320-X – ADULT BEHAVIORAL HEALTH THERAPEUTIC HOMES

EFFECTIVE DATES: 10/01/20, 07/22/25, 10/01/26

APPROVAL DATES: 07/16/20, 04/09/25, 06/09/26

I. PURPOSE

This Policy applies to ACC, ACC-RBHA, ALTCS E/PD, and DES DDD (DDD) Contractors; Fee-For-Service (FFS) Programs including: the American Indian Health Program (AIHP), 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 to members in Adult Behavioral Health Therapeutic Homes (ABHTHs).

An Adult Recovery Team (ART) recommendation is not required for FFS member's: however, an equivalent team process through the outpatient treatment team is required for care coordination for FFS members. For the purposes of this policy, an "equivalent team process" refers to a multidisciplinary outpatient treatment team serving FFS members that performs coordination and treatment planning functions comparable to an Adult Recovery Team (ART).

II. DEFINITIONS

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

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

ADULT BEHAVIORAL HEALTH THERAPEUTIC HOME (ABHTH)	A residence licensed by the Arizona Department of Health Services (ADHS) that provides behavioral health treatment, which maximizes the ability of an individual experiencing behavioral health symptoms to live and participate in the community and to function in an independent manner that includes assistance in the self-administration of medication and any ancillary services (such as living skills and health promotion) indicated by the member's Treatment Plan, as appropriate
BEHAVIORAL HEALTH RESPITE HOME	A residence licensed by Arizona Department of Health Services (ADHS) where respite care services, which may include assistance in the self-administration of medication, are provided to an individual based on the individual's behavioral health issue and need for behavioral health services. (AAC R9-10-101).

COLLABORATING HEALTH CARE INSTITUTION (CHI)	An AHCCCS registered provider that is a health care institution licensed to provide outpatient behavioral health services that has a written agreement with an adult behavioral health therapeutic home or a behavioral health respite home to: 1. Coordinate behavioral health services provided to a resident at the adult behavioral health therapeutic home or a recipient at a behavioral health respite home. 2. Work with the provider to ensure a resident at the adult behavioral health therapeutic home or a recipient at a behavioral health respite home receives behavioral health services according to the resident's treatment plan. AAC R9-10-101 (51).
DESIGNATED REPRESENTATIVE	An individual acting on behalf of the member with the written consent of the member or member's legal guardian. As used in this Policy the Designated Representative is distinct and separate from the Health Care Decision Maker.

III. POLICY

An ABHTH is a residential setting in the community that provides daily behavioral interventions within a licensed family setting. This service is designed to maximize the member's ability to live and participate in the community and to function independently, including assistance in the self-administration of medication and any ancillary services (such as living skills and health promotion) indicated by the member's service plan and the ABHTH Treatment Plan.

The care and services provided in an ABHTH are based on a per diem rate (24-hour day), and do not include room and board (Arizona State Plan for Medicaid). The Contractor shall refer to ACOM Policy 414 for information on timeframes and requirements regarding prior authorizations.

The Contractors shall monitor ABHTH bed capacity and utilization to ensure the network capacity required to meet the needs of enrolled members.

The ABHTH providers shall adhere to this Policy as well as procedure requirements as specified in AAC R9-10-1801 et. Seq and the Arizona State Plan for Medicaid. All ABHTH care and services rendered to FFS members shall adhere to the policy and procedure requirements specified in this Policy. Refer to the FFS provider billing manual for additional documentation and billing guidance.

A. CRITERIA FOR ADMISSION

For Contractor enrolled members, the Contractor shall develop admission criteria for medical necessity, which at a minimum includes all elements specified in this section. For FFS members, ABHTH providers shall apply admission criteria consistent with this policy and applicable FFS requirements.

1. Criteria for Admission:
   a. The recommendation for ABHTH members enrolled with a Contractor shall be addressed through the ART process and the service need shall be clearly indicated in the members Service Plan developed and maintained by the Health Home or Primary Behavioral Health Provider. An 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,
   b. Following a comprehensive assessment by a licensed Behavioral Health Professional (BHP), the member has a diagnosed behavioral health condition characterized by symptoms and behaviors that meet medical necessity criteria for ABHTH level of care,
   c. As a result of the diagnosed behavioral health condition, there is evidence that within the past 90 days, the member has experienced clinically significant symptoms that impair the member's ability to perform independent or age-appropriate self-care or self-regulation. This moderate functional and/or psychosocial impairment as per the comprehensive assessment by a BHP:
      i. It is not reasonably expected to improve in response to a less intensive level of care, and
      ii. Does not require or meet clinical criteria for a higher level of care, or
      iii. Demonstrates that appropriate treatment in a less restrictive environment has not been successful or is not available, therefore warranting a higher level of care.
   d. At time of admission to an ABHTH, in participation with the member/Health Care Decision Maker (HCDM) and all relevant stakeholders, there is a documented discharge plan which includes:
      i. Tentative disposition/living arrangement identified, and
      ii. Recommendations for aftercare treatment based upon treatment goals.

The Contractors shall publish the ABHTH placement medical necessity criteria on the Contractor's website.

B. EXCLUSIONARY CRITERIA

Admission to an ABHTH shall not be used for the following:

1. An alternative to detention or incarceration.

2. As a means of providing safe housing, shelter, supervision or permanent placement.

3. As a behavioral health intervention when other less restrictive alternatives are available and those alternatives meet the member's treatment needs.

C. EXPECTED TREATMENT OUTCOMES

1. Treatment outcomes shall align with:
   a. The Nine Guiding Principles for Recovery-Oriented Adult Behavioral Health Services and Systems as specified in AMPM Exhibit 300-3, and
   b. The member's individualized physical, behavioral, and developmentally appropriate needs.

2. Treatment goals for members placed in an ABHTH shall be:
   a. Specific to the member's behavioral health condition that warranted treatment,
   b. Measurable and achievable,
   c. Unable to be met in a less restrictive environment,
   d. Based on the member's unique needs,
   e. Inclusive of input and choices from the member,
   f. Inclusive of input and choices from the HCDM, and/or Designated Representative (DR) where applicable,
   g. Supportive of the member's improved or sustained functioning and integration into the community, and
   h. Reviewed by the treatment team with the member, the member's family/HCDM during each ART or equivalent care coordination team meeting for FFS members to ensure ongoing clinical appropriateness of treatment goals.

3. Active treatment with the services available at ABHTH level of care can reasonably be expected to:
   a. Improve the member's condition to achieve discharge from the ABHTH at the earliest possible time, and
   b. Facilitate the member's return to primarily outpatient care in a non-therapeutic/non-licensed setting.

D. ADULT BEHAVIORAL HEALTH THERAPEUTIC HOMES TREATMENT PLANNING

The ABHTH Treatment Plan shall be developed by the Collaborating Healthcare Institute (CHI) in collaboration with the ABHTH provider and the ART or equivalent team process for FFS members within the first 30 days of placement.

1. The ABHTH Treatment Plan shall:
   a. Document and describe strategies to address the ABHTH provider's needs, based on the needs of the member, to facilitate successful transition for the member to begin service with the ABHTH Provider, including pre-service visits when appropriate,
   b. Complement and not conflict with the member's Service Plan and shall also include reference to the member's:
      i. Current physical, emotional, and behavioral health and developmental needs,
      ii. Current educational needs (e.g., attending school, training),
      iii. Current medical treatment,
      iv. Current behavioral health treatment through other providers, and
      v. Current prescribed medications.
   c. Address safety, social, and emotional well-being, discharge criteria, acknowledgement of the member's permanency objectives and post-discharge services and supports,
   d. Include short-term, proactive treatment goals that are measurable, time-limited, and in keeping alignment with the members Service Plan,
   e. Clearly identify responsible individuals from the treatment team to implement each aspect of the ABHTH Treatment Plan and a timeline of completion. The CHI has the responsibility to ensure the treatment team is implementing the ABHTH Treatment Plan,

f. Include specific elements that build on the member's strengths while also promoting pro-social, adaptive behaviors, interpersonal skills and relationships, community, family and cultural connections, self-care, daily living skills, and educational achievement,
g. Include specific activities to coordinate with natural supports and informal networks as a part of treatment,
h. Include plans for engagement of the member's family of choice and other natural supports that can support the member during ABHTH placement and after transition,
i. Be reviewed by the ABHTH Provider and CHI at every home visit,
j. Be reviewed by the CHI Clinical Supervisor at each staffing,
k. Be updated/revised as clinically indicated or quarterly at minimum, and
l. Include documentation of the member's progress or regression toward achieving treatment plan goals. Documentation of the members' progress or regression can be included in the progress notes but shall also be summarized in the treatment plan to support the rationale for adjustments.

2. The Contractor and provider shall ensure that members/HCDM and DR receive a copy of the initial treatment plan and any updated treatment plans.

E. CRITERIA FOR CONTINUED STAY

The Contractor enrolled members, the Contractor shall develop medically necessary criteria for continued stay which, at a minimum, include all elements specified in this section. For FFS members, ABHTH providers shall apply admission criteria consistent with this policy and applicable FFS requirements:

1. The member continues to meet diagnostic threshold for the behavioral health condition that warranted admission to ABHTH.

2. The member continues to demonstrate (within the last 90 days of review) moderate functional or psychosocial impairment as a result of the behavioral health condition, as identified through disturbances of mood, thought, or behavior, which substantially impair independent or appropriate self-care or self-regulation.

3. Active treatment is reducing the severity of disturbances of mood, thought, or behaviors, which were identified as reasons for admission to ABHTH, and treatment at the ABHTH is empowering the member to gain skills to successfully function in the community.

4. There is an expectation that continued treatment at the ABHTH shall improve the member's condition so that this type of service shall no longer be needed.

5. The ART (or equivalent for FFS members) is meeting at least quarterly to review member's progress and have revised the ABHTH Treatment Plan at least quarterly or most often as clinically indicated to revise goals in response to any lack of progress to best meet the member's needs.

The Contractors shall publish the ABHTH continued stay medical necessity criteria on the Contractor's website.

F. ADULT BEHAVIORAL HEALTH THERAPEUTIC HOMES DISCHARGE PLANNING

A comprehensive discharge plan shall be created during the development of the initial ABHTH Treatment Plan and shall be reviewed and/or updated during each review of the ABHTH Treatment Plan thereafter.

The discharge plan shall document the following:

1. Clinical status for discharge.
2. Follow-up treatment, crisis, and safety plan.
3. Coordination of care and transition planning are in process when appropriate.
4. Tentative disposition/living arrangement identified.
5. Recommendations for aftercare treatment based upon treatment goals.

G. CRITERIA FOR DISCHARGE

For Contractor enrolled members, the Contractor shall develop medical necessity criteria for discharge from an ABHTH setting. For FFS members, ABHTH providers shall apply discharge criteria consistent with this policy and applicable FFS requirements. Medical necessity criteria for discharge from an ABHTH placement shall include, at a minimum, each of the elements specified in this section:

1. Sufficient relief of symptom(s) or behavior(s) is achieved as evidenced by completion of the member's treatment goals.
2. The member's functional capacity is improved, and the member can be safely cared for in a less restrictive environment.
3. The member can participate in needed monitoring and follow-up services, or a Provider is available to provide monitoring in a less restrictive environment.
4. Appropriate services, providers, and supports are available to meet the member's current behavioral health needs at a less restrictive environment.
5. There is no evidence to indicate that continued treatment in an ABHTH would improve the member's clinical outcome.
6. There is a potential risk that continued stay in an ABHTH may precipitate regression or decompensation of member's condition.

The Contractors shall publish medical necessity criteria for discharge on the Contractor's website.

H. COLLABORATING HEALTH CARE INSTITUTION (CHI) ROLE/RESPONSIBILITIES

The Collaborating Health Care Institutions (CHIs) are responsible for providing clinical oversight, coordination, and support to ensure services delivered within the ABHTH are implemented in accordance with the member's treatment plan and applicable requirements. Documentation of activities conducted by the CHI shall align with AMPM Policy 940 and AAC R9-10. Clinical documentation requirements for the members medical record apply to member-specific services, interventions, and treatment decisions. Supervisory, consultation, and oversight activities conducted by the CHI do not require individualized documentation in each member's medical record unless such activities result in member-specific clinical direction, interventions, or changes to the treatment plan. The CHI shall maintain documentation of oversight activities sufficient to demonstrate compliance with this policy and applicable licensure requirements, and such documentation shall be made available for audit, monitoring, or quality review upon request.

1. The CHIs shall comply with all programmatic and documentation requirements specified in AAC R9-10-118.

2. The CHIs shall provide clinical support to the ABHTH family provider as they meet the daily needs of the member, including:
   a. Assignment to an ABHTH agency worker that conducts home visits and participates in ARTs and treatment planning,
   b. Assist in the development of a clinically appropriate ABHTH treatment plan, which is reviewed by the BHP,
   c. Complete regular reviews of ABHTH family progress notes to ensure documentation reflects treatment plan implantation and member progress, and
   d. The BHP shall participate in monthly meetings with the ABHTH agency worker and the ABHTH family provider at least once per month, in-person or via telemedicine (i.e., interactive audio/video communications). The BHP shall also be available by request or as needed to provide any necessary support to the ABHTH family provider.
      i. Documentation of monthly meetings shall align with AMPM Policy 940 and AAC R9-10-1802.
      ii. Documentation in the member's clinical record is required only when the interaction results in member-specific clinical direction, intervention, or changes to the treatment plan.
      iii. The CHI shall maintain documentation of BHP participation in required monthly meetings, including date, participants, and general topics, sufficient to demonstrate clinical oversight and compliance with this policy.

3. The CHIs shall provide programmatic support to the ABHTH family providers 24 hours per day, seven days a week to assist in crisis intervention as needed. Contact information for the CHI 24-hour support team shall be provided to the ABHTH family and included in the written agreement between the CHI and the ABHTH family provider.

4. Meet the administrative requirements of AHCCCS, the State, and Tribal licensing authority. These requirements include but are not limited to ensure ABHTH Family Provider(s) comply with all State licensing requirements in AAC R9-10-Article 18, including application, training, life safety inspections, and administrative requirements.

5. Complete supporting documentation for each home visit, including verification that each of the following requirements were completed:
   a. Review of the ABHTH Treatment Plan, including daily progress notes documenting the members' progress toward treatment plan goals,
   b. Review of therapeutic interventions provided and required documentation,
   c. Review medical record documentation and medication logs, to ensure compliance with AAC R9-10-Article 18 and AMPM Policy 940, and
   d. Documentation of training support provided to the ABHTH family provider during the home visit.

6. Ensure ABHTH Family Providers complete full and accurate clinical documentation of all interventions, the documentation demonstrates progress toward meeting ABHTH Treatment Plan goals, and progress notes clearly indicate what services are provided to the member each day.

7. Ensure ABHTH Treatment Plan is shared with the member's Primary Behavioral Health Provider or Health Home, Primary Care Physician (PCP), other treating providers, and stakeholders to assure care coordination.

8. Encourage coordination/collaboration/advocacy with the between the ABHTH family provider and any day program or work program providers to support the members independence and community integration.

9. Provide notification to the PCP and all behavioral health providers involved in the member's treatment when a member is admitted to or discharged from an ABHTH.

I. ADULT BEHAVIORAL HEALTH THERAPEUTIC HOME (ABHTH) ROLE/RESPONSIBILITIES

The ABHTH family providers are responsible for implementing services and supports within the home setting in accordance with the member's treatment plan and applicable requirements. Documentation maintained by the ABHTH family provider shall align with AAC R9-10-1807 and reflect services provided, observations, and implementation of the treatment plan within the home setting. Documentation maintained by the ABHTH family provider is distinct from the member's clinical record. ABHTH provider documentation is not intended to replicate the full medical record maintained by the CHI but to support service delivery, coordination of care, and compliance with applicable licensure requirements.

1. Abide by all licensing regulations as outlined in current and relevant Federal and State statutes and rules, including rules in AAC R9-10-Article 18.

2. Provide basic household needs and functions of all members being served in the ABHTH (e.g., food, clothing, shelter, emotional support, medical need monitoring/coordination, transportation, teaching/modeling daily living skills, social skills, supporting participation in community activities to promote inclusion and independence).

3. Provide behavioral interventions (e.g., anger management, crisis de-escalation, psychosocial rehabilitation, living skills training and behavioral intervention) as indicated in the ABHTH Treatment Plan goals.

4. Provide a family environment that includes opportunities for:
   a. Familial and social interactions and activities,
   b. Use of behavioral interventions,
   c. Development of age-appropriate living and self-sufficiency skills, and
   d. Integration into a family and community-based setting.

5. Meet the individualized needs of the member, as defined in the member's ABHTH Treatment Plan.

6. Be available to care for the member 24 hours per day, seven days a week including a plan for support should the member not be able to participate in day programming or work activities due to illness or other unexpected reasons.

7. Participate in planning processes such as ARTs, ABHTH discharge planning, and other coordination activities based on the members' needs and other involved providers.

8. Maintain documentation of the members' progress toward ABHTH Treatment Plan goals, including:
   a. Daily Progress notes,
   b. Incident reports,
   c. Medication observation and current medication prescriptions from all providers,
   d. A current copy of the ABHTH Treatment Plan and Discharge Plan, and
   e. Documentation necessary to support implementation of the treatment plan and coordination of care, including a current copy of the treatment plan and relevant clinical information, as applicable.

9. Assist the member in maintaining contact with family, including family of choice, and natural supports.

10. Advocate for the member to achieve ABHTH Treatment Plan goals and to ensure timely access to vocational, medical, or other indicated services.

11. Report allegations of misconduct toward members in compliance with all Federal and State regulations and AMPM Policy 961.

12. Maintain confidentiality according to statutory, Health Insurance Portability and Accountability Act (HIPAA) and AHCCCS requirements.

13. Follow the member's safety plan for crisis intervention.

14. Coordinate with the CHI to adjust the safety plan or treatment plan as needed to prevent regression.