320-T1 – BLOCK GRANTS AND DISCRETIONARY GRANTS

EFFECTIVE DATES: 07/01/20, 10/01/20, 10/01/21, 10/01/22, 10/01/24

APPROVAL DATES: 05/04/21, 08/10/21, 09/15/22, 06/06/24

I. PURPOSE

This Policy applies to ACC, ACC-RBHA, ALTCS E/PD, DCS CHP (CHP), and DES DDD (DDD) Contractors; Fee-For-Service (FFS) Programs including: American Indian Health Program (AIHP), Tribal Behavioral Health Authorities (TRBHAs), Tribal ALTCS, DES DDD Tribal Health Program (DDD THP) and all FFS populations, and all other entities who have a direct Non-Title XIX/XXI funded contractual relationship or agreement with AHCCCS (collectively 'Contractors'). This excludes Federal Emergency Services (FES). (For FES, refer to AMPM Chapter 1100). This Policy specifies Contractor requirements for the provision and coordination of Non-Title XIX/XXI behavioral health services and allowable activities funded by Block Grants and Discretionary Grants. For Tribal ALTCS refer to the Intergovernmental Agreements (IGAs).

II. DEFINITIONS

Refer to the AHCCCS Contract and Policy Dictionary for common terms found in this Policy including:

BEHAVIORAL HEALTH PARAPROFESSIONAL (BHPP)	**BEHAVIORAL HEALTH PROFESSIONAL (BHP)**	**BEHAVIORAL HEALTH RESIDENTIAL FACILITIES (BHRF)**
BEHAVIORAL HEALTH TECHNICIAN (BHT)	**FIRST EPISODE PSYCHOSIS (FEP)**	**GENERAL MENTAL HEALTH (GMH)**
INTERGOVERNMENTAL AGREEMENT (IGA)	**INTERAGENCY SERVICE AGREEMENT (ISA)**	**MEMBER**
MEDICATIONS FOR OPIOID USE DISORDER (MOUD)	**SERIOUS EMOTIONAL DISTURANCES (SED)**	**SERIOUS MENTAL ILLNESS (SMI)**
SUBSTANCE USE DISORDER (SUD)		

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

EARLY SERIOUS MENTAL ILLNESS (ESMI)	A first onset of diagnostic and functional criteria consistent with a Serious Mental Illness as specified in Arizona Revised Statute ARS 36-550 (that may include a First Episode of Psychosis) and of an individual 18 years of age or older.
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)	A first episode of psychosis may manifest as symptoms that include problems in perception (such as seeing, hearing, smelling, tasting, or feeling something that is not real), thinking (such as believing in something that is not real even when presented with facts), mood, and social functioning that is not due to the psychological effects of a substance. An individual may be early in the course of a psychotic illness or treatment irrespective of being in the midst of a first 'episode' of illness.
FIRST EPISODE PSYCHOSIS (FEP) PROGRAM	A program focused on the early identification and provision of evidence-based treatment and support services to adults and adolescents 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.
NON-TITLE XIX/XXI FUNDING	AHCCCS funding sources outside of Title XIX/XXI Medicaid funds that could include but are not limited to: State appropriated general funds, State non-appropriated funds, County funds, block or formula grants, discretionary grants, or other grant-based funding.

PRIMARY PREVENTION

The Programs, interventions, and strategies that are directed at individuals who have not been determined to require treatment for substance use and delivered prior to the onset of a Substance Use Disorder (SUD). Substance use primary prevention strategies generally include education, information dissemination, problem identification and referral, environmental strategies, alternative activities, and community-based processes.

PRIMARY PREVENTION EVIDENCE BASED PRACTICES (SUBSTANCE USE ONLY)

Interventions that fall into one or more of four 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 (e.g., law enforcement officials, educators, or elders within indigenous cultures).
4. For tribal entities or communities, the model of "Culture Is Prevention" framework is accepted by AHCCCS as an evidence-based practice.

SUBRECIPIENT	A recipient of a subaward from a pass-through entity to carry out a portion of a federal award as specified in 2 CFR 200.1.
TERTIARY PREVENTION	Evidence based practice, also referred to as harm reduction, which includes prevention, risk reduction and health promotion. These are activities aimed to reduce the lasting impact of substance use or Substance Use Disorder (SUD). Emphasis is on engaging people who use drugs to prevent overdose and disease transmission, and to help people manage their disorder and its impacts through incremental change.

III. POLICY

The ACC-RBHAs and TRBHAs are responsible for the administration, oversight, and monitoring of Non-Title XIX/XXI funds and funded activities per the Non-Title XIX/XXI Contracts/Intergovernmental Agreements (IGAs). The ACC-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 and funded activities in a manner consistent with the Non-Title XIX/XXI's identified eligible populations as defined by the funding authority that governs each specific grant. The ACC, ALTCS E/PD, CHP, and DDD Contractors, AIHP, and FFS providers that do not receive or administer Non-Title XIX/XXI funding shall assist members in accessing services utilizing these funding sources and shall coordinate care for members as appropriate though established relationships and processes with those entities who do have a contractual relationship or agreement with AHCCCS to manage Non-Title XIX/XXI funding. For Tribal ALTCS members, providers shall contact the Tribal ALTCS program of enrollment if they feel a member qualifies for a Non-Title XIX services.

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 on the Medical Coding Resources page of 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 AAC 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. GENERAL REQUIREMENTS FOR FISCAL AND PROGRAMMATIC OVERSIGHT OF FEDERALLY FUNDED GRANT PROGRAMS

The ACC-RBHAs and TRBHAs shall develop policies and procedures to ensure that all sub-recipients have policies and procedures that demonstrate compliance with 2 CFR Part 200 uniform administrative requirements, cost principles and audit requirements for federal awards.

The ACC-RBHAs policies and procedures for subrecipient monitoring and oversight shall include, at minimum, a process for conducting site audits, a process for verification of single audit compliance as specified under the Single Audit Act. 31 USC 7502, and a process for grant year close out procedures. ACC-RBHAs shall conduct site audits shall be conducted for all new subrecipients within the first year of the award and then once every three years thereafter. ACC-RBHAs shall conduct site audits in-person and include a documented review of both financial and programmatic activities.

The ACC-RBHAs and TRBHAs shall ensure that all subrecipient proposed programs are consistent with the approved federal award allowable activities being requested and shall ensure that subrecipient policies and procedures are developed and approved prior to award to ensure ongoing compliance.

C. 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. For Non-Title XIX/XXI eligible populations, 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. Non-Title XIX/XXI funded services may be restricted to certain members as specified in this Policy, by the funding authority that governs each specific grant 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.

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 is the application of auricular acupuncture needles to the pinna, lobe, or auditory meatus to treat alcoholism, substance use, trauma, or chemical dependency by a certified acupuncturist practitioner as specified in ARS 32-3922.

2. Childcare (also referred to as child sitting services) are covered under SUBG and/or SOR funded programs 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. Residential programs that allow parenting women and their children to remain together during SUD treatment may request child sitting services to allow parents to fully participate in treatment. Child sitting services are subject to Contractor approved subrecipient program proposals, policies and procedures for outpatient and residential providers. The following limitations apply:
   a. The amount of childcare services and duration shall not exceed the duration of MAT or outpatient 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(ren) is(are) 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. Traditional Healing Services are 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. Room and Board is allowable for the provision of lodging and meals to an individual residing in a residential facility or supported independent living setting providing behavioral health or substance use treatment 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 (BHRF).

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, Social Security Income [SSI]) shall be exhausted prior to billing this service, and
b. For Substance Use Block Grant (SUBG) 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, or
    iii. Outpatient clinics may bill Room and Board code only when providing services to members in Supervised Independent Living settings.

5. 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 (OUD). 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 USC 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.

D. NON-TITLE XIX/XXI ELIGIBLE POPULATIONS

Non-Title XIX/XXI eligible members are enrolled with an ACC-RBHA or TRBHA and other entities who have a direct Non-Title XIX/XXI funded contractual relationship with AHCCCS and 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 ACC-RBHA shall require their providers to use the applicable pseudo-ID numbers that are assigned to each ACC-RBHA. For assistance, contact the AHCCCS Encounters Unit. Pseudo-ID numbers are not assigned to TRBHAs. Encounters are not submitted for substance use primary prevention services.

The ACC-RBHAs and TRBHAs are responsible for crisis intervention services, refer to AMPM Policy 590 or TRBHA Intergovernmental Agreement (IGA) for a detailed description of crisis intervention services and responsibilities.

E. SUBSTANCE USE BLOCK GRANT

1. Purpose and Goals
   The SUBG 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 SUBG 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 SUBG 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 SUBG covered services.

   Goals of the SUBG include, but are not limited to the following:
   a. To ensure coordination of access to a comprehensive system of care, including but not limited to: 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 prevention and treatment, where prevention effectively provides 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 members 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, and older adults,
   e. To promote recovery and reduce risks of communicable diseases related to substance use, and
   f. To increase accountability through uniform reporting on access, quality, and outcomes of services.

Additional guidance for SUBG treatment and prevention can be found in the Frequently Asked Questions (FAQ) document on the AHCCCS Grants SUBG webpage.

2. Eligible Populations
   All Members receiving SUBG-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 SUBG 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. Incarceration for longer than 12 months that indicates substance use in the 12 months prior to incarceration.

3. Priority Populations
   The SUBG 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. The Contractor and TRBHAs requesting to use SUBG 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 SUBG, 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 Programs and Practices (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 SUBG Providers - Members receiving SUD treatment services under the SUBG 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 SUBG 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 ACC-RBHAs or TRBHAs, of the referral and ensure that the member contacts the alternative provider. The ACC-RBHAs and TRBHAs shall develop and make available policies and procedures that indicate who the providers shall contact and how they shall notify the ACC-RBHAs or TRBHA of these referrals. The ACC-RBHA and TRBHA 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 (e.g., pregnant women, women with dependent children, and People Who Inject Drugs [PWID]) who are waiting for placement in a BHRF, to the AHCCCS SUBG 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 SUBG priority population waitlist.

   Priority population members who are not pregnant, parenting women, or PWID shall be added to the AHCCCS SUBG priority population waitlist if the ACC-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. Human Immunodeficiency Virus (HIV) Early Intervention Services - Because individuals with SUDs are considered at high risk for contracting HIV-related illness, the SUBG requires HIV intervention services to reduce the risk of transmission of this disease. With respect to individuals undergoing treatment for substance use, the ACC-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.

   The ACC-RBHAs and TRBHAs receiving SUBG funding, shall develop and make available to providers policies and procedures that describe where and how to access HIV early intervention services, noting that services are provided exclusively to populations with SUDs. The ACC-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 SUBG populations,
   d. Administer a minimum of one test per $600 in SUBG 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 SUBG 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 TB 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 TB,
   b. Testing to determine whether the individual has been infected with mycobacteria TB to determine the appropriate form of treatment for the individual, and
   c. Providing for or referring the individuals infected by mycobacteria TB for appropriate medical evaluation and treatment.

   The Contractor shall submit the SUBG 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 TB 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 TB services,

c. Implement infection control procedures designed to prevent the transmission of TB, 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 SUBG populations:
    a. SUBG 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/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 regarding allowability of grant funded services and activities are subject to specification by the governing federal funding source and may include restrictions not specifically outlined in this Policy. Members shall not be charged a copayment for treatment, or supportive services funded by the MHBG, SUBG and Discretionary Grant programs. Sliding scale fees established regarding room and board do not constitute a copayment.

F. SUBSTANCE USE BLOCK GRANT PRIMARY PREVENTION

AHCCCS directly administers the SUBG Primary Prevention funding, a 20% minimum set aside of the entire SUBG award, through various contracts and agreements.

1. 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.

2. 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).

3. 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.

4. 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.

5. 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/misuse prevention outcome.

G. 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), Serious Emotional Disturbances (SED), Early Serious Mental Illness (ESMI) including First Episode Psychosis (FEP). The MHBG provides funding for 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 by the state under 42 USC 300x–1(a) 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. To ensure coordination of access to a comprehensive system of care and promote recovery and community integration for adults with an SMI designation, children with an SED designation, and individuals experiencing ESMI including FEP,
   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, and
   d. 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 an SMI designation, an SED designation or Early Serious Mental Illness (ESMI) including FEP.

For the purposes of MHBG ESMI funding eligibility, an individual is considered ESMI beginning on the date of the diagnostic assessment that results in a qualifying diagnosis and prompts the submission of the SMI eligibility determination. Refer to AMPM Policy 320-P for SMI determination requirements. Contractors who do not have a Non-Title XIX/XXI funded contractual relationship or agreement with AHCCCS shall ensure that providers coordinate with the ACC-RBHA or TRBHA responsible for the administration of Non-Title XXI/XIX funding and complete referrals to ESMI providers based on the members identified needs. ESMI identified member remain eligible for ESMI MHBG funded services for up to 90 days regardless of the outcome of the SMI eligibility determination. If the individual is designated SMI via the determination process, the individual's eligibility transfers to SMI MHBG funding on the date of decision. If the individual is not designated SMI via the determination process, the individual remains eligible for ESMI MHBG funded services for the remainder of the 90 days during which time the Contractor shall ensure that services include active transition planning with the member including connection to all available community resources.

Screening/assessments are covered for Non-Title XIX/XXI eligible members when the screening/assessment is an initial screening/assessment, or the screening/ assessment is to determine appropriateness for admission to mental health facilities. A secondary provider screening/assessment to decide determinations is unallowable. Refer to AMPM Policy 320-O for additional information on behavioral health assessments and treatment/service planning.

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

Excluded conditions, as specified in the 58 Federal Register 29422 (May 20, 1993), are SUDs, 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 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.

For the purposes of this Policy, an individual qualifies as ESMI based on the early onset of diagnostic and functional impairment criteria specified in 2024 SMI Diagnosis List; refer to the AHCCCS Medical Coding Resources web page and AMPM Policy 320-P. These are not intended to include conditions that are attributable to: the physiologic effects of an SUD, an intellectual/developmental disorder, or another medical condition.

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

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

4. The 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. The MHBG funds for payment of behavioral health drugs for Individuals designated with an SED, SMI and ESMI including FEP (Both Title XIX/XXI and Non-Title XIX/XXI):
   a. The TRBHAs and ACC-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 SED or SMI designation and ESMI members including FEP, subject to the following:
      i. Coverage of cost sharing is to be used only for State and Federal reimbursable medications used to treat an SED, SMI or ESMI behavioral health diagnosis including medications to treat the side effects of these medications,
      ii. Medicare copayments and cost sharing are covered for members determined to have an SED or SMI designation or qualifying ESMI diagnosis for medications to treat an SED, SMI or ESMI qualifying behavioral health diagnoses when dispensed by an AHCCCS-registered provider,
      iii. The payment of Medicare Part D copayments and cost sharing amounts for medications used to treat an SED, SMI or ESMI behavioral health diagnosis for individuals with an SED or SMI designation or qualifying ESMI diagnosis, shall be provided regardless of whether or not the provider is in the Contractor's provider network and prior authorization shall not be required,
      iv. The ACC-RBHA Contractor shall not apply pharmacy benefit utilization management edits when coordinating reimbursement for Medicare Cost Sharing for medications to treat individuals with an SED or SMI designation or qualifying ESMI diagnosis, and
      v. When a request for a medication to treat an individual with an SED or SMI designation or ESMI 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 SED, SMI or ESMI behavioral health diagnosis.

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, and
c. The Contractor shall ensure the Pharmacy Benefit Manager (PBM) plan set up for Medicare cost sharing for individuals with an SED or SMI designation or ESMI qualifying diagnosis is the same PBM set up for all ACC-RBHA PBM subcontractors as approved by AHCCCS.

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 (including youth in detention) - Treatment during incarceration is an allowable use of the MHBG for individuals with an SED or SMI designation or a qualifying ESMI diagnosis, 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 which 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. The Contractor 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 BPPs,
      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.

8. Non-Encounterable MHBG Activities or Positions - Outreach activities or positions that are non-encounterable may 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.
9. 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, and

c. Funded positions or interventions need to focus on identifying those with an SED designation and getting those who do not qualify for Title XIX/XXI funded services engaged in services through the MHBG.

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.

H. PROJECT FOR ASSISTANCE IN TRANSITION FROM HOMELESSNESS

Project for Assistance in Transition from Homelessness (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. It is designed to be an outcome driven grant program to support outreach and service delivery to individuals demonstrating symptoms consistent with a serious mental illness or co-occurring SMI and SUDs and experiencing homelessness or at imminent risk of homelessness. PATH engages individuals not currently connected to mainstream mental health services, primary health care and substance use service systems. The SMI designation as described in AMPM Policy 320-P is not a prerequisite to the member receiving PATH services; however, PATH providers are expected to complete or make a referral for completion of the evaluation for SMI designation in addition to Title XIX eligibility to ensure comprehensive coverage for medically necessary services.

1. Eligible Populations
   a. Adults (individuals 18 years of age or older) demonstrating symptoms consistent with serious mental illness; or
   b. Adults demonstrating symptoms consistent with a serious mental illness and a substance use disorder; and
   c. Are homeless or at imminent risk of becoming homeless.

2. Funding Restrictions
   a. The PATH recipients are required to adhere to guidance listed in 45 CFR Part 75 Subpart F, which are available within the Electronic CFR. In addition, PATH recipients shall comply with the following funding restrictions:
      i. Grant funds shall only be used for purposes supported by the program, and
      ii. No more than 4% of the Federal PATH funds received shall be used for administrative expenses, 42 USC 290cc-22(f), and
      iii. No more than 20% of the Federal PATH funds allocated to the state may be expended for eligible housing services, as specified 42 USC 290cc-22 subsection (b)(10).
   b. Grant funds may not be used for the following:
      i. Supporting emergency shelters or construction of housing facilities,
      ii. For inpatient psychiatric treatment costs,
      iii. For inpatient substance use treatment costs, or
      iv. Making cash payments to intended recipients of mental health or substance use disorder services, or
      v. 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.

I. STATE OPIOID RESPONSE GRANT

The State Opioid Response (SOR) program aims to address the opioid and stimulant use crisis by increasing access to MAT, specifically Medications for Opioid Use Disorder (MOUD) 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 evidence-based prevention, harm reduction, treatment, and recovery activities for OUD (including illicit use of prescription opioids, heroin, and fentanyl and fentanyl analogs), this program also supports the Continuum of Care to address stimulant misuse and use disorders, including 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, interventions, and service delivery models that enable the full spectrum of treatment and recovery support services that facilitate positive treatment outcomes and long-term recovery from opioid and stimulant use disorders.

   Medically managed withdrawal (detoxification) is not the standard of care for OUD as it 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, SAMHSA does not recognize medically managed withdrawal (detoxification), when done in isolation, as an evidence-based practice for OUD. If medically managed withdrawal (detoxification) services are provided by the Contractor, TRBHAs, or subcontractors, it must be accompanied by the offer and provision of injectable extended-release naltrexone to protect such individuals from opioid overdose in case of return to use and improve treatment outcomes.

3. The Contractor and TRBHAs shall make available FDA approved MOUD for individuals diagnosed with OUD.

4. The Contractor and TRBHAs shall offer a comprehensive and effective array of prevention, harm reduction, treatment, and recovery services for OUD and stimulant use disorder that are tailored to individual, community, and program needs.

5. Reporting Requirements and Deliverables
   a. As SOR is a Center for Substance Abuse Treatment (CSAT) grant, a contractor, subrecipient or TRBHA who is identified to be providing treatment and/or recovery support services shall complete the Government Performance and Modernization Act (GPRA) Client Outcomes Measurement Tool for members as soon as possible but no later than four days after the client officially enters the substance abuse treatment program. Additionally, reasonable efforts shall be made to complete the tool again at both the six-month mark and at service discharge, and
   b. The Contractor and TRBHAs shall develop and implement a progressive action policy for subrecipients who are not meeting GPRA targets as specified in approved budgets or compliance standards for programmatic deliverables. The Contractor and TRBHAs shall provide technical assistance to subrecipients determined in need of a progressive action policy.

6. Deliverables - Reporting templates and submission deadlines are outlined as part of ACC-RBHA and TRBHA allocation letters as well as all direct contracts or agreements under the SOR program. Reporting requirements are subject to change at the discretion of the SAMHSA and/or AHCCCS. AHCCCS will provide technical assistance and support to the Contractor and TRBHAs if changes to the reporting requirements are made during the reporting period. Written requests for reasonable accommodation will be considered on a case-by-case basis and are subject to AHCCCS approval.

J. NON-TITLE XIX/XXI FUNDED CARE COORDINATION REQUIREMENTS

Non-ACC-RBHA Contractors shall ensure that providers work with the ACC-RBHA and/or TRBHA to enroll any identified uninsured or underinsured individuals to facilitate access to Non-Title XIX/XXI funded services immediately, while continuing to assist the individual with the processes to determine Title XIX/XXI eligibility and ensure MHBG and SUBG funds remain the payor of last resort. 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 actively collaborate with the care coordination teams of all involved Contractors or payors to ensure each member's continuity of care. Members with an SMI designation are enrolled with an ACC-RBHA unless they qualify for and are enrolled with an ALTCS-E/PD, DES DDD or Tribal ALTCS program. American Indian members with an SMI designation 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 actively attempt to prevent an interruption in services. The provider shall work with the care coordinators of the Contractor or ACC-RBHA in the Geographic Service Area (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 ACC-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 not eligible for Title XIX/XXI covered services may be considered uninsured or those who are covered by another health insurance plan, including Medicare, may be considered underinsured and still be eligible for Non-Title XIX/XXI services. The Contractor shall ensure that providers 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 Non-Title XIX/XXI funded behavioral health services. Refer to ARS 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 who qualify may 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 ACC-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.

The ACC-RBHAs, TRBHAs, and other entities who have a direct contractual relationship with AHCCCS are responsible for managing Non-Title XIX/XXI funding to ensure that funding is available for the fiscal period and if all Non-Title XIX/XXI funding is expended, ACC-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. 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 actively collaborate with the care coordination teams of all involved health plans or payors to overcome the identified barrier(s). 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, Clinical Resolutions Unit (CRU). If the provider believes that there are systemic problems, rather than an isolated concern, the provider shall notify AHCCCS, CRU of the potential barrier. AHCCCS will conduct research and work with the Contractor and responsible entities to address or remove the potential barriers.

K. NON-TITLE XIX/XXI FUNDING SOURCES

All Non-Title XIX/XXI funding, as listed in the AHCCCS Allocation Schedule and/or Allocation Letter, shall be used for medically necessary behavioral health services or allowable activities as specified the specific grant program.

The ACC-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.

The 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/ISA and/or Allocation Letters. An example of a discretionary grant includes, but is not limited to, the SOR grant.

L. 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/IGA. AHCCCS accomplishes monitoring objectives through a variety of techniques, including but not limited to, receiving, and reviewing reports and/or deliverables, holding regularly scheduled meetings with the Contractor, which may include TRBHAs, monitoring spending through Contractor Expense Reports (CERs), conducting Operational Reviews and/or desk reviews, completing site visits, and other opportunities required with each individual grant requirement.

M. THE SUBG 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 ACC-RBHA and TRBHA reporting requirements related to the Block Grants as specified in Contract, Section F, Attachment F3, Chart of Deliverables and as specified in IGAs, Allocation Letters or agreements.

The Federal Block Grant Report and Plan Reporting timeframes for the Block Grant Report 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 prior to due dates.

The reports shall comprehensively describe programmatic and financial activities funded by the block grants during the identified time period.

The Contractor is responsible for complying with oversight and monitoring including all subrecipient obligations under Federal Block Grant funds in accordance with 2 CFR 200 Subpart D - Subrecipient Monitoring and Management. The Contractor shall provide evidence of oversight and monitoring, and activities as requested by AHCCCS.

N. OVERSIGHT AND MONITORING

AHCCCS monitors the Contractor for compliance with federal and state statute, regulations, and guidelines to determine if the Contractor(s) are providing services outlined within their AHCCCS Contract/agreement. AHCCCS accomplishes monitoring objectives through a variety of techniques, including but not limited to:

1. Receiving and reviewing reports and/or deliverables.

2. Monitor spending through Contractor Expense Reports (CERs).

3. Conducting operational reviews.