),
      ii. Health and wellness education (e.g., benefits of routine medical check-ups, preventive care, communication with the PCP and other health practitioners),
      iii. Medication education and self-administration skills,
      iv. Relapse prevention,
      v. Psychoeducation services and ongoing support to maintain employment work and vocational skills, educational needs assessment and skill building,
      vi. Treatment for Substance Use Disorder (SUD) (e.g., substance use counseling, groups), and
      vii. Personal care services (refer to AAC R9-10-702, R9-10-715, R9-10-814 for additional licensing requirements).

4. The BHRFs shall demonstrate adherence to best practices for treating specialized service needs as applicable to the population served, within their identified scope of practice, including but not limited to:
   a. Cognitive/intellectual disability,
   b. Cognitive disability with comorbid behavioral health condition(s),
   c. Older adults, and co-occurring disorders (substance use and behavioral health condition(s), or
   d. Comorbid physical and behavioral health condition(s).

5. The BHRF providers shall ensure that the BHRF maintains a separate, individualized medical records for all members admitted which include the medical history, physical examination as required for admission to a BHRF and the individualized treatment plan in accordance with AAC R9-10-707.

6. The BHRF providers shall ensure that each member receives a behavioral health assessment before treatment is initiated, and within 48 hours of admission.

7. The BHRF providers shall ensure that each member receives a BHRF treatment plan, which connects back to the member's service plan. The applicable outpatient treatment team shall be included and involved in the development of the treatment plan within 48 hours of admission and ensure to include documentation in the event a medically necessary service is identified as a specific member need that cannot otherwise be met as required within the BHRF setting and scope of service, inclusive of the overseeing BHP:
   a. The BHRF staff, including the BHRF BHP, the outpatient treatment team, the member, and, as applicable, the HCDM, shall meet to review and modify the treatment plan at least once a month,
   b. The BHRF treatment plan shall align with The Arizona Vision 12 Principles for Children's Behavioral Health Service Delivery as directed in AMPM Policy 580, or The Nine Guiding Principles as specified in AMPM Exhibit 300-3 for Recovery Oriented Adult Behavioral Health Services and Systems,
   c. Be specific to the member's physical and behavioral health condition(s), and reason for admission,
   d. Be developmentally appropriate,
   e. Include measurable and achievable goals,
   f. Be based upon the member's unique needs and tailored to the member, HCDM, and/or family member(s) choices where possible, and
   g. Support the member's improved or sustained functioning and integration into the community.

**B. ADMISSION CRITERIA**

The Contractor shall develop admission criteria for medical necessity which, at a minimum, includes the below elements. The Contractor shall publish medical necessity criteria on the contractor's website as specified in ACOM Policy 404.

The BHRF providers, including those providing services to FFS members, are required to adhere to the below elements:

1. The member has a diagnosed behavioral health condition which reflects the symptoms and behaviors necessary for a request for residential treatment level of care. The behavioral health condition causing the significant functional and/or psychosocial impairment shall be evidenced in the assessment by the following:
   a. At least one area of significant risk of harm within the past three months as a result of:
      i. Thoughts or behaviors of suicide, homicide, or harm to self or others,
      ii. Impulsivity with poor judgment/insight,

iii. Maladaptive physical or sexual behavior, or
iv. Inability to remain safe within environment, despite environmental support (i.e., informal support),

**AND**

b. At least one area of serious functional impairment as evidenced by:
   i. An inability to complete developmentally appropriate self-care or self-regulation due to behavioral health condition(s),
   ii. Neglect or disruption of the ability to attend to majority of basic needs, such as personal safety, hygiene, nutrition, or medical care,
   iii. Frequent inpatient psychiatric admissions, or legal involvement due to lack of insight or judgment associated with psychotic or affective/mood symptoms or major psychiatric disorders,
   iv. Frequent withdrawal management services, which can include but are not limited to, detox facilities, Medicated Assisted Treatment (MAT), Medications for Opioid Use Disorder (MOUD) and ambulatory detox,
   v. An inability to independently self-administer medically necessary psychotropic medications despite interventions such as education, regimen simplification, daily outpatient dispensing, and long-acting injectable medications, or
   vi. Impairments persisting in the absence of situational stressors that delay recovery from the presenting problem.

2. A behavioral health need for 24-hour supervision to develop adequate and effective coping skills that will allow the member to live safely in the community.

3. Anticipated stabilization cannot be achieved in a less restrictive setting.

4. Evidence that behavioral health treatment in a less restrictive level of care (e.g., Intensive Outpatient Program (IOP), partial hospitalization program, etc.) has not been successful, is not clinically appropriate, or is not available, therefore warranting a higher level of care.

5. The member or guardian agrees to participate in the treatment. In the case of those who have a Health Care Decision Maker (HCDM), including minors, the HCDM also agrees to, and participates as part of, the treatment team.

6. The agreement to participate in treatment is not a requirement for individuals who are court ordered to a secured BHRF.

7. The member's outpatient treatment team shall be part of the pre-admission assessment and treatment plan formulation, including when the documentation is created by another qualified provider. Exception to this requirement exists when the member is evaluated by the crisis provider, Emergency Department (ED), Correctional Facility, or Behavioral Health Inpatient Facility (BHIF).

8. The BHRF shall notify the member's outpatient treatment team, including the TRBHA for members assigned to a TRBHA, of admission prior to creation of the BHRF treatment plan.

**C. EXCLUSIONARY CRITERIA**

Admission to a BHRF shall not be used as a substitute for the following:

1. An alternative to detention or incarceration.

2. As a means to ensure community safety in circumstances where a member is exhibiting primarily conduct disorder behavior without the presence of risk or functional impairment.

3. A means of providing safe housing, shelter, supervision, or permanent placement.

4. Behavioral health intervention when other less restrictive alternatives are available and meet the member's treatment needs, including situations where the member/HCDM are unwilling to participate in the less restrictive alternative.

5. An intervention for elopement or wandering behaviors unrelated to the individual's behavioral health condition.

**D. CRITERIA FOR CONTINUED STAY**

1. The Contractor shall develop and publish medical necessity criteria for continued stay on the Contractor's website, which at a minimum includes the below elements:
   a. A copy of the current treatment plan including documentation of required reviews and updates by the BHRF on a regular basis, and shall include the following:
      i. Review of all treatment services being provided to the member,
      ii. Review of member's progress towards the treatment goals,
      iii. Assessment of risk and functional impairment as a result of a behavioral health condition,
      iv. Availability and appropriateness of providers and supports available to meet the member's current behavioral and physical health needs at a less restrictive lower level of care, and
      v. Adjustments to treatment interventions, frequency, crisis/safety planning, and targeted discharge to support the need for continued stay.
   b. Documentation of current progress and/or regression toward meeting treatment goals,
   c. Documentation of the continued display of risk and functional impairment that cannot be supportive in a less restrictive lower level of care, and
   d. Documentation of treatment interventions, frequency, crisis safety planning and revised discharge plan.

2. The BHRF providers providing services to FFS members are required to submit to AHCCCS Division of Fee-For-Service Management (DFSM) documentation of all participants in the treatment planning during the continued stay review process and to adhere to the requirements specified above.

**E. DISCHARGE READINESS AND PLANNING**

1. The Contractor shall develop and publish medical necessity criteria on the contractor's website. Discharge planning shall begin at the time of admission. Discharge readiness shall be assessed by the BHRF staff in coordination with the applicable treatment team during each treatment plan review and update.

2. The Contractor shall ensure that discharge criteria include, at a minimum, the following:
   a. Reduction in symptoms and/or behavior(s) as evidenced by completion of treatment plan goals,
   b. Functional capacity is improved, essential functions such as eating or hydrating necessary to sustain life have significantly improved or are able to be cared for in a less restrictive level of care,
   c. The member can participate in needed monitoring, or a caregiver is available to provide monitoring in a less restrictive level of care,
   d. The providers and supports are available to meet current behavioral and physical health needs at a less restrictive level of care, and
   e. Ongoing support and service providers that the member will be engaged with upon discharge shall be included in discharge planning meetings, where initial step-down goals and follow-up treatment plans will be created.

3. The Contractor shall ensure that the member and HCDM, as applicable:
   a. Are involved and participate in the discharge planning process,
   b. Understand the written discharge plan, instructions, and recommendations provided by the facility, and
   c. Are provided resources, referrals and possible interventions, including housing, to meet the member's assessed and anticipated needs after discharge.

4. The final discharge plan shall be documented in the member's medical record and shall include:
   a. Progress toward treatment goals,
   b. Follow up treatment plan and safety plan compliant with AMPM Policy 320-0,
   c. Follow up appointment with the PCP and/or specialist for service, within seven days of discharge, is scheduled,
   d. Plan for medication pick up and coordination of outgoing medication management, and
   e. The BHRF coordination and/or referral is complete, acceptance confirmed, and discharge date has been communicated to ensure safe and clinically appropriate discharge, with the following:
      i. Confirmation of discharge location or step-down level of care,
      ii. Outpatient providers,
      iii. Community support services,
      iv. Transportation services, and
      v. All other support and services identified in the discharge plan, which may include but not limited to Durable Medical Equipment (DME) as specified in AMPM Policy 310-P, home health services as specified in AMPM Policy 310-I, etc.

5. The BHRFs shall notify the applicable Contractor, AHCCCS DFSM, the assigned TRBHA, and/or Tribal ALTCS case manager, upon member discharge and include the discharge plan with member's disposition including follow up appointments with outpatient behavioral health services. For FFS members, this notification shall take place via the PA process. The discharge plan for TRBHA enrolled members shall be submitted securely to the assigned TRBHA case manager or TRBHA designee.

6. The BHRF providers providing services to FFS members are required to adhere to all of the minimum discharge readiness and planning elements as described in this section.

## F. BEHAVIORAL HEALTH RESIDENTIAL FACILITY AND MEDICATION ASSISTED TREATMENT (MAT)/MEDICATIONS FOR OPIOID USE DISORDER (MOUD)

The Contractor and BHRF Providers, including BHRF providers serving FFS members, shall establish policies and procedures to ensure members on MAT or Medications for Opioid Use Disorder (MOUD) are not excluded from admission and are able to receive MAT to ensure compliance with ARS 36-2062.

## G. BEHAVIORAL HEALTH RESIDENTIAL FACILITES WITH PERSONAL CARE SERVICE LICENSE

The BHRFs that provide personal care services shall be licensed to provide personal care services. The services offered shall be in accordance with AAC Title 9, Chapter 10. The Contractors and BHRF providers shall ensure that all identified needs can be met in accordance with AAC R9-10-715.

Examples of services that may be provided include, but are not limited to:

1. Administration of oxygen.
2. Application and care of orthotic devices.
3. Application and care of prosthetic devices.
4. Application of bandages and medical supports, including high elastic stockings.
5. All Cotton Elastic wraps, arm, and leg braces, etc.
6. Application of topical medications.
7. Assistance with ambulation.
8. Assistance with correct use of cane/crutches.
9. Bed baths.
10. Blood sugar monitoring, Accu-Check diabetic care.

11. Care of hearing aids.
12. Catheter care.
13. Denture care and brushing teeth.
14. Dressing member.
15. Gastrostomy tube (G-tube) care.
16. Hair care, including shampooing.
17. Incontinence support, including assistance with bed pans/bedside commodes/ bathroom supports.
18. Measuring and giving insulin, glucagon injections.
19. Measuring and recording blood pressure.
20. Non-sterile dressing change and wound care.
21. Ostomy and surrounding skin care.
22. Passive range of motion exercises.
23. Radial pulse monitoring.
24. Respiration monitoring.
25. Use of pad lifts.
26. Shaving.
27. Shower assistance using shower chair.
28. Skin and foot care.
29. Skin maintenance to prevent and treat bruises, injuries, infections and pressure sores. Members with a stage 3 or 4 pressure sore are not to be admitted to BHRF [AAC R9-10-715(3)].
30. Supervising self-feeding of members with swallowing deficiencies.
31. Use of chair lifts.