320-V - BEHAVIORAL HEALTH RESIDENTIAL FACILITIES

EFFECTIVE DATES: 02/08/19, 10/01/19, 10/01/20, 10/01/21, 10/01/22[1]

APPROVAL DATES: 10/18/18, 02/07/19, 07/02/19, 05/07/20, 04/13/21, 04/28/22[2]

I. PURPOSE

This Policy applies to ACC, ACC-RBHA[3], ALTCS E/PD, DCS/CHP~~omprehensive Health Plan~~ (CHP), and DES/DDD (DDD), ~~and RBHA~~ Contractors, Behavioral Health Residential Facility (BHRF) Providers serving Fee-For-Service (FFS) Programs, including American Indian Health Program (AIHP), Tribal ALTCS, and TRBHA; and all FFS populations, excluding Federal Emergency Services (FES). (For FES, refer to AMPM Chapter 1100). This Policy establishes requirements for the provision of care and services in a BHRF.

Throughout this Policy, all references to outpatient treatment team can indicate Child and Family Team (CFT), ~~/~~Adult Recovery Team (ART), ~~–~~TRBHA, American Indian Medical Home (AIMH), Indian Health Services, Tribally operated 638 Facility, Urban Indian Health (I/T/U), Tribal ALTCS, and/or DDD[4] ~~pertain to the Contractor and not to FFS Programs or FFS populations.~~. A CFT/ART is not required in order for FFS members to receive services.

II. DEFINITIONS

Definitions are located on the AHCCCS website at: AHCCCS Contract and Policy Dictionary.

III. POLICY

Care and services provided in a BHRF are based on a per diem rate (24-hour day), require prior and continued authorization and do not include room and board. BHRF is considered a level of care that is inclusive of all treatment services provided by the BHRF, in accordance with the treatment plan created by the treatment team.[5]

The Contractor shall refer to ACOM Policy 414 for request timeframes and requirements regarding prior authorization. All authorization requests for BHRF services shall be treated as expedited requests.

Prior and continued authorization are not applicable to a Secured Behavioral Health Residential Facility (Secured BHRF) as placement of a member into a Secured BHRF is accomplished pursuant to an order of the Superior Court. Although a treatment plan is generally submitted as part of that process, the duration of a member's commitment to a Secured BHRF is ultimately determined by the Court as specified in A.R.S § 36-550.09.

[1] Date Policy is effective
[2] Date Policy is approved at APC
[3] Policy was revised to align with the Competitive Contract Expansion YH20-0002 to expand the provision of services for the awarded ACC Contractors
[4] Language was modified to be inclusive of all the teams rather than restating throughout the policy.
[5] Added language for clarity of treatment services and treatment plan

For information on prior authorization requirements for FFS members, refer to the FFS web page.

The Contractor and BHRF Providers shall ensure appropriate notification is sent to the Primary Care Physician and Behavioral Health Provider/Agency/TRBHA/Tribal ALTCS program upon intake to and discharge from the BHRF.

Sections applicable to Secured BHRF will not be effective until such time that these facilities are developed.

A. CRITERIA FOR ADMISSION

The Contractor shall develop admission criteria for medical necessity which at a minimum includes the below elements. The Contractor shall submit admission criteria to AHCCCS for approval, as specified in Contract, and publish the approved criteria to the Contractor's website as specified in ACOM Policy 404.

BHRF providers providing services to FFS members are required to adhere to the below elements.

1. Member has a diagnosed behavioral health condition which reflects the symptoms and behaviors necessary for a request for residential treatment level of care[6]. The behavioral health condition causing the significant functional and/or psychosocial impairment shall be evidenced in the assessment by the following:
   a. At least one area of significant risk of harm within the past three months as a result of:
      i. Suicidal/aggressive/self-harm/homicidal thoughts or behaviors without current plan or intent,
      ii. Impulsivity with poor judgment/insight,
      iii. Maladaptive physical or sexual behavior,
      iv. Inability to remain safe within environment, despite environmental supports (i.e. informal supports), or
      v. Medication side effects due to toxicity or contraindications.

AND

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

[6] Added language to specify and clarify the request of level of care.

vi. Impairments persisting in the absence of situational stressors that delay recovery from the presenting problem.

c. A behavioral health[7] need for 24 hour ~~behavioral health care and~~ supervision to develop adequate and effective coping skills that will allow the member to live safely in the community, and
d. Anticipated stabilization cannot be achieved in a less restrictive setting,
e. Evidence that behavioral health treatment ~~appropriate treatment~~ in a less restrictive ~~environment~~level of care (e.g., Intensive Outpatient Program (IOP), Partial Hospitalization Program, etc.) [8]has not been successful or is not available, therefore warranting a higher level of care, and
f. Member agrees to participate in treatment. In the case of those who have a Health Care Decision Maker (HCDM), including minors, the HCDM also agrees to, and participates as part of, the treatment team.
g. Agreement to participate in treatment is not a requirement for individuals who are court ordered to a secured BHRF.
h. Member's outpatient treatment team, shall be part of the pre-admission assessment and treatment plan formulation, including when the documentation is created by another qualified provider. Exception to this requirement exists when the member is evaluated by the Crisis provider, Emergency Department, or Behavioral Health Inpatient Facility.
~~f.~~i. The BHRF shall notify the member's outpatient treatment team of admission prior to creation of the BHRF treatment plan.[9]

B. EXPECTED TREATMENT OUTCOMES

1. Treatment outcomes shall align with:
   a. The Arizona Vision-12 Principles for Children's Behavioral Health Service Delivery as directed in AMPM Policy 430,
   b. The Nine Guiding Principles for Recovery-Oriented Adult Behavioral Health Services and Systems as outlined in Contract, and
   c. The member's individualized basic physical, behavioral, and developmentally appropriate needs.

2. Treatment goals shall be developed in accordance with the following:
   a. Specific to the member's behavioral health condition(s),
   b. Measurable and a~~A~~chievable,
   c. Cannot be met in a less restrictive environment or lower level of care[10],
   d. Based on the member's unique needs and tailored to the member and the family's/HCDM and designated representative's choices where possible, and
   e. Support the member's improved or sustained functioning and integration into the community.

[7] Realigned language for flow.
[8] Adding in examples of other types of BH treatment that may have been ineffective
[9] Added to ensure notification of appropriate outpatient treatment team members of admission.
[10] Added due to the clarification of BHRF as a distinct, more intensive level of care

C. EXCLUSIONARY CRITERIA

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

1. An alternative to detention or incarceration.
2. As a means to ensure community safety in circumstances where a member is exhibiting primarily conduct disorder behavior without the presence of risk or functional impairment.
3. A means of providing safe housing, shelter, supervision, or permanency placement.
4. A behavioral health intervention when other less restrictive alternatives are available and meet the member's treatment needs, including situations when the member/HCDM are unwilling to participate in the less restrictive alternative, or
5. As an intervention for runaway behaviors unrelated to a behavioral health condition.

D. CRITERIA FOR CONTINUED STAY

1. The Contractor shall develop medical necessity criteria for continued stay which at a minimum includes the below elements. The Contractor shall submit continued stay criteria to AHCCCS for approval, as specified in Contract, and publish the approved criteria within 10 days of the changes being approved.

   BHRF providers providing services to FFS members are required to submit to AHCCCS/Division of Fee-For-Service Management (DFSM) documentation of all participants in the treatment planning during the continued stay review process and to adhere to the below elements:[11]

   a. Continued stay shall be assessed by the BHRF staff in coordination with ~~and~~ the applicable outpatient treatment team during treatment plan review and update~~d~~.[12] Progress towards the treatment goals and continued display of risk and functional impairment shall also be assessed. Treatment interventions, frequency, crisis/safety planning, and targeted discharge shall be adjusted accordingly to support the need for continued stay. The following criteria shall be considered when determining continued stay:
      i. The member continues to demonstrate significant risk of harm and/or functional impairment as a result of a behavioral health condition, and
      ii. Providers and supports are not available to meet current behavioral and physical health needs at a less restrictive lower level of care.

E. DISCHARGE READINESS

1. The Contractor shall develop medical necessity criteria for discharge which at a minimum includes the below elements. The Contractor shall submit discharge criteria to AHCCCS for approval, as specified in Contract, and publish the approved criteria within 10 days of the changes being approved.

[11] Added clarification to indicate requirements for FFS members
[12] Added clarification to indicate requirements for FFS members for coordination of care

BHRF providers providing services to FFS members are required to adhere to the minimum discharge elements below.

a. Discharge planning shall begin at the time of admission. Discharge readiness shall be assessed by the BHRF staff ~~and~~ in coordination with the applicable treatment team[13] ~~CFT/ART/TRBHA~~ during each treatment plan review and update. The following criteria shall be considered when determining discharge readiness:
   i. Symptom or behavior relief is reduced as evidenced by completion of treatment plan goals,
   ii. Functional capacity is improved, essential functions such as eating or hydrating necessary to sustain life has significantly improved or is able to be cared for in a less restrictive level of care,
   iii. Member can participate in needed monitoring, or a caregiver is available to provide monitoring in a less restrictive level of care, and
   iv. Providers and supports are available to meet current behavioral and physical health needs at a less restrictive level of care.

F. ADMISSION, ASSESSMENT, TREATMENT AND DISCHARGE PLANNING

The Contractor shall establish a policy to ensure the admission, assessment, and treatment planning process is completed consistently among all providers in accordance with A.A.C. R9-10-707 and 708, ~~and~~ Contract requirements, and as stated below.

BHRF Providers rendering services to FFS members shall follow the below outlined admission, assessment, treatment, and discharge planning requirements.

1. Except as provided in subsection A.A.C. R9-10-707(A)(9), a behavioral health assessment for a member shall be completed before treatment is initiated and within 48 hours of admission.

2. The applicable outpatient treatment team ~~CFT/ART/TRBHA/Tribal ALTCS~~shall be included in the development of the treatment plan within 48 hours of admission ~~for members enrolled with a Contractor, TRBHA, or Tribal ALTCS~~.[14]

3. BHRF documentation shall reflect:
   a. All treatment services provided to the member,
   b. Each activity shall be documented in a separate, individualized medical record, including the date, time and professional conducting treatment activity,
   c. Which treatment plan goals are being achieved,
   d. Progress towards desired treatment goal, and
   e. Frequency, length and type of each treatment service or session.[15]

[13] Added clarification to applicable outpatient treatment and aligned language by removing specific call out of various populations change is made throughout policy
[14] Removed duplicative information for FFS members as indicated earlier in the policy for outpatient treatment team change is made throughout policy.
[15] Added for clarity of Behavioral Health Residential Facility (BHRF) documentation.

~~2.~~4. All BHRFs ~~serving TRBHA, or Tribal ALTCS members~~ shall coordinate care with the outpatient treatment team ~~TRBHAs, or Tribal ALTCS programs~~ throughout the admission, assessment, treatment, and discharge process.

~~3.~~5. The BHRF treatment plan shall connect back to the member's comprehensive service plan. ~~for members enrolled with a Contractor.~~

~~4.~~6. For secured BHRF the treatment plan also aligns with the court order.

a. A comprehensive discharge plan shall be created during the development of the initial treatment plan and shall be reviewed and/or updated at each review thereafter. The discharge plan shall document the following:
   i. Clinical status for discharge,
   ii. Member/health care decision maker and designated representative and, outpatient treatment team understands follow-up treatment, crisis and safety plan, and
   iii. Coordination of care and transition planning are in process (e.g. reconciliation of medications, applications for lower level of care submitted, follow-up appointments made, identification of wrap around supports and potential providers).

~~5.~~7. The BHRF staff and the outpatient treatment team shall meet to review and modify the treatment plan at least once a month.

~~6.~~8. A treatment plan may be completed by a BHP, or by a BHT with oversight and signature by a BHP within 24 hours.

~~7.~~9. Implementation of a system to document and report on timeliness of BHP signature/review when the treatment plan is completed by a BHT.

~~8.~~10. Implementation of a process to actively engage family/health care decision maker and designated representative in the treatment planning process as appropriate.

~~9.~~11. Clinical practices, as applicable to services offered and population served, shall demonstrate adherence to best practices for treating specialized service needs, including but not limited to:

a. Cognitive/intellectual disability,
b. Cognitive disability with comorbid behavioral health condition(s),
c. Older adults, and co-occurring disorders (substance use and behavioral health condition(s), or
d. Comorbid physical and behavioral health condition(s).

~~10.~~12. BHRF is a level of care available to members. Members cannot receive services under another level of care while receiving services in a BHRF. For additional guidance on billing and restrictions, see the FFS Provider Billing Manual and the Behavioral Health Services Matrix. [16]

Services deemed medically necessary through the assessment and/or ~~CFT/ART/ TRBHA/Tribal ALTCS~~ outpatient treatment team which are not offered at the BHRF, shall be documented in

[16] Adding language to address concerns about duplication of services for member in BHRF throughout policy.

the member's comprehensive[17] service plan and documentation shall include a description of the need, identified goals and identification of provider meeting the need. The following services shall be made available and provided by the BHRF and cannot be billed separately unless otherwise noted below:

a. Counseling and Therapy (group or individual):
   Group Behavioral Health Counseling and Therapy may not be billed on the same day as BHRF services unless specialized group behavioral health counseling and therapy have been identified in the service plan as a specific member need that cannot otherwise be met as required within the BHRF setting,
b. Skills Training and Development:
   i. Independent Living Skills (e.g. self-care, household management, budgeting, avoidance of exploitation/safety education and awareness),
   ii. Community Reintegration Skill building (e.g. use of public transportation system, understanding community resources and how to use them), and
   iii. Social Communication Skills (e.g. conflict and anger management, same/opposite-sex friendships, development of social support networks, recreation).
c. Behavioral Health Prevention/Promotion Education and Medication Training and Support Services including but not limited to:
   i. Symptom management (e.g. including identification of early warning signs and crisis planning/use of crisis plan),
   ii. Health and wellness education (e.g. benefits of routine medical check-ups, preventive care, communication with the PCP and other health practitioners),
   iii. Medication education and self-administration skills,
   iv. Relapse prevention,
   v. Psychoeducation services and ongoing support to maintain employment work and vocational skills, educational needs assessment and skill building,
   vi. Treatment for substance use disorder (e.g. substance use counseling, groups), and
   vii. Personal care services (refer to A.A.C. R9-10-702, R9-10-715, R9-10-814 for additional licensing requirements).

G. BHRF AND MEDICATION ASSISTED TREATMENT

Contractors and BHRF Providers shall establish policies and procedures to ensure members on MAT are not excluded from admission and are able to receive MAT to ensure compliance with Arizona Opioid Epidemic Act SB 1001, Laws 2018, First Special Session.

H. BHRF WITH PERSONAL CARE SERVICE LICENSE~~S~~[18]

BHRFs that provide personal care services[19] shall be licensed to provide personal care services. Services offered shall be~~offer services~~ in accordance with A.A.C R9-10-702 and A.A.C R9-10-715. Contractors and BHRF providers shall ensure that all identified needs can be met in accordance with A.A.C. R9-10-814 (A)(C)(D) and (E).

[17] Added language for clarity.
[18] Added "License" to ensure all providers delivering these services are aware of licensing requirements.
[19] POST APC CHANGE: added "that provide personal services" for clarity

1. ~~The following is a list of~~ Eexamples of services that may be provided include, but are not limited to:
   a. Administration of oxygen,
   b. Application and care of orthotic devices,
   c. Application and care of prosthetic devices,
   d. Application of bandages and medical supports, including high elastic stockings,
   e. ACE wraps, arm, and leg braces, etc.,
   f. Application of topical medications,
   g. Assistance with ambulation,
   h. Assistance with correct use of cane/crutches,
   i. Bed baths,
   j. Blood sugar monitoring, Accu-Check diabetic care,
   k. Care of hearing aids,
   l. Catheter care,
   m. Denture care and brushing teeth,
   n. Dressing member,
   o. G-tube care,
   p. Hair care, including shampooing,
   q. Incontinence support, including assistance with bed pans/bedside commodes/ bathroom supports,
   r. Measuring and giving insulin, glucagon injection,
   s. Measuring and recording blood pressure,
   t. Non-sterile dressing change and wound care,
   u. Ostomy and surrounding skin care,
   v. Passive range of motion exercise,
   w. Radial pulse monitoring,
   x. Respiration monitoring,
   y. Use of pad lifts,
   z. Shaving,
   aa. Shower assistance using shower chair,
   bb. Skin and foot care,
   cc. Skin maintenance to prevent and treat bruises, injuries, pressure sores. Members with a stage 3 or 4 pressure sore are not to be admitted to BHRF (A.A.C. R9-10-715(3)), and infections,
   dd. Supervising self-feeding of members with swallowing deficiencies, and
   ee. Use of chair lifts.[20]

[20] Example list edited to be in standard alphabetical order.