

**320-T1 – BLOCK GRANTS AND DISCRETIONARY GRANTS**

EFFECTIVE DATE: 07/01/20 as specified in Section F, MENTAL HEALTH BLOCK GRANT, 10/01/20, 10/01/21

APPROVAL DATES: 05/04/21, 08/10/21

**I. PURPOSE**

This Policy applies to ACC, DCS/Comprehensive Health Plan (CHP), DES/DDD (DDD), ALTCS E/PD, RBHA Contractors, and other entities who have a direct Non-Title XIX/XXI funded contractual relationship with AHCCCS (collectively ‘Contractors’; and Fee-For-Service (FFS) Programs including: American Indian Health Program (AIHP), TRBHAs, Tribal ALTCS, and all FFS populations. This Policy specifies Non-Title XIX/XXI behavioral health services funded by Block Grants and Discretionary Grants available for members and Care Coordination requirements of all involved entities to ensure each member’s continuity of care. For Tribal ALTCS refer to the Intergovernmental Agreements (IGAs).

**II. DEFINITIONS**

For purpose of this policy:

**ELIGIBLE POPULATION** Populations that are acknowledged within a specific grant or funding requirements that are identified as the only allowable population on whom those specific funds may be expended. Eligible populations are identified using demographic information. Different grants or funding sources may have varying priority populations.

**FIRST EPISODE PSYCHOSIS (FEP) PROGRAM** A program focused on the early identification and provision of evidence-based treatment and support services to individuals, who have experienced a First Episode of Psychosis (FEP) within the past two years. Evidence-based FEP programs have been shown to improve symptoms, reduce relapse, and lead to better outcomes. A commonly used evidenced based model is Coordinated Specialty Care, which is a recovery-based approach that uses shared decision making and offers case management, psychotherapy, medication management, family education and support, and supported education or employment.

**MEMBER** An eligible individual who is enrolled in AHCCCS, as defined in A.R.S. § 36-2931, § 36-2901, and A.R.S. § 36-2981, referred to as Title XIX/XXI member or Medicaid member. Also, an eligible individual who needs or may be at risk of needing covered health-related services but does not meet federal and state requirements for Title XIX or Title XXI eligibility, referred to as Non-Title XIX/XXI member.

**NON-TITLE  
XIX/XXI FUNDING**

Fixed, non-capitated funds, from Block Grants and Discretionary Grants which are used to fund services to Non-Title XIX/XXI members and for medically necessary services not covered by Title XIX or Title XXI programs.

**PRIMARY PREVENTION**

Delivered prior to the onset of a condition, these services or interventions are intended to prevent or reduce the risk of developing a behavioral health or substance use problem.

**PRIMARY PREVENTION  
EVIDENCE BASED  
PRACTICES  
(SUBSTANCE ABUSE  
ONLY)**

Interventions that fall into one or more of three categories:

1. The intervention is included in a federal registry of evidence-based interventions, or
2. The intervention produced positive effects on the primary targeted outcome, and these findings are reported in a peer-reviewed journal, or
3. The intervention has documented evidence of effectiveness, based on guidelines developed by the Center for Substance Abuse Prevention and/or the state, tribe, or jurisdiction in which the intervention took place. Documented evidence should be implemented under four recommended guidelines, all of which shall be followed. These guidelines require interventions to be:
  - a. Based on a theory of change that is documented in a clear logic or conceptual mode,
  - b. Similar in content and structure to interventions that appear in federal registries of evidence-based interventions and/or peer-reviewed journals,
  - c. Supported by documentation showing it has been effectively implemented in the past, multiple times, and in a manner attentive to scientific standards of evidence. The intervention results should show a consistent pattern of credible and positive effects, and
  - d. Reviewed and deemed appropriate by a panel of informed prevention experts that includes qualified prevention researchers experienced in evaluating prevention interventions similar to those under review, local prevention professionals, and key community leaders, as appropriate (for example, law enforcement officials, educators, or elders within indigenous cultures).

**SECONDARY  
PREVENTION**

Aims to reduce the impact of a behavioral health or substance use disorder that has already occurred. This is done by detecting and treating a behavioral health or substance use disorder as soon as possible to halt or slow its progress, encouraging personal strategies to prevent recurrence, and implementing programs to return people to their original health and function to prevent long-term problems.

Additional definitions are located on the AHCCCS website at: [AHCCCS Contract and Policy Dictionary](#).

### **III. POLICY**

ACCCHP, DDD, ALTCS E/PD Contractors, AIHP, and FFS Providers do not receive or administer Non-TXIX/XXI funds. Per the Non-Title XIX/XXI Contracts/Intergovernmental Agreements (IGAs), the RBHAs and TRBHAs are responsible for administering Non-Title XIX/XXI funds. The RBHAs, TRBHAs, and other entities that have a direct Non-Title XIX/XXI funded contractual relationship with AHCCCS shall manage available Non-Title XIX/XXI funds in a manner consistent with the Non-Title XIX/XXI's identified Eligible Populations.

Contractors, TRBHAs, Tribal ALTCS, and FFS providers shall assist Members in accessing services utilizing these funding sources and shall coordinate care for Members as appropriate. For Tribal ALTCS members, providers shall contact the Tribal ALTCS Program of enrollment if they feel a member qualifies for a Non-Title service.

#### **A. GENERAL REQUIREMENTS FOR CODING/BILLING**

All applicable Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) for Non-Title XIX/XXI Services are listed in the AHCCCS Behavioral Health Services Matrix () found on the AHCCCS website. Providers are required to utilize national coding standards including the use of applicable modifier(s). Refer to the AHCCCS Medical Coding Resources webpage.

For outpatient behavioral health services, services are considered medically necessary, as specified in A.A.C. R9-22-101, regardless of a member's diagnosis, if there are documented behaviors and/or symptoms that will benefit from behavioral health services and a valid International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) diagnostic code is utilized.

#### **B. NON-TITLE XIX/XXI BEHAVIORAL HEALTH SERVICES**

AHCCCS covers Non-Title XIX/XXI behavioral health services (mental health and/or substance use) within certain limits for Title XIX/XXI and Non-Title XIX/XXI members when medically necessary. Behavioral health services covered under the Block and Discretionary Grants are specified below. Refer to AMPM Policy 320-T2 for services covered under Non-Title XIX/XXI Funding (excluding Federal Grant Funds).

For information and requirements regarding Title XIX/XXI Behavioral Health Services, refer to AMPM Policy 310-B.

All services provided shall have proper documentation maintained in the Member's medical records. For billing limitations, refer to the AHCCCS FFS Provider Manual and AHCCCS Medical Coding Resources webpage.

1. Auricular Acupuncture services is the application of auricular acupuncture needles to the pinna, lobe, or auditory meatus to treat alcoholism, substance use or chemical dependency by a certified acupuncturist practitioner as specified in A.R.S. § 32-3922.

2. Childcare supportive services (also referred to as child sitting services) are covered when providing medically necessary Medication Assisted Treatment (MAT) or outpatient (non-residential) treatment or other supportive services for Substance Use Disorder (SUD) to members with dependent children, when the family is being treated. The following limitations apply:
  - a. The amount of childcare services and duration shall not exceed the duration of MAT or outpatient (non-residential) treatment or support services for SUD being provided to the member whose child(ren) is present with the member at the time of receiving services,
  - b. Childcare services shall ensure the safety and well-being of the child while the member is receiving services that prevent the child(ren) from being under the direct care or supervision of member,
  - c. The child is not an enrolled member receiving billable services from the provider, and
  - d. Other means of support for childcare for the child(ren) are not readily available or appropriate.
3. Mental Health Services (Traditional Healing Services) is Treatment services for mental health or substance use problems provided by qualified traditional healers. These services include the use of routine or advanced techniques aimed to relieve the emotional distress evident by disruption of the individual’s functional ability.
4. Supportive housing services are provided by behavioral health professionals, behavioral health technicians, or behavioral health paraprofessionals, to assist members or families to obtain and maintain housing in an independent community setting including the individual’s own home or apartments and homes owned or leased by a provider.
5. Mental Health Services, Room and Board for the provision of lodging and meals to an individual residing in a residential facility or supported independent living setting which may include but is not limited to:
  - a. Housing costs,
  - b. Services such as food and food preparation,
  - c. Personal laundry, and
  - d. Housekeeping.

This service may also be used to report bed hold/home pass days in Behavioral Health Residential facilities.

For room and board services, the following billing limitations apply:

- a. All other fund sources (e.g. Arizona Department of Child Safety (DCS) funds for foster care children, SSI) shall be exhausted prior to billing this service, and
- b. For Substance Abuse Block Grant (SABG) funding only, room and board services may be available for a member’s dependent child(ren) as a support service for the member when they are receiving medically necessary residential treatment services for a SUD. The room and board shall apply to a member with dependent children when the child(ren) resides with the member at the Behavioral Health Residential Facility (BHRF). The use of this service is limited to:

- i. Members receiving residential services for SUD treatment where the family is being treated as a whole, but the child is not an enrolled member receiving billable services from the provider.
  - ii. Where other means of supports for room and board for the child are not readily available or appropriate.
  - iii. Outpatient Clinics may bill Room and Board code only when providing services to members in Supervised Independent Living settings.
6. **Other Non-Title XIX/XXI Behavioral Health Services**  
For Non-Title XIX/XXI eligible populations, most behavioral health services that are covered through Title XIX/XXI funding are also covered through Non-Title XIX/XXI funding including but not limited to: services provided in a residential setting, counseling, case management, and supportive services, but Non-Title XIX/XXI funded services may be restricted to certain members as specified in this Policy and as specified in AMPM Exhibit 300-2B and are not an entitlement. Services provided through Non-Title XIX/XXI funding are limited by the availability of funds.
7. **Marijuana Restrictions**  
Grant funds may not be used, directly or indirectly, to purchase, prescribe, or provide marijuana or treatment using marijuana. Treatment in this context includes the treatment of opioid use disorder. Grant funds also cannot be provided to any individual who, or organization that, provides or permits marijuana use for the purpose of treating substance use or mental disorders. For example, refer to 45 CFR 75.300(a) which requires Health and Human Services HHS to ensure that federal funding is expended in full accordance with U.S. statutory requirements; and 21 U.S.C. 812(c) (10) and 841 which prohibits the possession, manufacture, sale, purchase, or distribution of marijuana. This prohibition does not apply to those providing such treatment in the context of clinical research permitted by the Drug Enforcement Administration (DEA) and under the Food and Drug Administration (FDA) approved investigational new drug application where the article being evaluated is marijuana or a constituent thereof that is otherwise a banned controlled substance under federal law.

### **C. NON-TITLE XIX/XXI ELIGIBLE POPULATIONS**

Non-Title XIX/XXI eligible members are enrolled with a RBHA or TRBHA and other entities who have a direct Non-Title XIX/XXI funded contractual relationship with AHCCCS, enrollment is based on the zip code or tribal community in which the member resides. When encounters are submitted for “unidentified” members (such as in crisis situations when an individual’s eligibility or enrollment status is unknown), The Contractor shall require their providers to use the applicable pseudo-ID numbers that are assigned to each RBHA. For assistance, contact the AHCCCS/Division of Health Care Management (DHCM)/Operations, Encounters Unit. Pseudo-ID numbers are not assigned to TRBHAs. Encounters are not submitted for prevention services.

RBHAs and TRBHAs are responsible for crisis intervention services for Non-Title XIX/XXI members for up to 72 hours. Refer to AMPM Policy 310-B or TRBHA Intergovernmental Agreement (IGA) for a detailed description of crisis intervention services and responsibilities.

**D. SUBSTANCE ABUSE BLOCK GRANT****1. Purpose and Goals**

The SABG is a Formula Grant, which supports treatment services for Title XIX/XXI and Non-Title XIX/XXI members with SUDs and primary substance use and misuse prevention efforts. The SABG is used to plan, implement, and evaluate activities to prevent and treat SUDs. Grant funds are also used to provide early intervention services for Human Immunodeficiency Virus (HIV) and tuberculosis disease in high-risk members who use substances.

The SABG is specifically allocated to provide services that are not otherwise covered by Title-XIX/XXI funding. Refer to AMPM Exhibit 300-2B for additional information on SABG covered services.

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

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

**2. Eligible Populations**

All Members receiving SABG-funded services are required to have a Title XIX/XXI eligibility screening and application completed and documented in the medical record at the time of intake and annually thereafter.

- a. Members shall indicate active substance use within the previous 12 months to be eligible for SABG treatment services. This includes individuals who were incarcerated and reported using while incarcerated. The 12 month standard may be waived for individuals:
  - i. On medically necessary methadone maintenance upon assessment for continued necessity, and/or
  - ii. Incarcerated for longer than 12 months that indicate substance use in the 12 months prior to incarceration.

**3. Priority Populations**

SABG funds are used to ensure access to treatment and long-term supportive services for the following populations (in order of priority):

- a. Pregnant women/teenagers who use drugs by injection,

- b. Pregnant women/teenagers with a SUD,
  - c. Other individuals who use drugs by injection,
  - d. Women and teenagers with a SUD, with dependent children and their families, including women who are attempting to regain custody of their children, and
  - e. All other individuals with a SUD, regardless of gender or route of use, (as funding is available).
4. Grant funding is the payor of last resort for Title XIX/XXI behavioral health covered services which have been exhausted (e.g. respite), Non-Title XIX/XXI covered services, and for Non-Title XIX/XXI eligible members for any services. Grant funding shall not be used to supplant other funding sources. If funds from the Indian Health Services (IHS) and/or Tribal owned/or operated facilities are available, the IHS/638 funds shall be treated as the payor of last resort.
5. Adolescents in Detention - Most adjudicated youth from secure detention do not have community follow-up or supervision, therefore, risk factors remain unaddressed. Youth in juvenile justice systems often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Contractors and TRBHAs requesting to use SABG funding shall provide AHCCCS with a comprehensive and detailed plan that includes services and activities that will be provided to adolescents in detention. AHCCCS approval is contingent on funding availability and the Contractor's and TRBHA's comprehensive and detailed plan. For adolescents in detention the following limitations apply:
  - a. Services may only be provided in juvenile detention facilities meeting the description provided by the Office of Juvenile Justice and Delinquency Prevention (OJJDP). Although Title XIX services are limited for inmates of public institutions, for purposes of administering SABG, juvenile detention facilities are used only for temporary and safe custody, are not punitive, and are not correctional or penal institutions,
  - b. Services shall be provided:
    - i. Only to voluntary members,
    - ii. By qualified Behavioral Health Professional (BHPs)/Behavioral Health Technician (BHTs)/Behavioral Health Paraprofessional (BHPPs),
    - iii. Based upon assessed need for SUD services,
    - iv. Utilizing Evidence-Based Psychotherapy Practice (EBPPs),
    - v. Following an individualized service plan,
    - vi. For a therapeutically indicated amount of duration and frequency, and
    - vii. With a relapse Prevention plan completed prior to discharge/transfer to a community-based provider.
6. Charitable Choice of SABG Providers - Members receiving SUD treatment services under the SABG have the right to receive services from a provider to whose religious character they do not object. Behavioral health providers providing SUD treatment services under the SABG shall notify members at the time of intake of this right utilizing Attachment A. Providers shall document that the member has received notice in the member's medical record.

If a member objects to the religious character of a behavioral health provider, the provider shall refer the member to an alternate provider within seven days, or earlier when clinically indicated, after the date of the objection. Upon making such a referral, providers shall notify the RBHAs or TRBHAs, of the referral and ensure that the member contacts the alternative provider. RBHAs and TRBHAs shall develop and make available policies and procedures that indicate who the providers shall contact and how they shall notify the RBHAs or TRBHA of these referrals. RBHAs and TRBHAs' providers shall maintain a list of all referrals to alternate providers regarding charitable choice requirements to be provided to AHCCCS upon request [42 CFR Part 54 and 54a].

7. Ensure that providers promptly submit information for priority population members (i.e. pregnant women, women with dependent children, and PWID) who are waiting for placement in a BHRF, to the AHCCCS SABG priority population waitlist, or in a different format upon written approval from AHCCCS as specified in Contract. Title XIX/XXI members may not be added to the AHCCCS SABG priority population waitlist.

Priority population members who are not pregnant, parenting women, or PWID shall be added to the AHCCCS SABG priority population waitlist if the RBHAs, TRBHAs, or their providers are not able to place the member in a BHRF within the response timeframes for designated behavioral health services as specified in Contract.

For women who are pregnant, the requirement is within 48 hours, for women with dependent children the requirement is within five calendar days, and for all PWID the requirement is within 14 calendar days.

8. HIV Early Intervention Services - Because individuals with SUDs are considered at high risk for contracting HIV-related illness, the SABG requires HIV intervention services to reduce the risk of transmission of this disease. With respect to individuals undergoing treatment for substance use, the RBHAs/TRBHAs shall make available to the individual HIV early intervention services as specified in 45 CFR 96.121 at the sites in which the individuals are undergoing such treatment.

RBHAs and TRBHAs receiving SABG funding, shall develop and make available to provider's policies and procedures that describe where and how to access HIV early intervention services, noting that services are provided exclusively to populations with SUDs. RBHAs and TRBHAs offering intervention services shall:

- a. Provide early intervention services for HIV in geographic areas of the state that have the greatest need and rural areas,
- b. Require programs to establish linkages with a comprehensive community resource network of related health and social services organizations to ensure a wide-based knowledge of the availability of these services,
- c. Ensure behavioral health providers provide specialized, evidence-based treatment and recovery support services for all SABG populations,
- d. Administer a minimum of one test per \$600 in SABG HIV early intervention services,



- e. Conduct site visits to HIV early intervention services providers where the Contractor’s HIV Coordinator, subcontracted provider staff, and supervisors are present. Each site visit shall include the attendance at one education class, and
  - f. Collect SABG HIV Activity Reports from providers, training materials provided to HIV coordinators and HIV early intervention services providers, and other ad hoc reports related to HIV prevention issues.
9. Tuberculosis (TB) Services
- As specified in 45 CFR Part 96 Sect. 127, providers shall routinely make available tuberculosis services as defined in 45 CFR 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. As per 45 CFR 96.121, TB services include:
- a. Counseling the individual with respect to tuberculosis,
  - b. Testing to determine whether the individual has been infected with mycobacteria tuberculosis to determine the appropriate form of treatment for the individual, and
  - c. Providing for or referring the individuals infected by mycobacteria tuberculosis for appropriate medical evaluation and treatment.

The Contractor shall submit the SABG TB Services Treatment Procedure and Protocol as specified in Contract. This deliverable shall include the following information items:

- a. At the time of intake, 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,
  - b. In the case of an individual in need of such treatment who is denied admission to the program on the basis of the lack of the capacity of the program to admit the individual, will refer the individual to another provider of tuberculosis services,
  - c. Implement infection control procedures designed to prevent the transmission of tuberculosis, including the following:
    - i. Screening of patients,
    - ii. Identifying those individuals who are at high risk of becoming infected,
    - iii. Meeting all state reporting requirements while adhering to federal and state confidentiality requirements, including 42 CFR part 2, and
    - iv. Conducting case management activities to ensure that individuals receive such services.
10. Considerations for providers when delivering services to SABG populations:
- a. SABG treatment services shall be designed to support the long-term treatment and substance-free recovery needs of eligible members,
  - b. Providers of treatment services that include clinical care to those with a SUD shall also be designed to have the capacity and staff expertise to utilize FDA-approved medications for the treatment of SUD/Opioid Use Disorder (OUD) and/or have collaborative relationships with other providers for service provision,
  - c. Specific requirements apply regarding preferential access to services and the timeliness of responding to a member’s identified needs, and
  - d. Providers shall submit specific data elements and record limited clinical information. Refer to the AHCCCS DUGless Portal Guide for requirements.

11. Restrictions - Members shall not be charged a copayment for SUD treatment or supportive services funded by the SABG. Sliding scale fees established regarding room and board do not constitute a copayment.

#### **E. SUBSTANCE ABUSE BLOCK GRANT PRIMARY PREVENTION**

Effective as of July 1, 2021, AHCCCS will discontinue allocating the portion of the Substance Abuse Block Grant (SABG) used for substance abuse primary prevention services to the RBHAs. AHCCCS will retain this portion of the SABG substance abuse primary prevention funding and directly contract with providers for substance abuse primary prevention services. TRBHA primary prevention funding mechanisms will remain unchanged.

The purpose of the SABG Primary Prevention funds is to implement strategies that are directed at individuals not identified to need substance abuse treatment.

1. Eligible Populations

Populations at risk for developing substance abuse disorders and related behavioral health consequences.

2. Primary prevention funding shall be used on interventions that prevent the use of substances, or the onset of substance use disorders.

3. A comprehensive prevention program employs a variety of strategies to prevent and reduce substance use. Substance Abuse and Mental Health Services Administration (SAMHSA) developed and approved the following strategies for primary prevention, referred to as Center for Substance Abuse Prevention (CSAP) strategies. Services shall be tailored to individual community or program needs and shall follow the six CSAP strategies.

- a. Information Dissemination- Provides knowledge and increases awareness of the nature and extent of alcohol and other drug use, misuse, and addiction, as well as their effects on individuals, families, and communities,
- b. Education - Builds skills through structured learning processes. Critical life and social skills include decision making, peer resistance, coping with stress problem solving, interpersonal communication, and systematic and judgmental capabilities,
- c. Alternatives - Provides opportunities for target populations to participate in activities that exclude alcohol and other drugs,
- d. Problem Identification and Referral - Aims to identify individuals who have indulged in illegal or age-inappropriate use of tobacco or alcohol, and individuals who have indulged in the first use of illicit drugs, and seeks to refer those individuals out to the appropriate services as needed,
- e. Community-based Process - Provides ongoing networking activities and technical assistance to community groups or agencies, and
- f. Environmental - Establishes or changes written and unwritten community standards, codes, and attitudes.

4. Risk and Protective Factors

Prevention services shall be tailored to address the specific risk and protective factors that are present in the community. Risk factors are defined as characteristics at the

biological, psychological, family, community, or cultural level that precede and are associated with a higher likelihood of negative outcomes. Risk and protective factors and an individual's character interact through six life or activity domains. Within each domain are characteristics and conditions that can function as risk or protective factors, thus each of these domains presents opportunities for prevention. The six domains are as follows: Individual, Family, Peer, School, Community, and Environment/Society.

Protective factors are defined as characteristics associated with a lower likelihood of negative outcomes or that reduce a risk factor's impact. Protective factors may be seen as positive countering events. Risk and protective factors and an individual's character interact through six life or activity domains. Within each domain are characteristics and conditions that can function as risk or protective factors, thus each of these domains presents opportunities for prevention. The six domains are as follows: Individual, Family, Peer, School, Community, and Environment/Society.

5. Evidence Based, Promising, and Innovative Practices/Interventions

Services shall be implemented utilizing Evidenced Based Practices (EBPs) as much as possible, with promising and innovative practices used only in the event there is not an appropriate EBP available to meet the substance abuse prevention needs within the target population.

Evidence Based Practices/Interventions for primary prevention services are defined as interventions that fall into one or more of three categories:

- a. The intervention is included in a federal registry of evidence-based interventions, or
- b. The intervention produced positive effects on the primary targeted outcome, and these findings are reported in a peer-reviewed journal, or
- c. The intervention has documented evidence of effectiveness, based on guidelines developed by the Center for Substance Abuse Prevention and/or the state, tribe, or jurisdiction in which the intervention took place. Documented evidence shall be implemented under four recommended guidelines, all of which shall be followed. These guidelines require interventions to be:
  - i. Based on a theory of change that is documented in a clear logic or conceptual mode,
  - ii. Similar in content and structure to interventions that appear in federal registries of evidence-based interventions and/or peer-reviewed journals,
  - iii. Supported by documentation showing it has been effectively implemented in the past, multiple times, and in a manner attentive to scientific standards of evidence. The intervention results shall show a consistent pattern of credible and positive effects, and
  - iv. Reviewed and deemed appropriate by a panel of informed prevention experts that includes qualified prevention researchers experienced in evaluating prevention interventions similar to those under review, local prevention professionals, and key community leaders, as appropriate (e.g. law enforcement officials, educators, or elders within indigenous cultures).

6. Promising Practices/Interventions for primary prevention services are defined as interventions based on statistical analyses or a well-established theory of change,

shows potential for meeting the “evidence-based” or “research based” criteria, and shall include the use of a program that is evidence-based for outcomes other than the alternative use.

7. Innovative Practices/Interventions for primary prevention services are defined as interventions that serve a target population and have a promising approach but need further refinement to become ready for rigorous evaluation.
8. Restrictions - Funds cannot be used to provide treatment services, general mental health services, secondary or tertiary prevention, or suicide prevention. All funded interventions shall have a substance use/abuse outcome.

#### **F. MENTAL HEALTH BLOCK GRANT**

The Mental Health Block Grant (MHBG) is a Formula Grant, which provides treatment services for Title XIX/XXI and Non-Title XIX/XXI members with Serious Mental Illness (SMI) and Serious Emotional Disturbances (SED) or First Episode Psychosis (FEP). The MHBG provides services that are not otherwise covered by Title-XIX/XXI funding. This includes mental health treatment and supportive services for individuals who do not qualify for Title XIX/XXI eligibility. MHBG funds are only to be used for allowable services identified in AMPM Exhibit 300-2B.

1. The MHBG is allocated by SAMHSA for:
  - a. Providing services within the immediate community,
  - b. Providing community mental health services for adults with a serious mental illness and children with a serious emotional disturbance,
  - c. Providing crisis services to eligible populations,
  - d. Carrying out the plan submitted under section 300x-1(a) of U.S.C 42 by the state for the fiscal year involved,
  - e. Evaluating programs and services carried out under the plan, and
  - f. Planning, administration, and educational activities related to providing services under the plan.
2. Goals of the MHBG include, but are not limited to the following:
  - a. Ensuring access to a comprehensive system of care, including employment, housing services, case management, rehabilitation, dental services, and health services, as well as mental health services and supports,
  - b. Promoting participation by consumer/survivors and their families in planning and implementing services and programs, as well as in evaluating state mental health systems,
  - c. Ensuring access for underserved populations, including people who are homeless, residents of rural areas, and older adults,
  - d. Promoting recovery and community integration for adults with SMI and children with SED, and
  - e. Increasing accountability through uniform reporting on access, quality, and outcomes of services.

3. Eligible Populations

All Non-Title XIX/XXI individuals receiving MHBG-funded services are required to have a Title XIX/XXI eligibility screening and application completed and documented in the medical record at the time of intake and annually thereafter.

To be eligible for services under MHBG, members shall be determined to have a SMI, an SED, or Early Serious Mental Illness (ESMI)/FEP.

Screening/assessments are covered for Non-Title XIX/XXI eligible members when the screening is a primary screening, and/or the screening are being considered for admission to mental health facilities to determine the appropriateness of such admission. A secondary provider assessment and screening to decide determinations is unallowable. Other funding sources, such as the State General Fund appropriations for SMI shall be utilized before block grant funding to ensure block grants are the payor of last resort. Refer to AMPM Policy 320-O for additional information on behavioral health assessments and treatment/service planning.

For information regarding SMI eligibility determination, refer to AMPM Policy 320- P.

For more information regarding qualifying diagnoses, refer to the AHCCCS Behavioral Health Diagnosis List found on the AHCCCS website [www.azahcccs.gov](http://www.azahcccs.gov). Excluded conditions, as specified in the 58 Federal Register 29422 (May 20, 1993), are substance use disorders, developmental disorders, such as autism, and disorders as specified in Z codes as listed in ICD-10 CM unless the condition is co-occurring with a diagnosable serious emotional disturbance.

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

- 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, and
- i. Depressive Disorders, with psychotic features.

Members do not have to be or designated as SMI or SED to be eligible for FEP services.

Individuals who are accessing FEP MHBG services can be General Mental Health (GMH) at the beginning, or throughout their FEP episode of care.

4. MHBG funding is the payor of last resort for Title XIX/XXI behavioral health covered services which have been exhausted (e.g. respite), Non-Title XIX/XXI covered

- services, and for Non-Title XIX/XXI eligible Members for any services. Grant funding shall not be used to supplant other funding sources except that, if funds from the Indian Health Services (IHS) and/or Tribal owned/or operated facilities are available, the IHS/638 funds shall be treated as the payor of last resort.
5. Effective 7/1/20, MHBG Funds for Payment of Behavioral Health Drugs for Individuals Designated with an SMI (Both Title XIX/XXI and Non-Title XIX/XXI):
    - a. The TRBHAs and RBHA Contractors shall utilize available MHBG Funds to cover applicable Medicare Part D copayments and cost sharing amounts, including payments for the Medicare Part D coverage gap, for medications to treat behavioral health diagnoses for Title XIX/XXI and Non-Title XIX/XXI individuals with an SMI designation, subject to the following:
      - i. Coverage of cost sharing is to be used only for federal and state reimbursable medications used to treat an SMI diagnoses,
      - ii. Medicare copayments and cost sharing are covered medications to treat an SMI behavioral health diagnoses when dispensed by an AHCCCS-registered provider,
      - iii. The payment of Medicare Part D copayments and cost sharing amounts for medications to treat individuals with an SMI designation, shall be provided regardless of whether or not the provider is in the Contractor's provider network or whether or not prior authorization has been obtained,
      - iv. The RBHA Contractors shall not apply pharmacy benefit utilization management edits when coordinating reimbursement for Medicare Cost Sharing for medications to treat individuals with an SMI designation,
      - v. When a request for a medication to treat an individual with an SMI designation has been denied by the Medicare Part D plan and the denial has been upheld through the appeals process, the Contractor shall evaluate the request and may elect to utilize MHBG Funds, if applicable, to cover the cost of the non-covered Medicare Part D medication to treat an individual with an SMI designation, and
    - b. The Contractor does not have the responsibility to make Medicare Part D copayments and cost sharing payments to pharmacy providers that are not AHCCCS registered.
  6. Services - The MHBG covers community mental health treatment and support services for eligible populations within certain limits for Title XIX/XXI and Non-Title XIX/XXI Members when medically necessary. Refer to AMPM Exhibit 300-2B for additional information on MHBG covered services.
  7. Incarcerated Populations - Treatment during incarceration is an allowable use of the MHBG within the SMI and SED populations, provided that the treatment services as well as provider of such services meets the statutory requirements of the MHBG. Provision of comprehensive services shall occur through appropriate qualified community programs. Service providers can include community-based mental health centers, child mental health programs, psychosocial rehabilitation programs, mental health/peer support services, and mental health primary consumer-directed programs. Allowable services within this population include 24-hour a day crisis intervention services, day treatment/partial hospital, intensive outpatient treatment, and psychiatric rehabilitation services.

Adolescents in Detention - Most adjudicated youth from secure detention do not have community follow-up or supervision, therefore, risk factors remain unaddressed. Youth in juvenile justice systems often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Contractors and TRBHAs not already providing these services for the SED population in detention facilities requesting to use MHBG funding shall provide AHCCCS with a comprehensive and detailed plan that includes services and activities that will be provided. AHCCCS approval is contingent on funding availability and contractor's and TRBHA's comprehensive and detailed plan.

Adolescents in Detention Coverage Limitations:

- a. Services may only be provided in juvenile detention facilities meeting the description provided by the OJJDP. Juvenile detention facilities are used only for temporary and safe custody, are not punitive, and are not correctional or penal institutions,
  - b. Services shall be provided:
    - i. Only to voluntary members,
    - ii. By qualified BHPs/BHTs/BHPPs,
    - iii. Based upon assessed need for SED services,
    - iv. Utilizing EBPPs,
    - v. Following an individualized service plan,
    - vi. For a therapeutically indicated amount of duration and frequency, and
    - vii. With a transition plan completed prior to transfer to a community-based provider, and
8. Non-Encounterable MHBG Activities or Positions - MHBG SED services for outreach activities or positions that are non-encounterable can be an allowable expense, but they shall be tracked, activities monitored, and outcomes collected on how the outreach is getting access to care for those members with SED. Furthermore, the use of MHBG SED funds in schools is allowable if the following requirements are met:
- a. Funded positions or interventions cannot be used to fulfill the requirement for the same populations as the funds for Behavioral Health Services for School-Aged Children listed in the Title XIX/XXI Contract,
  - b. Funded positions cannot bill for services provided,
  - c. Funded positions or interventions need to focus on identifying those with SED and getting those who do not qualify for Title XIX/XXI engaged in services through the MHBG, and
  - d. This funding shall be utilized for intervention, not prevention, meaning that members who are displaying behaviors that could be signs of SED can be assisted, but MHBG funding shall not be used for general prevention efforts to children who are not showing any risks of having SED.

Restricted members shall not be charged a copayment for mental health treatment or supportive services funded by the MHBG. Sliding scale fees established regarding room and board do not constitute a copayment.

Project for Assistance in Transition from Homelessness (PATH) is designed to be an outcome driven grant program to support service delivery to individuals with a SMI, co-occurring SMI and substance use disorders, individuals experiencing homelessness or at imminent risk of homelessness via street outreach and to engage individuals not currently connected to mainstream mental health services, primary health care and substance use service systems. PATH is a formula-based grant program where funds are used to provide a menu of allowable services, including street outreach, case management, and services not supported by mainstream mental health programs.

1. Eligible Populations

- a. Adults (individuals 18 years of age or older) who request or consent to a SMI Eligibility Determination, and
- b. Adults suffering from SMI and/or have co-occurring substance use disorder, or
- c. Adults and families with children who are homeless, or at imminent risk of homelessness.

2. Funding Restrictions

- a. PATH recipients are required to adhere to guidance listed in 45 CFR Part 75 Subpart F, which are available within the Electronic Code of Federal Regulations. In addition, PATH recipients shall comply with the following funding restrictions:
  - i. Grant funds shall only be used for purposes supported by the program,
  - ii. No more than four percent of the Federal PATH funds received shall be used for administrative expenses, as specified in Section 522(f) of the Public Health Service (PHS) Act, as amended (42 U.S.C. § 290cc-22(f), and
  - iii. No more than 20 percent of the Federal PATH funds allocated to the state may be expended for eligible housing services, as specified in Section 522(h)(1) of the PHS Act, as amended (42 U.S.C. § 290cc22(h).
- b. Grant funds may not be used for the following:
  - i. Supporting emergency shelters or construction of housing facilities, providing inpatient psychiatric treatment,
  - ii. Providing inpatient substance use treatment,
  - iii. Making cash payments to intended recipients of mental health or substance use services, or
  - iv. Lease arrangements in association with the proposed PATH project beyond the project period nor for any leased portion of space not supported by the project.

**H. EMERGENCY GRANTS TO ADDRESS MENTAL AND SUBSTANCE USE DISORDERS DURING COVID-19 (EMERGENCY COVID-19)**

The purpose of this program is to provide crisis intervention services, mental and substance use disorder treatment, and other related recovery supports for children and adults impacted by the COVID-19 pandemic. Funding will be provided for states, territories, and tribes to develop comprehensive systems to address these needs. The purpose of this program is specifically to address the needs of individuals with SMI. Additionally, the program will also focus on meeting the needs of individuals with mental disorders that are less severe than serious mental illness, including those in the healthcare profession.



1. Eligible Populations
  - a. Individuals diagnosed with a SMI,
  - b. Individuals diagnosed with SUD,
  - c. Individuals with a co-occurring (SMI/SUD), and
  - d. Individuals with mental disorders that are less severe than SMI.
2. The Contractor and TRBHAs shall use grant funds primarily to provide direct services. Direct service provision shall be implemented as follows:
  - a. 70 percent of direct service funding shall be used to provide direct services to one of the following: those with SMI, those with SUDs, or those with co-occurring SMI and SUDs,
  - b. 10 percent of direct service funding shall be used for healthcare practitioners with mental disorders (less severe than SMI) requiring mental health care because of COVID-19, and
  - c. 20 percent of direct service funding shall be used for all other individuals with mental disorders less severe than SMI. The Contractor(s) shall clearly specify which population(s) will be served.
3. The Contractor and TRBHAs shall utilize third party reimbursements and other revenue realized from the provision of services to the extent possible and use SAMHSA grant funds only for services to individuals who are not covered by public or commercial health insurance programs, individuals for whom coverage has been formally determined to be unaffordable, or for services that are not sufficiently covered by an individual's health insurance plan.
4. The Contractor and TRBHAs shall facilitate the health insurance application and enrollment process for eligible uninsured clients.
5. The Contractor and TRBHAs shall also consider other systems from which a potential member may be eligible for services (e.g. the Veterans Health Administration or senior services), if appropriate for, and desired by, that individual to meet their needs.
6. The Contractor and TRBHAs shall implement policies and procedures that ensure other sources of funding are utilized before Emergency COVID-19 Grants funds are used when other funding sources are available for that individual.
7. Services the Contractor(s) and TRBHAs shall provide the following services as stated in their contract with AHCCCS and approved budget:
  - a. Develop and implement a comprehensive plan of evidence-based mental and/or substance use disorder treatment services for individuals impacted by the COVID-19 pandemic. Ensure that service provision may occur in a telehealth context including the use of telephone,
  - b. Screen and assess clients for the presence of mental and substance use disorders and/or co-occurring disorders, and use the information obtained from the screening and assessment to develop appropriate treatment approaches,
  - c. Provide evidence-based and population appropriate treatment services,
    - i. Provide recovery support services (e.g. linkages to nutrition/food services, individual support services, childcare, vocational, educational, linkages to housing services, and transportation services) which will improve access to,

and retention in services. The Contractor shall ensure the ability to provide these services virtually where needed, and

- ii. Develop and implement crisis mental health services.

8. Restrictions Emergency COVID-19 Grants funds shall not be used to:

- a. Directly or indirectly, purchase, prescribe, or provide marijuana or treatment using marijuana. Treatment in this context includes the treatment of opioid use disorder. Grant funds also cannot be provided to any individual who or organization that provides or permits marijuana use for the purposes of treating substance use or mental disorders. Refer to 45 CFR 75.300(a) (requiring HHS to “ensure that federal funding is expended in full accordance with U.S. statutory requirements.”), 21 U.S.C. §§ 812(c)(10) and 841 (prohibiting the possession, manufacture, sale, purchase, or distribution of marijuana). This prohibition does not apply to those providing such treatment in the context of clinical research permitted by the DEA and under an FDA-approved investigational new drug application where the article being evaluated is marijuana or a constituent thereof that is otherwise a banned controlled substance under federal law,
- b. Pay for promotional items including, but not limited to, clothing and commemorative items such as pens, mugs/cups, folders/folios, lanyards, and conference bags,
- c. Pay for the purchase or construction of any building or structure to house any part of the program,
- d. Provide residential or outpatient treatment services when the facility has not yet been acquired, sited, approved, and met all requirements for human habitation and services provision,
- e. Provide inpatient treatment or hospital-based detoxification services. Residential services are not considered to be inpatient or hospital-based services,
- f. Make direct payments to individuals to enter treatment or continue to participate in prevention or treatment services,
- g. Provide meals unless they are an integral part of a conference grant or specifically stated as an allowable expense. Grant funds may be used for light snacks, not to exceed \$3.00 per individual per day,
- h. 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,
- i. Purchase of Personal Protective Equipment (PPE) except for use by staff charged to the grant. Purchase of PPE for other employees or clients is not an allowable use of these funds, or
- j. Purchase equipment or supplies (e.g. pre-paid minutes, cell phones, hotspots, iPad, tablets) for clients.

## **I. STATE OPIOID RESPONSE GRANT**

The State Opioid Response (SOR) program aims to address the opioid crisis by increasing access to MAT using the three FDA-approved medications including: methadone, buprenorphine products, including single-entity buprenorphine products, buprenorphine/naloxone tablets, films, buccal preparations, long-acting injectable buprenorphine products, buprenorphine implants, and injectable extended-release naltrexone for the treatment of OUD. As well as reducing unmet treatment need and reducing opioid overdose related deaths through the provision of prevention, treatment, and recovery activities for OUD (including illicit use of prescription opioids, heroin, and fentanyl and fentanyl analogs). This program also supports evidence-based prevention, treatment, and recovery support services to address stimulant misuse and use disorders, including for cocaine and methamphetamine.

1. Eligible Populations

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

2. The Contractor and TRBHAs shall implement evidence-based treatments, practices, and interventions for OUD and make available FDA-approved MAT to those diagnosed with OUD.
3. The Contractor and TRBHAs shall implement FDA approved MAT for OUD.

Medical withdrawal (detoxification) is not the standard of care for OUD, is associated with a very high relapse rate, and significantly increases an individual's risk for opioid overdose and death if opioid use is resumed. Therefore, medical withdrawal (detoxification) when done in isolation is not an evidence-based practice for OUD. If medical withdrawal (detoxification) is performed, it shall be accompanied by injectable extended-release naltrexone to protect such individuals from opioid overdose in relapse and improve treatment outcomes.

The Contractor and TRBHAs shall employ effective prevention and recovery support services to ensure that individuals are receiving a comprehensive array of services across the spectrum of prevention, treatment, and recovery.

The Contractor and TRBHAs shall implement evidence-based prevention, treatment, and recovery support services to address stimulant misuse and use disorders.

4. Services - The Contractor and TRBHAs shall offer a comprehensive array of services across the spectrum of prevention, treatment, and recovery for opioid use disorder and stimulant use disorder that shall be tailored to individual community or program needs.

**J. STATE PILOT GRANT PROGRAM FOR TREATMENT FOR PREGNANT AND POSTPARTUM WOMEN**

1. The purpose of the State Pilot Grant Program for Treatment for Pregnant and Postpartum Women (PPW-PLT) is to enhance flexibility in the use of funds designed to:
  - a. Support family-based services for pregnant and postpartum women with a primary diagnosis of a substance use disorder, including opioid use disorder,

- b. Help state substance abuse agencies address the continuum of care, including services provided to pregnant and postpartum women in nonresidential-based settings, and
    - c. Promote a coordinated, effective, and efficient state system managed by state substance abuse agencies by encouraging new approaches and models of service delivery.
  2. Eligible Populations:
    - a. Pregnant and Postpartum Women (PPW) with SUD.
  3. Restrictions - SAMHSA grant funds may not be used to:
    - a. Directly or indirectly, purchase, prescribe, or provide marijuana or treatment using marijuana. Treatment in this context includes the treatment of OUD. Grant funds also cannot be provided to any individual, who or organization that, provides or permits marijuana use for the purposes of treating substance use or mental disorders. See, e.g. 45 C.F.R. 75.300(a) (requiring HHS to “ensure that Federal funding is expended in full accordance with the U.S. statutory requirements.”); 21 U.S.C. §§ 812(c)(10) and 841 (prohibiting the possession, manufacture, sale, purchase, or distribution of marijuana). This prohibition does not apply to those providing such treatment in the context of clinical research permitted by the DEA and under an FDA-approved investigational new drug application where the article being evaluated is marijuana or a constituent thereof that is otherwise a banned controlled substance under federal law,
    - b. Pay for promotional items including, but not limited to, clothing and commemorative items such as pens, mugs/cups, folders/folios, lanyards, and conference bags,
    - c. Pay for the purchase or construction of any building or structure to house any part of the program. (Applicants may request up to \$75,000 for renovations and alterations of existing facilities, if necessary and appropriate to the project),
    - d. Provide residential or outpatient treatment services when the facility has not yet been acquired, sited, approved, and met all requirements for human habitation and services provision. Expansion or enhancement of existing residential services is permissible,
    - e. Provide inpatient treatment or hospital-based detoxification services. Residential services are not considered to be inpatient or hospital-based services,
    - f. Make direct payments to individuals to enter treatment or continue to participate in prevention or treatment services,  
Note: A recipient or treatment or prevention provider may provide up to \$30 non-cash incentive to individuals to participate in required data collection follow up. This amount may be paid for participation in each required follow-up interview,
    - g. For meals unless they are an integral part of a conference grant or specifically stated as an allowable expense in the Funding Opportunity Announcement (FOA). Grant funds may be used for light snacks, not to exceed \$3.00 per person per day, and
    - h. Consolidated Appropriations Action, 2017 (Public Law 115-31) Division H, Section 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.

#### **K. NON-TITLE XIX/XXI FUNDED CARE COORDINATION REQUIREMENTS**

Providers shall make it a priority to work with the RBHA and/or TRBHA to enroll the individual in Non-Title XIX/XXI funded services immediately, while continuing to assist the individual with the processes to determine Title XIX/XXI eligibility. If the individual is deemed eligible for Title XIX/XXI funding, the member can choose a Contractor and American Indian members may choose either a Contractor, or AIHP, or a TRBHA if one is available in their area and receive covered services through that Contractor or AIHP or a TRBHA. The provider shall work with the Care Coordination teams of all involved Contractors or payers to ensure each member’s continuity of care. Members designated as SMI are enrolled with a RBHA. American Indian members designated as SMI have the choice to enroll with a TRBHA for their behavioral health assignment if one is available in their area.

If a Title XIX/XXI member loses Title XIX/XXI eligibility while receiving behavioral health services, the provider shall attempt to prevent an interruption in services. The provider shall work with the care coordinators of the Contractor or RBHA in the GSA where the member is receiving services, or Contractor enrolled or AIHP enrolled members, or the assigned TRBHA, to determine whether the member is eligible to continue services through available Non-Title XIX/XXI funding. If the provider does not receive Non-Title XIX/XXI funding, the provider and member shall work, together to determine where the member can receive services from a provider that does receive Non-Title XIX/XXI funding. The provider shall then facilitate a transfer of the member to the identified provider and work with the Care Coordination teams of all involved Contractors or payors. Contract language and measures stipulate that providers will be paid for treating members while payment details between entities are determined. If a Title XIX/XXI member, whether Contractor or AIHP enrolled, requires Non-Title XIX/XXI services, the provider shall work with the RBHA in the GSA where the member is receiving services, or the assigned TRBHA, to coordinate the Non-Title XIX/XXI services.

An individual who is found not eligible for Title XIX/XXI covered services may still be eligible for Non-Title XIX/XXI services. An individual may also be covered under another health insurance plan, including Medicare. The Contractor shall ensure that subcontractors educate and encourage individuals to enroll in a qualified health plan through the federal health insurance exchange in accordance with ACOM Policy 434 and assist individuals with applying for benefits and programs at the time of intake for behavioral health services. This shall include Arizona Public Programs (Title XIX/XXI, Medicare Savings Programs, Nutrition Assistance, and Cash Assistance), and Medicare Prescription Drug Program (Medicare Part D), including the Medicare Part D “Extra Help with Medicare Prescription Drug Plan Costs” low income subsidy program.

Individuals who refuse to participate in the AHCCCS screening/application process are ineligible for state funded behavioral health services. Refer to A.R.S. § 36-3408 and AMPM Policy 650. The following conditions do not constitute an individual's refusal to participate:

1. An individual's inability to obtain documentation required for the eligibility determination, and/or
2. An individual is incapable of participating because of their mental illness and does not have a legal guardian.

As specified in the U.S. Attorney General's Order No. 2353.2001.4(a), individuals presenting for and receiving crisis, mental health or SUD treatment services are not required to verify U.S. citizenship/lawful presence prior to or in order to receive crisis services.

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

The RBHAs, TRBHAs, and other entities who have a direct Non-Title XIX/XXI funded contractual relationship with AHCCCS are responsible for managing and prioritizing Non-Title XIX/XXI funds to ensure, within the limitation of available funding, that services are available for all individuals, prioritizing those with the highest level of need and eligible members.

RBHAs, TRBHAs, and other entities who have a direct contractual relationship with AHCCCS are responsible for managing Non-TXIX/XXI funding to ensure that funding is available for the fiscal period and if all Non-Title XIX/XXI funding is expended, RBHAs, TRBHAs, and other entities who have a direct Non-Title XIX/XXI funded contractual relationship with AHCCCS shall provide coordination services to address the needs through other community-based options and shall maintain a database of members referred for services that are unable to receive the service due to funding depletion and shall maintain a database of members referred for services that are unable to receive the service due to funding. Members pending services due to funding depletion shall receive follow up to provide alternative services as possible and available until the referred service can be provided.

In addition, the Contractor(s) are responsible for ensuring a comprehensive system of care for Non-Title XIX/XXI eligible members, and members shifting in and out of Title XIX/XXI eligibility. Refer to policy AMPM Policy 100 for information on the Nine Guiding Principles for the Adult System of Care, and on the Twelve Guiding Principles for the Children's System of Care. System development efforts, programs, service provision, and stakeholder collaboration shall be guided by the principles therein.

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

#### **L. NON-TITLE XIX/XXI FUNDING SOURCES**

All Non-Title XIX/XXI funding, as listed in the AHCCCS Allocation Schedule, shall be used for medically necessary behavioral health services only.

RBHAs, TRBHAs, and other entities who have a direct Non-Title XIX/XXI funded contractual relationship shall report each Non-Title XIX/XXI funding source and services separately and provide information related to Non-Title XIX/XXI expenditures to AHCCCS upon request and/or in accordance with AHCCCS Contract/Interagency Service Agreement (ISA)/IGA or as specified in the Allocation Schedule and/or Allocation Letter.

Services provided under Non-Title XIX/XXI funds are to be encounterable. Outreach activities or positions that are non-encounterable can be allowable expenses, but they shall be pre-approved by AHCCCS, tracked, activities monitored, and outcomes collected on how the activities or funded positions are facilitating access to care for Non-Title XIX/XXI eligible populations, as specified in the Non-TXIX/XXI Contract.

Additionally, positions funded exclusively through the Non-Title XIX/XXI funding shall not bill for services to receive additional funding from any fund source. Positions partially funded through the Non-Title XIX/XXI funding may only bill for services during periods when they are not being paid with Non-Title XIX/XXI funds.

Discretionary Grants - This funding can be used for purposes set forth in the various federal grant requirements and as defined in the terms and conditions of the Allocation Schedules or AHCCCS Contract/IGA/[Interagency Service Agreement \(ISA\)](#) and/or Allocation Letters. An example of a discretionary grant includes, but is not limited to, the SOR grant.

#### **M. AHCCCS OVERSIGHT AND MONITORING**

AHCCCS monitors the Contractor and TRBHA for compliance with federal and state statute, regulations, and guidelines to determine if the Contractor(s) are providing services outlined within its AHCCCS Contract. AHCCCS accomplishes monitoring objectives through a variety of techniques, including but not limited to, receiving, and reviewing reports and/or deliverables, holding monthly meetings, monitoring spend through Contractor Expense Reports (CERs), conducting Operational Reviews and/or desk reviews, completing site visits, and other opportunities required with each individual grant requirement.

**N. SABG AND MHBG REPORTING REQUIREMENTS**

Deliverable requirements regarding material changes to Contractor’s Non-Title XIX/XXI provider network are identified in Non-Title XIX/XXI Contracts. For Templates and requirements regarding the submission of a notification indicating material change to provider network, refer to ACOM Policy 439. For reporting requirements related to the Block Grants, RBHAs shall utilize Attachment A through L of this Policy for the corresponding deliverable submissions and as specified in Contract.

The Federal Block Grant Report and Plan Reporting timeframes for the Block Grant Report and are identified in each applicable Contract or IGA/ISA. Templates and other reporting requirements for these deliverables are mandated by SAMHSA and are subject to change. As such, templates for the Federal Block Grant Report and Federal Block Grant Plan will be provided by prior to due dates.

Reports shall include the use of MHBG and SABG programs, and funds documenting activities completed during the time period for monitoring block grant funding.

The Contractor is responsible to comply with oversight and monitoring including all sub-recipient obligations under Federal Block Grant funds.