

October 1, 2026

The Honorable Katie Hobbs
Governor of Arizona
1700 W. Washington
Phoenix, AZ 85007

The Honorable Steve Montenegro
Arizona House of Representatives
1700 W. Washington
Phoenix, AZ 85007

The Honorable Warren Petersen
Arizona State Senate
1700 W. Washington
Phoenix, AZ 85007

Dear Governor Hobbs, Speaker Montenegro, and President Petersen:

Pursuant to Laws 2025, Chapter 233, Sec. 11 The Arizona Health Care Cost Containment System (AHCCCS) administration and the Arizona Department of Health Services (ADHS) have coordinated to produce an implementation plan that contains recommendations regarding secure behavioral health facilities for populations subject to section 36-425.06 or 13-4521, Arizona Revised Statutes, for the Governor, the President of the Senate and the Speaker of the House of Representatives including analysis regarding:

1. A proposed fee schedule for secure behavioral health residential facilities, including possible enhancement rates and modifiers.
2. Utilization projections for Medicaid eligible and Non-Title XIX members of the Arizona Health Care Cost Containment System, incorporating existing network analysis.
3. Potential impacts to capitation rates given utilization projections for Medicaid eligible members of the Arizona Health Care Cost Containment system.
4. Whether utilization projections for Medicaid eligible and Non-Title XIX members of the Arizona Health Care Cost Containment System will impact the state general fund or require reductions in other covered services.
5. A network adequacy evaluation and proposed mitigation of any network issues.

6. Whether the Arizona Health Care Cost Containment System will be required to submit a proposed 1115 waiver amendment to the centers for Medicare and Medicaid services, and any other considerations regarding maximizing matching federal monies.

7. Whether additional licensing statutes and regulations should be updated.

8. Proposed policies regarding secure behavioral health facilities for the Arizona Health Care Cost Containment System medical policy manual, including policies regarding discharge readiness indicators.

9. After coordinating with the Arizona Office of the Courts and other relevant stakeholders, proposed updates to any relevant court ordered treatment forms or proposed orders.

10. Analysis regarding whether providing covered services in secure behavioral health facilities would violate the laws of this state or federal law, including relevant precedent related to disability rights, including *Olmstead v. L.C.* and *Arnold v. Sarn*.

If you have any questions regarding this letter, please feel free to contact Damien Carpenter, Chief Legislative Liaison, at (602) 396-0767.

Sincerely,

A handwritten signature in black ink, appearing to read 'Roberta Harrison', followed by a stylized flourish.

Roberta Harrison,
Interim Director

Cc: Meaghan Kramer, Health Policy Advisor, Office of the Governor
Ben Henderson, Director, Governor's Office of Strategic Planning and Budgeting

Secure Behavioral Health Residential Facility (SBHRF) Implementation Plan

October, 2026



Secure Behavioral Health Residential Facility (SBHRF) Implementation Plan

Background

This report is submitted pursuant to the State of Arizona, Laws 2025, Chapter 233 – SB 1735 (“general appropriations act; 2025-2026”) Sec. 11. Arizona Health Care Cost Containment System, Medical services and behavioral health services.

The Arizona Health Care Cost Containment System administration and the Department of Health Services shall coordinate to produce an implementation plan that contains recommendations regarding secure behavioral health facilities for populations subject to section 36-425.06 or 13-4521, Arizona Revised Statutes, to the governor, the president of the senate and the speaker of the house of representatives and shall include analysis regarding:

1. A proposed fee schedule for secure behavioral health residential facilities, including possible enhancement rates and modifiers.
2. Utilization projections for Medicaid eligible and Non-Title XIX members of the Arizona Health Care Cost Containment System, incorporating existing network analysis.
3. Potential impacts to capitation rates given utilization projections for Medicaid eligible members of the Arizona Health Care Cost Containment system.
4. Whether utilization projections for Medicaid eligible and Non-Title XIX members of the Arizona Health Care Cost Containment System will impact the state general fund or require reductions in other covered services.
5. A network adequacy evaluation and proposed mitigation of any network issues.
6. Whether the Arizona Health Care Cost Containment System will be required to submit a proposed 1115 waiver amendment to the centers for Medicare and Medicaid services, and any other considerations regarding maximizing matching federal monies.
7. Whether additional licensing statutes and regulations should be updated.
8. Proposed policies regarding secure behavioral health facilities for the Arizona Health Care Cost Containment System medical policy manual, including policies regarding discharge readiness indicators.
9. After coordinating with the Arizona Office of the Courts and other relevant stakeholders, proposed updates to any relevant court ordered treatment forms or proposed orders.
10. Analysis regarding whether providing covered services in secure behavioral health facilities would violate the laws of this state or federal law, including relevant precedent related to disability rights, including *Olmstead v. L.C.* and *Arnold v. Sarn*.

Overview

The Arizona Health Care Cost Containment System (AHCCCS), in partnership with the Arizona Department of Health Services (ADHS), is developing an implementation plan for Secure Behavioral Health Residential Facilities (SBHRFs) as required by State of Arizona, Laws 2025, Chapter 233– SB 1735 (“general appropriations act; 2025-2026”) Sec. 11, additionally appropriating \$5 million which AHCCCS shall distribute to SBHRFs that intend to apply for licensure with ADHS pursuant to A.R.S 36-425.06. Disbursement of these funds shall occur through a

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competitive Request for Proposals (RFP) process and must adhere to all applicable Arizona procurement statutes to ensure compliance and transparency.

AHCCCS published the Secure Behavioral Health Residential Facility Request for Proposals (Solicitation YH26-0005, BPM007546) on April 30, 2026 through the Arizona Procurement Portal. The solicitation remains open, with proposals accepted through January 1, 2027, so that prospective operators can respond after the ADHS licensing rules, the AHCCCS rate model, and the AHCCCS policy framework described in this plan are settled rather than before. The RFP was published while the ADHS rules were still in proposed form. The agencies received feedback from providers that they could not responsibly commit to a secure multi-bed facility without knowing the licensing standard they must meet, the rate they will be paid, and the admission and discharge policies that will govern censuses. AHCCCS therefore elected to hold the solicitation open across the rulemaking period rather than close it without award and reissue. No award has been made to date. AHCCCS intends to award the full appropriation and will offer technical assistance to interested offerors during the remaining solicitation period. Unlike the 2020 grant, which failed when the awardee could not secure property within budget, the current RFP permits offerors to propose retrofit of an existing licensed residential site, and permits award to more than one offeror.

A.R.S 36-425.06 provides the authority to ADHS to license SBHRFs that provide secure on-site supportive treatment to persons who are determined to be seriously mentally ill, who are chronically resistant to treatment and who are placed in the facility pursuant to a court order pursuant to section 36-550.09, Arizona Revised Statutes, as well as to SBHRFs that provide treatment to persons who have been committed pursuant to a court order issued pursuant to section 13-4521, Arizona Revised Statutes. By contrast, while A.R.S. 36-502 provides AHCCCS with the statutory authority to regulate service delivery for individuals ordered into SBHRFs pursuant to A.R.S. 36-550.09, AHCCCS does not regulate service delivery in SBHRFs that provide treatment to persons who have been committed pursuant to a court order issued pursuant to A.R.S. 13-4521, and does not oversee SBHRFs providing services pursuant to that title.

SBHRFs that provide treatment to individuals placed there pursuant to A.R.S. 36-550.09 will be added to the current Arizona community residential treatment continuum, which exists to provide care to eligible individuals living with mental health and/or substance use disorders. It was the intent of the stakeholders who conceived of SBHRFs and ultimately succeeded in getting legislation passed to create and fund these facilities, to resemble current Behavioral Health Residential Facilities (BHRFs), while adding requirements that they be secured (locked) and that individuals be placed there involuntarily through court approval pursuant to A.R.S. 36-550.09. BHRFs are healthcare facilities licensed by ADHS, pursuant to Arizona Administrative Code Title 9, Chapter 10, Article 7, and provide a level of care designed for individuals with significant symptoms of mental illness to receive treatment in a homelike environment without sacrificing safety or care, as they provide 24/7 supervision by staff with behavioral health training, as well as treatment services such as counseling, in accordance with the treatment plan created by the treatment team. For AHCCCS members, placement in a BHRF level of care is subject to prior authorization and continued authorization on the basis of medical necessity. The admission criteria for BHRFs, described in AHCCCS Medical Policy Manual (AMPM) Policy 320-V, reflect the need for the services BHRFs are required to provide and can be summarized as follows:

1. The member must be diagnosed with a behavioral health condition (inclusive of substance use disorders) that is causing significant functional and/or psychosocial impairment leading to at least one area of significant risk of harm in the past three months.

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2. The functional/psychosocial impairment and risk of harm warrant the need for 24-hour supervision and support while the member engages in treatment intervention to address behavioral health conditions that will allow the member to live safely in the community.

Continued placement in a BHRF is contingent upon medical necessity for this level of care continuing to be met, and it is the expectation that once treatment plan goals related to symptom and functional improvement are met, and the member is able to be served in a less restrictive setting, discharge to a lower level of care occur. These facilities are not locked (secured) and treatment in a BHRF is voluntary, meaning that the member and/or their healthcare decision maker must agree to this service, and if a member chooses to leave against the advice of their treatment team, it is within the member's rights to do so.

Extensive work involving collaboration with diverse stakeholders from both public and private sectors led to the identification of a critical gap in Arizona's Serious Mental Illness (SMI) system of care, the lack of secured residential treatment facilities, which has contributed to individuals with an SMI designation becoming trapped in the so-called "revolving door" of mental health treatment; this "revolving door" refers to the cycle of admit, treat, discharge, decompensate that tends to occur to individuals with an SMI designation suffering from *anosognosia*, a condition common in certain psychiatric disorders that results in the individual lacking insight into their own illness or disability. Some individuals with an SMI designation and anosognosia fall into a small segment of individuals who are chronically, severely ill, and unable to meaningfully participate in care long enough to gain stability so that they may embark on or maintain a recovery journey. Once these individuals no longer meet medical necessity for a locked inpatient setting, they are discharged to the community where they often walk away from effective treatment, resulting in decompensation that may lead to homelessness, increased physical and mental illness burden, substance use, arrests and incarceration, hospitalizations, and premature mortality. The ability to retain this small population of individuals in effective community-based treatment for long enough to progress in their recovery remains elusive in the current Arizona SMI continuum of care. Inclusion of SBHRFs in the continuum of care provides a significant opportunity to stop the "revolving door" and create, for these individuals, a meaningful chance to recover and live outside of institutional settings.

To fulfill statutory obligations related to SBHRFs with the intentions of the relevant stakeholders and lawmakers in mind, AHCCCS and ADHS collaborated to produce this plan containing projections and recommendations regarding funding, utilization, regulation, and clinical modeling for SBHRFs. Sources used to inform this implementation plan include extensive consultation with subject matter experts from both agencies, research on similar facilities in other states, Court Ordered Treatment (COT) monitoring data, outside counsel legal analysis, AHCCCS data analysis by the Arizona State University Center for Health Information Research (ASU CHiR), and stakeholder feedback.

Purpose of the Report

This report outlines the steps AHCCCS and ADHS will take to implement SBHRFs, including stakeholder engagement, rate-setting methodology, and coordination with the Arizona Office of the Courts. It provides a roadmap for ensuring these facilities operate within a secure yet least restrictive framework, maintain separation of civil and criminal justice cohorts, and integrate with Arizona's behavioral health continuum. In addition, the report incorporates evidence-based projections drawn from SFY 2025 utilization trends, identifies initial statewide capacity constraints (16–32 beds based on expected proposals to the RFP with a cap of \$5M), and proposes mitigation strategies to address network adequacy gaps. It details fiscal modeling approaches for

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capitation and State General Fund (SGF) impacts, explores opportunities for federal financing through waiver pathways, and includes a phased access plan prioritizing urban hubs with transport coordination for rural courts. By aligning statutory requirements with real-world data and stakeholder input, this plan ensures SBHRFs advance treatment goals while reducing reliance on inpatient psychiatric settings and emergency boarding.

Implementation History

SBHRFs were authorized in Laws 2019, Chapter 270, which also appropriated \$3.5 million for construction or renovation. AHCCCS awarded that funding through a competitive grant in 2020. The grantee was unable to secure a suitable property within budget as construction costs rose, and AHCCCS terminated the agreement in 2022 after the grantee did not meet its milestones. The Legislature appropriated \$25 million in 2022 for up to five facilities, but that appropriation was reverted before it could be deployed, and subsequent efforts to restore it were not enacted.

Separately, A.R.S. 36-425.06 as originally enacted would have permitted persons committed under A.R.S. 13-4521, following a criminal finding of dangerousness and incompetence to stand trial, to be housed in the same facility as persons under civil court-ordered treatment. That issue created uncertainty for prospective Title 36 operators about who could be placed in their facilities. Laws 2025, Chapter 113 (SB 1604) resolved that issue by prohibiting co-location, and the ADHS rules now establish separate licensing articles for each population, after significant stakeholder feedback. In the meantime, ADHS opened the rulemaking docket on April 23, 2025, and the two efforts proceeded in parallel. Laws 2026, Chapter 160 (SB 1242) resolved a second structural problem by clarifying that an SBHRF is not a mental health treatment agency.

With those statutory issues resolved and the \$5 million appropriation in Laws 2025, Chapter 233, the remaining work has been the sequence that any new Medicaid level of care requires in Arizona. ADHS licensing rules must be adopted through the Administrative Procedure Act and reviewed by the Governor's Regulatory Review Council. AHCCCS must then develop a rate from the final licensing scope and have it certified as actuarially sound, adopt an AMPM policy, create a provider type, amend managed care contracts, and award a competitive procurement under state procurement law. Each step carries mandatory public comment, stakeholder engagement, and review periods. The rulemaking timeline in Section 7 reflects four rounds of stakeholder review between July 2025 and April 2026, with participation from provider organizations, family advocates, county attorneys, courts, and disability rights organizations. That input shaped the final rules and the safeguards described in Section 10. It did not move the effective date, which was set by the statutory rulemaking calendar. The Title 36 facilities described in this plan will be funded through Medicaid capitation and, for Non-Title XIX members with an SMI designation, the State General Fund, so no additional operating appropriation is required for them to open.

While grants may be issued to facilities intended to support Title 13 patients, as of the date of this report, no funding source has been identified to support the ongoing costs of Title 13 SBHRF facilities for individuals who are found to be dangerous and incompetent to stand trial and court-ordered to SBHRFs pursuant to A.R.S. 13-4521.

Population Served

SBHRFs implemented through AHCCCS may serve both Medicaid-eligible and Non-Title XIX individuals who are approved, by the court, for placement in the facility pursuant to A.R.S. 36-550.09. If a court determines that a

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patient meets the criteria for court-ordered treatment pursuant to A.R.S. 36-550, is seriously mentally ill, and chronically resistant to treatment, the court may approve placement in a licensed SBHRF, upon the recommendation of the treatment team. Chronic resistance to treatment is defined in A.R.S. 36-550.09(B)(1) and “includes persistent or recurrent unwillingness or inability to participate in or adhere to treatment for a mental disorder despite having treatment offered, prescribed, recommended or ordered to improve the person’s condition or to prevent a relapse or harmful deterioration of the person’s condition” within the past 24 months. Pursuant to A.R.S. 36-425.06(A), “patients who are committed pursuant to section 36-550.09 may not be treated in a secure behavioral health residential facility that treats patients who are committed pursuant to section 13-4521.” Since involuntary commitments ordered under Title 13 require specific findings by the County’s Superior Court instead of relying on demonstration of medical necessity as determined by a treatment team, and are the financial responsibility of the County, they are not covered in this document.

The Title 13 population faces a different and more fundamental obstacle. Individuals committed under A.R.S. 13-4521 are not eligible for Medicaid reimbursement for this service, are the financial responsibility of the committing county, and by statute, cannot be served in a facility that also serves the Title 36 population. Treatment in a secure residential setting for the Title 13 population is expected to cost in the range of the current BHRF Medicaid reimbursement rate, roughly \$90,000 per person per year, and the cost of care at the Arizona State Hospital, which exceeds \$250,000 per person per year. Because many Title 13 patients may have a cooccurring disability that is not merely behavioral in nature (like developmental disability, traumatic brain injury, or dementia), costs will likely be highly individualized, and could easily exceed \$250,000, since the Arizona State Hospital does not provide care for these diagnoses, and provides care at scale.

For a single sixteen-bed facility at full occupancy, that is an ongoing operating cost in the range of \$1.5 million to \$4 million annually per facility, before accounting for the additional costs to treat co-occurring conditions. While the Legislature has appropriated one-time funding to construct or retrofit secure facilities, it has never appropriated an ongoing operating funding source for Title 13 placements, and no county has identified one. The ADHS licensing rules for Title 13 facilities are in effect currently, so a county or provider that identifies operating funding could pursue licensure now. Absent such a source, neither AHCCCS nor ADHS has a mechanism to stand up Title 13 facilities, and this plan does not project any.

Modeling Assumptions

Modeling assumptions continue to be refined as AHCCCS develops policy incorporating recently finalized ADHS licensing rules. The following modeling assumptions have been established to date.

- An SBHRF may not have more than sixteen beds per facility (A.R.S 36-425.06(A)) and must be secure, defined as “premises that limit a patient's egress in the least restrictive manner consistent with the patient's court-ordered treatment plan.” (A.R.S. 36-425.06(C)).
- SBHRFs will require higher security and staffing standards than current BHRFs, resulting in cost increases.
- SBHRFs will be treatment-focused, similar to current BHRFs, but designed for members with specialized needs requiring enhanced oversight.
- Utilization estimates will assume gradual adoption, with occupancy ramping up as new facilities come online.
- Initial projections are based on members with active COT orders with the potential for meeting the

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statutory criteria for chronic resistance to treatment based on insights gleaned from existing data sources.

1. Proposed Fee Schedule

AHCCCS has not finalized a proposed fee schedule for SBHRFs as rates for this level of care depend heavily on the scope of services defined by ADHS licensing rules. ADHS Rules became effective August 5, 2026, and AHCCCS is now incorporating the information into the rate model to develop the fee schedule, ensuring rates provide adequate reimbursement that aligns with statutory timelines and clinical standards. Prior to ADHS rule finalization, AHCCCS collected feedback through a Request For Information (RFI) published February 6, 2026, and will solicit additional stakeholder feedback to inform rate-setting now that the ADHS rules have been finalized.

Rate-Setting Process

- Finalize scope of services in alignment with ADHS licensing rules.
- Collect stakeholder input through RFI and other stakeholder engagement processes.
- Apply AHCCCS rate-setting methodology incorporating regulatory requirements, cost comparisons, and market benchmarks.

Rate Development Methodology

- Comparative Cost Analysis: Review of ADHS regulations to determine compliance costs for SBHRFs. Compare these costs to existing Behavioral Health Residential Facilities (BHRFs), sub-acute facilities, and inpatient psychiatric hospitals to identify relative cost differences, including security infrastructure and staffing ratios.
- Rate Alignment: Evaluate current Arizona rates for BHRFs, sub-acute facilities, and inpatient psychiatric hospitals to ensure SBHRF rates remain consistent and appropriate within the continuum of care.
- Cross-State Benchmarking: Analyze utilization patterns and rate structures in other states with secure residential models, adapting relevant practices to Arizona's context.

Potential Enhancement Rates and Modifiers

- Acuity Modifier: For members requiring intensive observation and monitoring.
- Complex Medical Comorbidity Add-On: For members with complex physical health conditions that require additional care.

Fiscal Responsibility and Federal Match

- AHCCCS will evaluate opportunities to maximize federal match through waiver amendments, ensuring compliance with Centers for Medicare & Medicaid Services (CMS) requirements and fiscal sustainability.
- Treatment in an SBHRF is a Medicaid-covered benefit, for eligible individuals who meet medical necessity criteria and must be covered through the SGF for Non-Title XIX eligible members with an SMI designation.
- Past stakeholder feedback included concerns surrounding identification of the most appropriate payor source, when it is determined that an individual no longer meets medical necessity criteria but remains placed in the SBHRF, as approved through court order. AHCCCS continues to evaluate and plan for mitigation of this potential risk.

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2. Utilization Projections

As required by A.R.S. 36-425.06, utilization projections address both Title XIX and Non-Title XIX populations and incorporate existing network adequacy evaluations. These projections will inform rate setting, network planning, and fiscal impact analysis for SBHRFs.

Estimating anticipated utilization for SBHRFs is particularly challenging due to the imprecision inherent to translating the legislative language defining chronic resistance to treatment into clear clinical eligibility criteria and then identifying the most appropriate proxy markers that indicate an individual meets or may meet criteria from existing available data sources. While preliminary markers have been identified for the purposes of establishing these estimates, the AHCCCS clinical team may revise these proxies over time in collaboration with relevant stakeholders to inform more precise projections. Thus, it should be noted that, due to data limitations, reliance on disparate data sources, and broad assumptions needed to inform these estimates, actual utilization may vary significantly once SBHRFs are fully implemented.

Pursuant to A.R.S. 36-550.09, the court must find clear and convincing evidence of all the following in order to approve placement in an SBHRF:

1. The person received treatment in less-restrictive settings, such as unsecured residential treatment with 24-hour supportive care and supervision by trained behavioral health staff, and that treatment was either unsuccessful or unlikely to succeed due to the person's unwillingness to cooperate.
2. The person's nonadherence or nonparticipation in treatment led to one or more of the following:
 - a. Serious harm to self
 - b. Serious harm or threats of harm to others
 - c. Recurrent homelessness due to mental disorder
 - d. Recurrent serious medical issues due to poor self-care or failure to follow medical advice
 - e. Recurrent arrests due to behavior stemming from mental disorder
3. Any other evidence relevant to the person's willingness or ability to participate in treatment or their need for placement in a secure residential setting to ensure compliance with court-ordered treatment.

Reflecting the statutory criteria to the best of our ability, projected utilization estimates were calculated using the following framework:

1. The total number of AHCCCS members assigned to Court Ordered Treatment (COT) was established.
2. The average number of these members with an active COT in any given month was established.
3. Of those members with active COT orders, the number identified as non-compliant with treatment was established.
4. The number of months these members were non-compliant with treatment was calculated to estimate the number of SBHRF bed-days needed in a calendar year.

Total, Active, and Non-Compliant COT Members

To determine the number of AHCCCS members assigned to COT, AHCCCS relied on COT tracking data captured in the Regional Behavioral Health Agreement (RBHA) COT Monitoring deliverables from 2025. This data provided a list of all members with either new or active (ongoing from the previous month) COT orders, as well as a variety of data points for each COT member, including court order start and end dates, legal basis for COT, and non-

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compliance indicators. Because COT orders are issued throughout the year on a rolling basis, the total orders at any given point in time varies, making the average members with active COT orders each month the best figure to gauge the size of the initial pool of potential SBHRF candidates. Analysis of the data from the RBHA COT Monitoring deliverables yielded an average of approximately 4,401 members with active COT orders each month.

Given that the need for placement in an SBHRF must be established, in part, by the member's inability or unwillingness to comply with COT outside of a secured setting, the next step in developing utilization projections involved identifying members who were non-compliant with COT orders. In the same RBHA COT Monitoring datasets, markers of non-adherence indicated that, of the approximately 4,401 members with active COT orders each month, approximately 667 of these members could be identified as non-compliant with court orders at some point during 2025, further homing in on the group of potential SBHRF candidates.

Here, we encounter our first notable data limitation. The aforementioned RBHA COT Monitoring data included a marker for non-compliance, but this marker indicated that a member was non-compliant at some point during their COT period without specifying when the non-compliance occurred, or the number of times non-compliance recurred. As a result, there is no way of establishing the degree of month-to-month variability in the identities of the 667 members identified as non-compliant with court orders at some point in 2025 relying on these datasets alone. Additionally, the non-adherence criterion contained within the statutory definition of chronic resistance to treatment is narrower than the broadly defined non-compliance marker utilized in the RBHA COT Monitoring datasets, with the statutory criteria requiring evidence of specific consequences of the individual's non-compliance with treatment.

While AHCCCS is unable to link non-compliance with COT to the consequences identified in the statute on an individual member level, due to these datapoints existing in unconnected data systems, AHCCCS was able to estimate the number of members who were actively non-adherent with COT each month utilizing a different dataset. To do so, AHCCCS utilized data, provided by the RBHA with the largest SMI population, that identified the number of months each member with documented non-adherence with a court order was non-compliant throughout the 12-month period of their COT, allowing AHCCCS to calculate the range of non-compliant portions of the COT period for those members.

By comparing the number of non-adherent months to the total months for the COT period, AHCCCS estimated that non-compliant members were non-adherent for 20-33% of their total COT period. This assumption was applied to the 667 members who were marked as non-compliant during any point in 2025, resulting in an estimated 167 members who were actively non-compliant during any given month. This number varies considerably depending on what point in the 20-33% range is used for this assumption.

Beds Needed Statewide

Assuming that there are approximately 167 members eligible for SBHRF placement based on statutory criteria each month, the final challenge was determining the duration a member who meets these criteria is likely to be assigned to an SBHRF. Because SBHRFs will be an entirely new level of care with a unique service model, it is not possible to predict the average time we could expect treatment in an SBHRF to result in adequate stabilization to support stepdown to a less restrictive level of care.

For the sake of producing reasonable estimates of SBHRF beds needed statewide, this analysis assumes that

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members assigned to COT, who are chronically resistant to treatment, will be assigned to SBHRFs for the duration of their COT period. In this scenario, approximately 108 members will be housed in SBHRFs every month, requiring seven facilities with 16-bed capacity to meet the demand.

This estimate is a monthly census, not a prevalence figure, and it should not be compared directly to estimates of the total number of Arizonans with an SMI designation who might benefit from a secure setting at some point in their lives. That population may include people not currently under a court order, people whose orders have expired, and people whose nonadherence has not yet produced the consequences the statute requires a court to find in order to approve placement in an SBHRF. The figure of 108 describes how many beds would be occupied at a given time if every member currently on COT who meets the statutory criteria were placed for the duration of the order. AHCCCS's SB 1311 SMI Monitoring Report found that nearly half of the roughly 8,000 members discharged from unsecured residential facilities in SFY 2025 were hospitalized within a year, and ADHS data shows Arizona State Hospital beds occupied by patients who no longer require that level of care. Both indicate that the pool of members who could progress to an SBHRF placement is larger than the current COT data capture. For that reason AHCCCS treats these projections as a floor for initial procurement rather than a ceiling on eventual capacity.

S-BHRF Utilization Estimates (Assuming All Months Non-Compliant)			
Member Type	Count	% Previous	% Total
Members with Court Ordered Treatment (COT)	5,035		100.0%
Members with Active COT	4,401	87.4%	87.4%
Non-Compliant COT Members ¹	667	15.2%	13.2%
Non-Compliant COT Members (monthly) ²	167	25.0%	3.3%
Non-Compliant COT Members, Chronically Resistant to Treatment³	108	64.5%	2.1%

Housing Capacity Estimates	
Bed-Days per Month	108
Bed-Days per Year	1,290
Number of S-BHRF Facilities Needed (16-bed capacity)	6.7

The actual utilization following SBHRF implementation may differ from these estimates. It is possible that members who meet the criteria utilized to indicate chronic resistance to treatment will not immediately be ordered to an SBHRF upon identification, and/or not be required to remain there for the durations of their court orders, in which case actual utilization may be lower than projected. Conversely, it is also possible that more members than AHCCCS has been able to identify with current datasets will meet the statutory criteria and be assigned to SBHRFs for longer periods, in which case the utilization may be higher than projected.

Limitations

The preceding estimates come with numerous limitations stemming from source data constraints, reliance on imprecise markers available in existing data sources to reflect instances of statutory criteria for chronic resistance to treatment being met, and the inability to predict treatment efficacy and rate of uptake of a service that does not currently exist. As a result, AHCCCS's ability to reliably predict SBHRF utilization is significantly

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restricted.

Considering these limitations, it is critical to keep in mind that these estimates are only intended to provide broad, reasonable estimates to assist with RFP development and support next steps in SBHRF implementation planning.

Data Sources

- Regulatory Framework: Statutory Requirements for approval of placement in an SBHRF.
- Regional Behavioral Health Agreements (RBHA) COT Monitoring Data
- Stakeholder Input: RFI and public comment.

3. Potential Impact to Capitation Rates

This section outlines AHCCCS's approach to assessing the fiscal impact of SBHRFs on managed care capitation rates and Fee-for-Service (FFS) programs. The analysis will ensure compliance with CMS actuarial soundness requirements and maintain fiscal responsibility while supporting statutory implementation under A.R.S. 36-425.06.

The capitation rate impact analysis incorporates utilization projections (Section 2) and fee schedule development (Section 1) to model anticipated costs. These projections account for existing capacity limitations, expected increases in SBHRF utilization, and offsetting reductions in other services such as inpatient psychiatric admissions, crisis stabilization services, and emergency department boarding.

Methodology

- Integration of Utilization Projections
 - Model scenarios for SBHRF occupancy growth and associated service substitution for members who are chronically resistant to treatment under Court-Ordered Treatment (COT) as described in Section 2.
- Unit Cost Application
 - Use the proposed fee schedule (Section 1) as the basis for per diem unit costs.
 - Incorporate modifiers as determined by AHCCCS following licensing rule finalization and incorporation of stakeholder feedback as described in Section 1.
- Fiscal Impact Modeling
 - Calculate total projected expenditures for SBHRFs under Title XIX and Non-Title XIX populations.
 - Identify offsets from reduced utilization of higher-cost settings (e.g., inpatient psychiatric admissions, crisis observation admissions, emergency department boarding).
- Allocation to Funding Streams
 - Distribute modeled costs between:
 - Fee-for-Service (FFS) Programs.
 - Managed Care Capitation Rates for enrolled members.
 - SGF for non-Title XIX eligible members with an SMI designation
 - Apply actuarial adjustments for trend, risk, and administrative load.

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Budget Review and Funding Strategy

- Coordinate with AHCCCS Budget Office to:
 - Validate funding sources (Medicaid FMAP, SGF).
 - Ensure compliance with CMS actuarial soundness standards.
 - Evaluate need for 1115 waiver amendment to maximize federal match.

Fiscal Modeling Assumptions

- SBHRFs will replace some inpatient psychiatric utilization, reducing overall cost Per Member Per Month (PMPM) volatility.
- Ramp-up period will require temporary risk mitigation strategies.
- Non-Title XIX costs will be monitored for potential impact on the State General Fund (SGF).
- Occupancy projections assume gradual adoption.

Next Steps

- Complete fiscal modeling after finalization of utilization projections and fee schedule.
- Submit actuarial certification for capitation adjustments to CMS.
- Incorporate stakeholder feedback from RFI and public comment into final assumptions.

4. Potential Impact to State General Fund or Reductions in Other Covered Services

AHCCCS will evaluate whether utilization projections for Medicaid-eligible and Non-Title XIX populations will impact the SGF or require reductions in other covered services. This analysis ensures fiscal transparency and alignment with statutory obligations under A.R.S. 36-425.06. SBHRFs will serve both Title XIX members (Medicaid-eligible) and Non-Title XIX members. Title XIX costs will be largely absorbed into managed care capitation rates (see Section 3) and to a lesser extent paid through AHCCCS Fee For Service Programs, while Non-Title XIX costs will be direct SGF obligations. Fiscal impact will consider prioritization of SGF dollars for SBHRFs, projected occupancy, per diem rates and modifiers (Section 1), and potential offsets from reduced inpatient psychiatric, crisis services utilization, and emergency department boarding. (Section 3).

The AHCCCS 2025 SMI Annual Behavioral Health Report indicates more than \$1.2 billion was spent on behavioral health services for members with an SMI designation in SFY 2024. The members who meet the statutory criteria for SBHRF placement are among the highest-cost members in that population, with repeated inpatient admissions, crisis episodes, and emergency department boarding, are also the members most likely to be delayed in discharge from the Arizona State Hospital for want of a secure step-down setting. Because Title XIX placements will be funded through capitation and offset by reductions in those higher-cost services. Utilization of a new service is difficult to project with accuracy, so AHCCCS actuaries will continue to study utilization once services commence.

Methodology

- Utilization-Based Cost Modeling:
 - Apply Non-Title XIX projections (Section 2) and per diem rates (Section 1), including acuity and service modifiers.

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- Offset Analysis:
 - Quantify avoided costs in state-funded programs such as the Arizona State Hospital, which reported 46 discharges and 29 readmissions in SFY 2025, and jail diversion programs.
 - Incorporate potential savings from reduced crisis system utilization for mobile crisis responses and reductions in emergency department boarding for high-acuity members.
- Scenario Testing:
 - Conduct high/low utilization scenarios and sensitivity analysis for ramp-up delays or higher acuity cases.
 - Model fiscal impact under varying occupancy assumptions, including gradual adoption and accelerated demand driven by court-approved placements.

Risk Factors

- Variability in court-ordered placements for Non-Title XIX members.
- Workforce shortages delaying facility openings and impacting projected occupancy.
- Inflationary pressures on staffing and security costs, particularly for SBHRFs requiring enhanced clinical oversight and security infrastructure.

5. Network Adequacy Evaluation

SBHRFs will be a new addition to the continuum of care; therefore, a network adequacy evaluation cannot be completed at this time. As SBHRFs are implemented, AHCCCS will conduct ongoing comprehensive network adequacy evaluations to ensure SBHRFs are accessible statewide and integrated within the continuum of care for members with an SMI designation. This evaluation will align with A.R.S. 36-425.06, CMS managed care standards, and AHCCCS contractual requirements for timely access, geographic distribution, transportation, and capacity sufficiency.

Evaluation Framework

1. Geographic Distribution and Access Standards
 - a. Assess SBHRF placement relative to Arizona's population centers and rural regions.
 - b. SFY 2025 monitoring data indicates high involuntary inpatient psychiatric utilization concentrated in Maricopa and Pima counties, underscoring the need for SBHRF capacity in urban hubs while ensuring regional access for rural communities.
2. Capacity and Occupancy Modeling
 - a. Apply utilization projections from Section 2.
3. Service Array and Clinical Capability
 - a. Validate SBHRFs meet ADHS licensing requirements for secure settings and provide enhanced service array and clinical oversight as outlined in AHCCCS policy.
 - b. Incorporate modifiers for acuity and comorbidities as outlined in Section 1.
4. Workforce Adequacy
 - a. Evaluate staffing ratios and recruitment strategies to mitigate workforce shortages identified as a risk factor in Section 4.

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- b. Monitor compliance with minimum qualifications for behavioral health technicians, nurses, and Behavioral Health Professionals.
- 5. Coordination with Existing Network
 - a. Ensure SBHRFs complement existing BHRFs, crisis stabilization units, and inpatient psychiatric facilities to reduce emergency department boarding and jail placements.
 - b. Leverage crisis system data (74,336 responses in SFY 2025) to identify regions with high acute care demand.
 - c. Mitigation Planning
 - d. Network adequacy evaluation and gap mitigation strategies will include enhanced COT reporting to track SBHRF court orders, SBHRF bed availability monitoring, and implementation of escalation processes with health plans to resolve access issues.
 - e. Ongoing evaluation and planning are underway to develop a mitigation strategy specific to lack of SBHRF bed availability.

6. Federal Authority Review (1115 Waiver and State Plans)

Arizona operates its Medicaid program under the federal authority of two primary documents. The State Plan and the 1115 Demonstration Waiver. Both documents serve as a written contract between AHCCCS and CMS that describes the nature and scope of the Arizona Medicaid program. The State Plan assures that Arizona will administer the Medicaid and Children's Health Insurance (KidsCare) programs according to federal requirements under the provisions of the Social Security Act (SSA) and provides a basis for Federal Financial Participation (FFP). The 1115 Demonstration Waiver allows AHCCCS to waive or be exempt from certain federal provisions in order to implement innovative approaches to Medicaid service delivery while still maintaining compliance with other federal requirements. CMS has the responsibility for approval of any new additions or changes to both the State Plan and 1115 Waiver at the federal level.

At this time, no additional changes are needed to either the State Plan or the 1115 Demonstration Waiver to implement and access federal matching funds for the proposed SBHRFs. However, as the scope of work may evolve over time, AHCCCS will continue to evaluate whether additional State Plan or Waiver authorities are needed to support coverage of services in these settings and accessing federal matching funds.

The sixteen-bed cap in A.R.S. 36-425.06(A) keeps SBHRFs below the federal threshold at which a facility is treated as an Institution for Mental Diseases (IMD), so federal financial participation is available for Medicaid-eligible members without an IMD waiver or a change to Arizona's existing IMD authority. Physical and behavioral health services delivered in alignment with court-ordered placement in a licensed residential facility are covered services under the existing State Plan and waiver authority for BHRF-level care, and the new provider type and rate will be implemented under that authority. This is why no waiver amendment is required, and why no federal approval stands between rule finalization and facility opening. The remaining federal touchpoint is actuarial certification of the capitation adjustment, which is a routine part of the annual rate cycle.

Key considerations for ongoing evaluation include:

- Compliance with CMS Requirements: All proposed changes will be developed in alignment with CMS guidance to ensure federal match eligibility and adherence to Medicaid program integrity standards.

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- Potential Federal Authority Amendments: Depending on the final scope of services, AHCCCS may seek amendments to incorporate SBHRFs into existing behavioral health initiatives under the 1115 Demonstration and State Plans.
- State Plan Evaluation: AHCCCS will assess whether updates to the State Plan are required to reflect SBHRF service coverage, provider qualifications, and reimbursement methodologies.
- Stakeholder and Federal Engagement: AHCCCS will maintain ongoing collaboration with CMS and engage stakeholders throughout the process to ensure transparency and compliance.

Next Steps:

- Monitor SBHRF policy development.
- Conduct fiscal modeling to determine federal match opportunities.

7. Licensing Statute and Regulation Update Needs

ADHS completed rulemaking to implement A.R.S. 36-425.06, which requires licensure of SBHRFs. The new rules are effective as of August 5, 2026. The rules under Title 9, Chapter 10, Article 23 and Article 24 establish minimum standards for SBHRFs that provide 24-hour on-site supportive treatment and supervision for individuals who are seriously mentally ill and chronically resistant to treatment and court-ordered to the secure behavioral health residential facility under A.R.S. 36-550.09 or for individuals who are dangerous and incompetent to stand trial and court-ordered to the secure behavioral health residential facility under A.R.S. 13-4521. The rulemaking establishes two separate articles to address the different clinical and security needs of the Title 36 SMI and chronically resistant to treatment population and the dangerous, incompetent and non-restorable population committed under Title 13. This effectuates Laws 2025, Chapter 113 (SB 1604) which ADHS and AHCCCS worked with lawmakers on to clarify that those patient population cannot be treated in the same facility. For both populations, the rules include requirements for administration, quality management, personnel qualifications, admission criteria, treatment planning, and physical plant security. The rules define “secure” consistent with statute and incorporate provisions for court-ordered placements under A.R.S. 36-550.09 and 13-4521.

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TIMELINE FOR SBHRF RULEMAKING

DATE	RULEMAKING ACTIONS
April 22, 2025	Approval to conduct rulemaking
	Schedule rulemaking meetings with the Program to discuss/draft rules
April 23, 2025	File Notice of Rulemaking Docket Opening
May 16, 2025	Notice of Rulemaking Docket Opening published in Register (3-weeks later)
July 9, 2025	Post 1 st draft and online survey for stakeholder comment
July 9, 2025	E-mail stakeholders a request to review/comment on draft rules using an online survey Comment period closed August 10, 2025
	Program meetings to discuss stakeholder comments
October 6, 2025	ADHS and AHCCCS weekly meetings begin
December 5, 2025	Post 2 nd draft and online survey for stakeholder comment
December 5, 2025	E-mail stakeholders a request to review/comment on draft rules using an online survey Comment period closed December 22, 2025
January 23, 2026	E-mail stakeholders an invitation to attend the 1st Stakeholder Meeting
February 3, 2026	1 st Stakeholder Meeting
February 5, 2026	E-mail stakeholders follow-up to stakeholder meeting
February 19, 2026	2nd Stakeholder Meeting (Title 13) - 9am-11pm
February 20, 2026	3 rd Stakeholder Meeting (Title 36) - 10am-12pm
March 27, 2026	3rd draft posted for stakeholder comment
April 16, 2026	Email stakeholders inviting them to stakeholder meeting
April 23, 2026	4th Stakeholder Meeting
	Department Draft & Finalize Economic Impact Statement (EIS)
May 4, 2026	File Notice of Proposed Rulemaking, including close of record
May 4, 2026	Stakeholder notification sent regarding NPR and invitation to Oral Proceeding
May 22, 2026	NPR published in Register (3-weeks later)

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May 29, 2026	Preapproval pursuant to ARS 41-1039(B) request to submit to GRRC
June 22, 2026	Oral Proceeding & Close of Record (30 days after NPR is published)
June 2026	Review comments; if no substantial changes, prepare NFR
June 2026	Program approves Notice of Final Rulemaking
June 22, 2026	Governor's Office approval to submit to GRRC pursuant to ARS 41-1039(B)
June 23, 2026	Submit NFR to Governor's Regulatory Review Council
July 28, 2026	GRRC Study Session
August 4, 2026	GRRC Approval meeting
August 5, 2026	File Notice of Final Rulemaking with SOS
August 5, 2026	Rules are effective
August 28, 2026	NFR published in Register (3-weeks later)

See the ADHS's Administrative Council and Rules [rulemaking webpage](#) for additional details, including the final rule and drafts.

In addition to the rulemaking effort, ADHS successfully worked with AHCCCS, stakeholders, and the legislature to address an unintended consequence of the underlying SBHRF law by clarifying through Laws 2026, Chapter 160 (SB 1242) that an SBHRF is not a mental health treatment agency (MHTA). Prior to the statutory clarification of SB 1242, SBHRFs met the definition of mental health treatment agency under Title 36, Chapter 5. Specifically, because it was a "health care agency that is licensed by the department and provides the services that are required of the agency by this chapter" (ARS 36-501(28)(b)). As a result, SBHRFs would have been required to have a medical director and provide services more typical of an SMI clinic but not typical of an unsecured BHRF like psych services, case management, medication, etc. While the aforementioned ADHS rulemaking included flexibilities to accommodate this statutory outcome, some additional clarification in the rules may be necessary.

At this time, no additional statutory regulatory updates are anticipated.

8. Proposed AHCCCS Policy, Contract, and Reporting Needs

AHCCCS currently maintains a policy for Behavioral Health Residential Facilities (BHRFs) under AMPM Policy 320-V, which establishes requirements for admission criteria, treatment planning, discharge readiness, and service scope for non-secure residential settings. However, SBHRFs, as defined under A.R.S. 36-425.06 and implemented through ADHS licensing rules (Article 23), represent a distinct level of care with statutory requirements for security, court-approved placement, and enhanced clinical oversight. Therefore, AHCCCS must develop a new policy specific to SBHRFs to ensure compliance with state law, alignment with ADHS licensing standards, and integration into managed care and Fee-for-Service programs.

Now that ADHS has completed SBHRF Rulemaking, AHCCCS will be initiating meetings with stakeholders regarding policy development for SBHRFs in the fall of 2026.

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Evaluation Framework

AHCCCS anticipates the following sequence, subject to stakeholder input and procurement requirements.

- Stakeholder policy sessions will begin in November 2026. AHCCCS will meet with family advocacy organizations, provider associations, the Administrative Office of the Courts, disability rights organizations, and contracted health plans to gather rate and policy input.
- SBHRF policy and a proposed rate will be published for a 30-day public comment period.
- RFP submissions will be evaluated and contracts awarded.
- ADHS licensure of awarded facility(s) will follow retrofit.
- AHCCCS will report progress against these milestones annually, as required by A.R.S. 36-425.06(B).

Key Policy Development Areas

1. Alignment with ADHS Licensing Rules
 - a. Incorporate requirements from AAC Title 9, Chapter 10, Article 23, including:
 - i. Secure premises and physical plant standards.
 - ii. Admission limited to individuals whose placement is approved by the court pursuant to A.R.S. 36-550.09
 - iii. Enhanced staffing standards.
2. Clinical Scope of Work
 - a. Define SBHRF as a treatment-focused secure setting, not solely custodial care.
 - b. Require individualized treatment plan updates within seven days of admission, incorporating judicial review requirements under A.R.S. 36-546 and A.R.S. 36-540 (C)(2).
 - c. Mandate continuous protective oversight and integration of behavioral health and personal care services as outlined in ADHS rules.
3. Admission and Continued Stay Criteria
 - a. Adapt BHRF medical necessity framework to reflect:
 - i. Court-approved placement as primary admission pathway.
 - ii. Exclusion of voluntary admissions unless authorized by statute.
 - iii. Continued stay reviews tied to judicial timelines and treatment progress.
 - iv. Discharge Planning
 - b. Align with statutory requirements for discharge to less restrictive alternatives.
 - c. Ensure coordination with courts, outpatient providers, and community supports.
 - d.
4. Alignment with and updates to existing AHCCCS policy, service models and contracts.
5. Reporting
 - a. Enhanced COT reporting to track SBHRF court orders.
 - b. Development of SBHRF bed availability monitoring.
 - c. Development of SBHRF-specific utilization and service delivery monitoring.
 - d. Development of escalation processes with health plans to resolve access issues.

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Update to Statewide Community Residential Treatment Plan

AHCCCS will update the Statewide Community Residential Treatment Plan to comply with A.R.S. 36-550.01, ensuring SBHRFs are integrated into a statewide system of mental health residential treatment programs that provide alternatives to institutional care. The updated plan will:

- Include a county-by-county description of current programs and service delivery mechanisms for individuals with an SMI designation.
- Identify opportunities for intergovernmental collaboration across jurisdictions.
- Establish goals, objectives, and priorities for service delivery, with evaluation methods for effectiveness.
- Outline strategies for cooperation with counties to maintain a coordinated system of residential care.
- Define methods for estimating statewide need and allocating state funds based on that need.

New Provider Type Development

AHCCCS will create a distinct provider type for SBHRFs to:

- Enable enrollment of facilities licensed under Article 23.
- Support accurate claims adjudication and rate-setting.
- Facilitate network adequacy monitoring specific to secure residential care.

Provider type requirements will include:

- ADHS license verification for SBHRF.
- Compliance with AHCCCS policy and contractual obligations.
- Capability to submit encounter data reflecting secure placement and specialized services.

Policy Integration and Implementation Timeline

- Draft SBHRF policy following finalization of ADHS rules.
- Incorporate:
 - Admission, continued stay, and discharge criteria.
 - Service scope and documentation standards.
 - Prior authorization exceptions for court-ordered placements.
- Publish policy updates in the AHCCCS Medical Policy Manual.
- Update AHCCCS Managed Care Organization (MCO) contracts to:
 - Include coverage for SBHRF services as prescribed in the new policy.
 - Require MCOs to maintain an adequate network of SBHRFs consistent with the updated Statewide Community Residential Treatment Plan and statutory requirements under A.R.S. 36-550.01.
- Coordinate with AHCCCS Provider Enrollment to activate the new provider type concurrent with policy effective date.

9. Proposed Updates to Court Ordered Treatment Forms and Proposed Orders

Arizona's Court-Ordered Evaluation (COE) and Court-Ordered Treatment (COT) processes under Title 36, Chapter 5 rely on standardized forms prescribed by AHCCCS in Arizona Administrative Code, Title 9, Chapter 21. Recent stakeholder feedback and AHCCCS analysis have identified that these forms can be utilized to ensure courts are

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receiving consistent, clinically informed recommendations from evaluating medical professionals regarding whether the criteria for SBHRF placement are met, as well as to permit standardized data gathering and tracking statewide. As such, AHCCCS intends to partner with courts to align proposed orders with updated forms, and subsequently initiate formal rulemaking to revise Title 9, Chapter 21, Article 5 to:

1. Standardize Forms Statewide
 - a. Mandate use of uniform forms by providers and courts for COE and COT processes across all counties.
 - b. Collaborate with Arizona courts to require adoption of standardized forms for filing petitions and orders.
2. Expand Data Fields in Standardized Forms and Orders
 - a. Petition for COE:
 - i. Legal basis for COT (DTS, DTO, PAD, GD).
 - b. Petition for COT:
 - i. Legal basis for COT (DTS, DTO, PAD, GD).
 - ii. SBHRF recommendation and how statutory criteria for establishing the need for SBHRF order pursuant to A.R.S. 36-550.09(B) are met.
 - c. Order for COT:
 - i. Legal basis for COT (DTS, DTO, PAD, GD).
 - ii. Start and expiration dates of orders.
 - iii. SBHRF recommendation and how statutory criteria for SBHRF order are met.
 - iv. Start and end date for SBHRF order.
 - v. Renewal status and reasons for non-renewal.
 - vi. Treatment adherence metrics and tolling status.

10. Legal Analysis

After a comprehensive legal analysis into whether providing covered services in SBHRFs would violate state or federal law, AHCCCS has concluded that SBHRFs are permissible under both Arizona and federal law when implemented with required safeguards.

SBHRFs are authorized under Arizona law (A.R.S. 36-3407) as part of the continuum of care for individuals with an SMI designation and are consistent with the *Arnold v. Sarn* settlement, provided comprehensive services are maintained. SBHRFs, when established through court order, do not violate the Americans with Disabilities Act (ADA) or the *Olmstead* decision, provided legal safeguards are observed. These safeguards generally include:

- Placement only by court order, with the court confirming that an SBHRF is the least restrictive setting.
- Individualized, documented treatment plans that are regularly reviewed.
- Access to required covered services while in the SBHRF.
- Placement only for as long as medically necessary.
- A plan for timely transition to less restrictive settings when appropriate.

These safeguards respond to concerns raised during rulemaking by disability rights organizations, and they are consistent with the position of the family and provider organizations that sought the facilities. Placement in an SBHRF is not an alternative to community-based services and does not divert resources from them. A court may

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approve placement only after finding by clear and convincing evidence that treatment in less restrictive settings, including unsecured residential care, was attempted and failed or was refused, and that the person's nonadherence produced serious harm, recurrent homelessness, recurrent medical crises, or recurrent arrests. The population that meets that standard is small. Placement is intended to be time-limited and followed by return to community treatment with the same service array Arizona is obligated to provide under *Arnold v. Sarn*. Members placed in an SBHRF retain their rights under A.R.S. Title 36, Chapter 5, including judicial review of the order, access to the AHCCCS Office of Human Rights, and the ADHS complaint process, and the ADHS rules require that restrictions on egress be the least restrictive consistent with the court-ordered treatment plan.

AHCCCS will continue to monitor compliance with these safeguards to ensure ongoing adherence to state and federal requirements as the SBHRF level of care is implemented and integrated into the existing continuum of care.

Summary

The implementation of SBHRFs represents a critical advancement in Arizona's behavioral health continuum, addressing the needs of individuals with an SMI designation who require secure, court-ordered treatment under Title 36 outside of the Arizona State Hospital setting in order to maximize the benefits derived from COT. This report provides a comprehensive roadmap for operationalizing SBHRFs, including proposed fee structures, utilization projections, fiscal impact modeling, network adequacy strategies, licensing requirements, policy development, and legal compliance considerations.

The interval between authorization in 2019 and the opening of the first facility has been the product of an initial grant that did not succeed, a statutory drafting issue that made providers unwilling to proceed until the Legislature acted in 2025, and the sequence of rulemaking, rate-setting, policy development, and procurement that state and federal law require before Medicaid can pay for a new level of care. That sequence is public and stakeholder-heavy by design. It has now been completed on the licensing side and is underway on the Medicaid side, on the schedule described in Section 8. The RFP is open and funded, and AHCCCS intends to award it.

SFY 2025 COT monitoring data shows 71% of individuals on COT reside in the Central GSA, 23% reside in the Southern GSA, and 5% reside in the Northern GSA. The Trends in Population Size and Utilization of Facility Services by the Title 36 Population in Arizona Medicaid Report, developed by The Arizona State University Center for Health Information Research (ASU CHiR), longitudinally support these findings, indicating the vast majority of individuals on COT reside in Maricopa County. Given this information and the funding allotted through the State of Arizona general appropriations act; 2025-2026, one or two SBHRFs could be developed, giving prioritization to Maricopa County locations.

By aligning statutory mandates with evidence-based practices and stakeholder input, AHCCCS and ADHS aim to ensure that SBHRFs operate within a secure, clinically appropriate framework that prioritizes recovery, safety, and integration. The plan emphasizes:

- Maintaining robust community-based services consistent with *Arnold v. Sarn* obligations.
- Adhering to least restrictive placement standards and *Olmstead* principles.
- Leveraging federal financing opportunities to maximize sustainability.
- Implementing standardized policies, forms, and reporting to enhance transparency and accountability.

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Successful implementation will require continued collaboration among AHCCCS, ADHS, the Arizona Office of the Courts, AHCCCS-contracted MCOs, providers, and other stakeholders. As policy writing and rate-setting processes advance, AHCCCS will incorporate feedback from stakeholder sessions to refine operational requirements. Through these coordinated efforts, Arizona will establish a secure treatment option that reduces reliance on inpatient psychiatric facilities and the crisis system, improves continuity of care, and supports long-term recovery outcomes for individuals with an SMI designation who meet the statutory definition of chronically resistant to treatment.