Arizona

UNIFORM APPLICATION
FY 2026/2027 Combined MHBGSUPTRS BG ApplicationBehavioral Health Assessment and Plan

SUBSTANCE ABUSE PREVENTION AND TREATMENT
and
COMMUNITY MENTAL HEALTH SERVICES
BLOCK GRANT

OMB - Approved 05/28/2025 - Expires 01/31/2028
(generated on 08/13/2025 6.43.07 PM)

Center for Substance Abuse Prevention
Division of Primary Prevention

Center for Substance Abuse Treatment
Division of State and Community Systems (DSCS)

and

Center for Mental Health Services
Division of State and Community Systems Development

State Information

State Information

Plan Year

Start Year	2026
End Year	2027

State SUPTRS BG Unique Entity Identification

Unique Entity ID

I. State Agency to be the SUPTRS BG Grantee for the Block Grant

Agency Name	Arizona Health Care Cost Containment System (AHCCCS)
Organizational Unit	Division of Grants Administration
Mailing Address	801 E Jefferson
City	Phoenix
Zip Code	85034

II. Contact Person for the SUPTRS BG Grantee of the Block Grant

First Name	Alisa
Last Name	Randall
Agency Name	Arizona Health Care Cost Containment System
Mailing Address	801 East Jefferson MD1900
City	Phoenix
Zip Code	85034
Telephone	602-417-4794
Fax	
Email Address	alisa.randall@azahcccs.gov

State CMHS Unique Entity Identification

Unique Entity ID

I. State Agency to be the CMHS Grantee for the Block Grant

Agency Name	Arizona Health Care Cost Containment System
Organizational Unit	Division of Grants Administration
Mailing Address	801 East Jefferson
City	Phoenix
Zip Code	85034

II. Contact Person for the CMHS Grantee of the Block Grant

First Name	Alisa
Last Name	Randall
Agency Name	Arizona Health Care Cost Containment System (AHCCCS)
Mailing Address	801 E Jefferson MD4100
City	Phoenix
Zip Code	85034
Telephone	602-417-4794
Fax	
Email Address	alisa.randall@azahcccs.gov

III. Third Party Administrator of Mental Health Services

Do you have a third party administrator? Yes No

First Name

Last Name

Agency Name

Mailing Address

City

Zip Code

Telephone

Fax

Email Address

IV. State Expenditure Period (Most recent State expenditure period that is closed out)

From

To

V. Date Submitted

Submission Date

Revision Date

VI. Contact Person Responsible for Application Submission

First Name

Last Name

Telephone

Fax

Email Address

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [SUPTRS]

Fiscal Year 2026

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Substance Abuse Prevention and Treatment Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1921	Formula Grants to States	**42 USC § 300x-21**
Section 1922	Certain Allocations	**42 USC § 300x-22**
Section 1923	Intravenous Substance Abuse	**42 USC § 300x-23**
Section 1924	Requirements Regarding Tuberculosis and Human Immunodeficiency Virus	**42 USC § 300x-24**
Section 1925	Group Homes for Recovering Substance Abusers	**42 USC § 300x-25**
Section 1926	State Law Regarding the Sale of Tobacco Products to Individuals Under Age 18	**42 USC § 300x-26**
Section 1927	Treatment Services for Pregnant Women	**42 USC § 300x-27**
Section 1928	Additional Agreements	**42 USC § 300x-28**
Section 1929	Submission to Secretary of Statewide Assessment of Needs	**42 USC § 300x-29**
Section 1930	Maintenance of Effort Regarding State Expenditures	**42 USC § 300x-30**
Section 1931	Restrictions on Expenditure of Grant	**42 USC § 300x-31**
Section 1932	Application for Grant; Approval of State Plan	**42 USC § 300x-32**
Section 1935	Core Data Set	**42 USC § 300x-35**
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	**42 USC § 300x-51**
Section 1942	Requirement of Reports and Audits by States	**42 USC § 300x-52**

Section 1943	Additional Requirements	**42 USC § 300x-53**
Section 1946	Prohibition Regarding Receipt of Funds	**42 USC § 300x-56**
Section 1947	Nondiscrimination	**42 USC § 300x-57**
Section 1953	Continuation of Certain Programs	**42 USC § 300x-63**
Section 1955	Services Provided by Nongovernmental Organizations	**42 USC § 300x-65**
Section 1956	Services for Individuals with Co-Occurring Disorders	**42 USC § 300x-66**

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
    a. Checking the Exclusion Extract located on the System for Award Management (SAM) at **http://sam.gov [sam.gov]**
    b. Collecting a certification statement similar to paragraph (a)
    c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work place in accordance with 2 CFR Part 182 by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;

b. Establishing an ongoing drug-free awareness program to inform employees about--
    1. The dangers of drug abuse in the workplace;
    2. The grantee's policy of maintaining a drug-free workplace;
    3. Any available drug counseling, rehabilitation, and employee assistance programs; and
    4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;

d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
    1. Abide by the terms of the statement; and
    2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
    1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
    2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or

attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)

3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-construction Programs and other Certifications summarized above.

State: _____

Name of Chief Executive Officer (CEO) or Designee: _____

Signature of CEO or Designee[1]: _____

Title: _____ Date Signed: _____

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [MH]

Fiscal Year 2026

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Community Mental Health Services Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1911	Formula Grants to States	**42 USC § 300x**
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	**42 USC § 300x-1**
Section 1913	Certain Agreements	**42 USC § 300x-2**
Section 1914	State Mental Health Planning Council	**42 USC § 300x-3**
Section 1915	Additional Provisions	**42 USC § 300x-4**
Section 1916	Restrictions on Use of Payments	**42 USC § 300x-5**
Section 1917	Application for Grant	**42 USC § 300x-6**
Section 1920	Early Serious Mental Illness	**42 USC § 300x-9**
Section 1920	Crisis Services	**42 USC § 300x-9**

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1941	Opportunity for Public Comment on State Plans	**42 USC § 300x-51**
Section 1942	Requirement of Reports and Audits by States	**42 USC § 300x-52**
Section 1943	Additional Requirements	**42 USC § 300x-53**
Section 1946	Prohibition Regarding Receipt of Funds	**42 USC § 300x-56**
Section 1947	Nondiscrimination	**42 USC § 300x-57**

Section 1953	Continuation of Certain Programs	**42 USC § 300x-63**
Section 1955	Services Provided by Nongovernmental Organizations	**42 USC § 300x-65**
Section 1956	Services for Individuals with Co-Occurring Disorders	**42 USC § 300x-66**

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State

management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
    a. Checking the Exclusion Extract located on the System for Award Management (SAM) at **http://sam.gov [sam.gov]**
    b. Collecting a certification statement similar to paragraph (a)
    c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 2 CFR Part 182by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
    1. The dangers of drug abuse in the workplace;
    2. The grantee's policy of maintaining a drug-free workplace;
    3. Any available drug counseling, rehabilitation, and employee assistance programs; and
    4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
    1. Abide by the terms of the statement; and
    2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
    1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
    2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Alisa Randall

Signature of CEO or Designee[1]: _____

Title: AHCCCS Mental Health Commissioner and Assistant Deputy Director

Date Signed: _____

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [MH]

Fiscal Year 2026

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Community Mental Health Services Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1911	Formula Grants to States	**42 USC § 300x**
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	**42 USC § 300x-1**
Section 1913	Certain Agreements	**42 USC § 300x-2**
Section 1914	State Mental Health Planning Council	**42 USC § 300x-3**
Section 1915	Additional Provisions	**42 USC § 300x-4**
Section 1916	Restrictions on Use of Payments	**42 USC § 300x-5**
Section 1917	Application for Grant	**42 USC § 300x-6**
Section 1920	Early Serious Mental Illness	**42 USC § 300x-9**
Section 1920	Crisis Services	**42 USC § 300x-9**

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1941	Opportunity for Public Comment on State Plans	**42 USC § 300x-51**
Section 1942	Requirement of Reports and Audits by States	**42 USC § 300x-52**
Section 1943	Additional Requirements	**42 USC § 300x-53**
Section 1946	Prohibition Regarding Receipt of Funds	**42 USC § 300x-56**
Section 1947	Nondiscrimination	**42 USC § 300x-57**

Section 1953	Continuation of Certain Programs	**42 USC § 300x-63**
Section 1955	Services Provided by Nongovernmental Organizations	**42 USC § 300x-65**
Section 1956	Services for Individuals with Co-Occurring Disorders	**42 USC § 300x-66**

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State

management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
    a. Checking the Exclusion Extract located on the System for Award Management (SAM) at **http://sam.gov [sam.gov]**
    b. Collecting a certification statement similar to paragraph (a)
    c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 2 CFR Part 182by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
    1. The dangers of drug abuse in the workplace;
    2. The grantee's policy of maintaining a drug-free workplace;
    3. Any available drug counseling, rehabilitation, and employee assistance programs; and
    4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
    1. Abide by the terms of the statement; and
    2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
    1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
    2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: **Alisa Randall**

Signature of CEO or Designee[1]: [redacted]

Title: **AHCCCS Mental Health Commissioner and Assistant Deputy Director** Date Signed: 07/24/2025

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

State Information

Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL).
Standard Form LLL (click here)

Name
Alisa Randall

Title
Mental Health Commissioner and Assistant Deputy Director

Organization
Arizona Health Care Cost Containment System (AHCCCS)

Signature: [redacted] Date: 07/24/2025

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes: **No lobbying activities to disclose.**

State Information

Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL).

Standard Form LLL (click here)

Name

Alisa Randall

Title

AHCCCS Mental Health Commissioner and Assistant Deputy Director

Organization

AHCCCS

Signature: Date:

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

State Information

Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL).
Standard Form LLL (click here)

Name
Alisa Randall

Title
Mental Health Commissioner and Assistant Deputy Director

Organization
Arizona Health Care Cost Containment System (AHCCCS)

Signature: [redacted] Date: 07/24/2025

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes: **No lobbying activities to disclose.**

Planning Steps

Step 1: Assess the strengths and organizational capacity of the service system to address the specific populations

Narrative Question

Provide an overview of the state's prevention system (description of the current prevention system's attention to individuals in need of substance use primary prevention), early identification, treatment, and recovery support systems, including the statutory criteria that must be addressed in the state's Application. Describe how the public behavioral health system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of mental health and SUD services. States should also include a description of regional, county, tribal, and local entities that provide mental health and SUD services or contribute resources that assist in providing these services. This narrative must include a discussion of the current service system's attention to the MHBG and SUPTRS BG priority populations listed above under "Populations Served."

1. Please describe how the public mental health and substance use services system is currently organized at the state level, differentiating between child and adult systems.

1. AHCCCS Overview
a. Arizona Health Care Cost Containment System (AHCCCS) is the single state Medicaid agency for the State of Arizona. In that capacity, it is responsible for operating the Title XIX and Title XXI programs through the State's 1115 Research and Demonstration Waiver, which allows for the operation of a total managed care model.
b. AHCCCS' mission "reaching across Arizona to provide comprehensive, quality health care to those in need" is implemented through the vision of "shaping tomorrow's managed care…from today's experience, quality, and innovation." Built on a system of competition and choice, AHCCCS' $14 billion program operates under an integrated managed care model.
2. ACC Plans
a. ACC plans and the American Indian Health plan (AIHP) and other Fee For Service (FFS) provide a comprehensive network of providers to deliver all covered physical and behavioral health services to child and adult members without a Serious Mental Illness (SMI) designation and services for members with Children's Rehabilitative Services (CRS) conditions. ACC plans and AIHP address the whole health needs of our state's Medicaid population which is vitally important to improving service delivery for AHCCCS members and reducing the fragmentation that has existed in our healthcare system.
b. Children in out-of-home care are eligible for medical and dental care, inpatient, outpatient, behavioral health, and other services through the Mercy Care Department of Child Safety Comprehensive Health Plan (Mercy Care DCS CHP). Children who have been adopted out of foster care may apply for AHCCCS and enroll in a ACC plan. Children adopted from DCS custody follow the same Medicaid enrollment process as other eligible children.
3. ACC-RBHAs, TRBHAs
a. Three of the ACC plans hold additional Regional Behavioral Health Agreements with AHCCCS (referred to as ACC-RBHAs) and align the RBHA and ACC contracts under one organization. An ACC-RBHA is a contracted Managed Care Organization (also known as a health plan) responsible for the provision of comprehensive behavioral health services to all eligible individuals assigned by the administration in addition to a provision for comprehensive physical health services to eligible persons with a Serious Mental Illness enrolled by the Administration. The function of the ACC-RBHAs include:
i. Providing integrated services for Individuals with Serious Mental Illness.
ii. Providing behavioral health services for individuals identified with Serious Emotional Disturbance.
iii. Development and support of a regional crisis system.
iv. Allocation of non-title XIX/XXI funding including Substance Abuse and Mental Health Services Administration (SAMHSA) grants and other sources of funding
b. Arizona's three ACC - Regional Behavioral Health Agreements (ACC-RBHAs) are required to maintain comprehensive networks of behavioral health providers to deliver prevention, intervention, treatment, and rehabilitation services to members enrolled in AHCCCS.
i. Mercy Care – ACC-RBHA serving central Arizona, including Maricopa, Pinal and Gila Counties
ii. Arizona Complete Health South – ACC-RBHA serving southern Arizona
iii. Arizona Complete Health North – ACC-RBHA serving northern Arizona
c. Tribal Regional Behavioral Health Authority (TRBHA) is a tribal entity that has an Intergovernmental Agreement (IGA) with AHCCCS, the primary purpose of which is to coordinate the delivery of comprehensive behavioral health to all eligible individuals assigned by the administration to the tribal entity. Tribal governments, through an agreement with the State, may operate a Tribal Regional Behavioral Health Authority for the provision of behavioral health services to American Indian members. Refer to A.R.S. §36-3401 and A.R.S. §36-3407.
i. White Mountain Apache – TRBHA serving the White Mountain Apache Nation
ii. Gila River – TRBHA serving the Gila River Indian Community
iii. Pascua Yaqui – TRBHA serving the Pascua Yaqui Tribe
iv. Navajo Nation – TRBHA serving the Navajo Nation
4. Comprehensive System

a. The ACCs, MCOs, ACC-RBHAs, and TRBHAs are required to maintain a comprehensive network of behavioral health providers to deliver prevention, intervention, treatment, and rehabilitative services to members enrolled in the AHCCCS system. This structure allows communities to provide services in a manner appropriate to meet the unique needs of members and families residing within their local areas.
b. A map of the geographic service areas for AHCCCS behavioral health services can be found at https://www.azahcccs.gov/Members/BehavioralHealthServices/.
c. Through the ACC contracts, Managed Care Organizations (MCOs) are responsible for providing physical, behavioral, and long-term care services. AHCCCS also operates the AIHP, a fee for service program that is responsible for care for American Indian members who select AIHP. AHCCCS also has five unique intergovernmental agreements with Tribes or Tribal Regional Health Authorities (TRBHAs) for the coordination of behavioral health services for American Indian members enrolled with a TRBHA. Contracted health plans coordinate and pay for physical and behavioral health care services delivered by more than 1040,000 health care providers.
5. Continuum of Care (Child and Adult Systems)
a. As a leader in the public behavioral health field, Arizona's approach to managed care and service delivery is nationally recognized. AHCCCS focuses its efforts and energies toward providing leadership in activities designed to integrate and adapt the behavioral health system to meet the needs of those we serve.
b. AHCCCS fosters an environment of person-centered planning that includes the voice and choice of the person being served, their family, identified persons of support, advocates (as designated) and service providers, as identified. The Individual Service Planning (ISP) progress is transparent, fluid and the ISP is a living and breathing document that can change as a persons' choices and treatment needs change.
c. AHCCCS has an Adult System of Care (ASOC) that is a continuum of coordinated community and facility-based services and support for adults with, or at risk for, behavioral health challenges. The ASOC is organized into a comprehensive network to create opportunities to foster recovery and improve health outcomes by:
i. Building meaningful partnerships with individuals served,
ii. Addressing the individuals' cultural and linguistic needs and preferences, and
iii. Assisting the individual in identifying and achieving personal and recovery goals.
d. The ASOC developed the following Nine Guiding Principles to promote recovery in the adult behavioral health system and for engaging with adults who have a serious mental illness:
e. Nine Guiding Principles:
i. RESPECT: Respect is the cornerstone. Meet the person where they are without judgment, with great patience and compassion.
ii. PERSONS IN RECOVERY CHOOSE SERVICES AND ARE INCLUDED IN PROGRAM DECISIONS AND PROGRAM DEVELOPMENT EFFORTS: A person in recovery has choice and a voice. Their self-determination in driving services, program decisions, and program development is made possible, in part, by the ongoing dynamics of education, discussion, and evaluation, thus creating the "informed consumer" and the broadest possible palette from which choice is made. Persons in recovery should be involved at every level of the system, from administration to service delivery.
iii. FOCUS ON INDIVIDUAL AS A WHOLE PERSON, WHILE INCLUDING AND/OR DEVELOPING NATURAL SUPPORTS: A person in recovery is held as nothing less than a whole being: capable, competent, and respected for their opinions and choices. As such, focus is given to empowering the greatest possible autonomy and the most natural and well-rounded lifestyle. This includes access to and involvement in the natural supports and social systems customary to an individual's social community.
iv. EMPOWER INDIVIDUALS TAKING STEPS TOWARDS INDEPENDENCE AND ALLOWING RISK TAKING WITHOUT FEAR OF FAILURE: A person in recovery finds independence through exploration, experimentation, evaluation, contemplation, and action. An atmosphere is maintained whereby steps toward independence are encouraged and reinforced in a setting where both security and risk are valued as ingredients promoting growth.
v. INTEGRATION, COLLABORATION, AND PARTICIPATION WITH THE COMMUNITY OF ONE'S CHOICE: A person in recovery is a valued, contributing member of society and, as such, is deserving of and beneficial to the community. Such integration and participation underscore one's role as a vital part of the community, the community dynamic being inextricable from the human experience. Community service and volunteerism are valued.
vi. PARTNERSHIP BETWEEN INDIVIDUALS, STAFF, AND FAMILY MEMBERS/NATURAL SUPPORTS FOR SHARED DECISION MAKING WITH A FOUNDATION OF TRUST: A person in recovery, as with any member of a society, finds strength and support through partnerships. Compassion-based alliances with a focus on recovery optimization bolster self-confidence, expand understanding in all participants, and lead to the creation of optimum protocols and outcomes.
vii. PERSONS IN RECOVERY DEFINE THEIR OWN SUCCESS: A person in recovery – by their own declaration – discovers success, in part, by quality-of-life outcomes, which may include an improved sense of well-being, advanced integration into the community, and greater self-determination. Persons in recovery are the experts on themselves, defining their own goals and desired outcomes.
viii. STRENGTHS-BASED, FLEXIBLE, RESPONSIVE SERVICES REFLECTIVE OF AN INDIVIDUAL'S CULTURAL PREFERENCES: A person in recovery can expect and deserves flexible, timely, and responsive services that are accessible, available, reliable, accountable, and sensitive to cultural values and mores. A person in recovery is the source of his/her own strength and resiliency. Those who serve as supports and facilitators identify, explore, and serve to optimize demonstrated strengths in the individual as tools for generating greater autonomy and effectiveness in life.
ix. HOPE IS THE FOUNDATION FOR THE JOURNEY TOWARDS RECOVERY: A person in recovery has the capacity for hope and thrives best in associations that foster hope. Through hope, a future of possibility enriches the life experience and creates the environment for uncommon and unexpected positive outcomes to be made real. A person in recovery is held as boundless in potential and possibility.
f. AHCCCS has a Children's System of Care (CSOC) that incorporates collaboration with the youth before the age of 18, family, and

others to provide services that are tailored to meet the needs of youth, youth with serious emotional disturbances, children with rehabilitative services' conditions (CRS), and their caregivers. The goal is to ensure that services are provided to the youth and family in the most appropriate setting, in a timely manner, in accordance with the best practices and respecting the child, family, and their cultural heritage.

g. Arizona/AHCCCS developed The Twelve (12) Principles for Children's in the Behavioral Health Service Delivery System. Twelve (12) Guiding Principles:

i. COLLABORATION WITH THE CHILD AND FAMILY: Respect for and active collaboration with the child and parents is the cornerstone to achieving positive behavioral health outcomes. Parents and children are treated as partners in the assessment process, and the planning, delivery, and evaluation of behavioral health services, and their preferences are taken seriously.

ii. FUNCTIONAL OUTCOMES: Behavioral health services are designed and implemented to aid children to achieve success in school, live with their families, avoid delinquency, and become stable and productive adults. Implementation of the behavioral health services plan stabilizes the child's condition and minimizes safety risks.

iii. COLLABORATION WITH OTHERS: When children have multi-agency, multi-system involvement, a joint assessment is developed and a jointly established behavioral health services plan is collaboratively implemented. Client centered teams plan and deliver services. Each child's team includes the child and parents and any foster parents, any individual important in the child's life who is invited to participate by the child or parents. The team also includes all other persons needed to develop an effective plan, including, as appropriate, the child's teacher, DCS and/or DES/DDD caseworker, and the child's probation officer. The team (a) develops a common assessment of the child's and family's strengths and needs, (b) develops an individualized service plan, (c) monitors implementation of the plan, and (d) makes adjustments in the plan if it is not succeeding.

iv. ACCESSIBLE SERVICES: Children have access to a comprehensive array of behavioral health services, sufficient to ensure that they receive the treatment they need. Plans identify transportation the parents and child need to access behavioral health services, and how transportation assistance will be provided. Behavioral health services are adapted or created when they are needed but not available.

v. BEST PRACTICES: Competent individuals who are adequately trained and supervised provide behavioral health services. Behavioral health services utilize treatment modalities and programs that are evidenced based and supported by Substance Abuse and Mental Health Services Administration (SAMSHA) or other nationally recognized organizations. Behavioral health service plans identify and appropriately address behavioral symptoms that are reactions to death of a family member, abuse or neglect, learning disorders, and other similar traumatic or frightening circumstances, substance abuse problems, the specialized behavioral health needs of children who are developmentally disabled, maladaptive sexual behavior, including abusive conduct and risky behavior, and the need for stability and the need to promote permanency in class member's lives, especially class members in foster care. Behavioral Health Services are continuously evaluated and modified if ineffective in achieving desired outcomes.

vi. MOST APPROPRIATE SETTING: Children are provided behavioral health services in their home and community to the extent possible. Behavioral health services are provided in the most integrated setting appropriate to the child's needs. When provided in a residential setting, the setting is the most integrated and most home-like setting that is appropriate to the child's needs.

vii. TIMELINESS: Children identified as needing behavioral health services are assessed and served promptly.

viii. SERVICES TAILORED TO THE CHILD AND FAMILY: The unique strengths and needs of children and their families dictate the type, mix, and intensity of behavioral health services provided. Parents and children are encouraged and assisted to articulate their own strengths and needs, the goals they are seeking, and what services they think are required to meet these goals.

ix. STABILITY: Behavioral health service plans strive to minimize multiple placements. Service plans identify whether a class member is at risk of experiencing a placement disruption and, if so, identify the steps to be taken to minimize or eliminate the risk. Behavioral health service plans anticipate crises that might develop and include specific strategies and services that will be employed if a crisis develops. In responding to crises, the behavioral health system uses all appropriate behavioral health services to help the child remain at home, minimize placement disruptions, and avoid the inappropriate use of the police and criminal justice system. Behavioral health service plans anticipate and appropriately plan for transitions in children's lives, including transitions to new schools and new placements, and transitions to adult services.

x. RESPECT FOR THE CHILD AND FAMILY'S UNIQUE CULTURAL HERITAGE: Behavioral health services are provided in a manner that respects the cultural tradition and heritage of the child and family. Services are provided in Spanish to children and parents whose primary language is Spanish.

xi. INDEPENDENCE: Behavioral health services include support and training for parents in meeting their child's behavioral health needs, and support and training for children in self-management. Behavioral health service plans identify parents' and children's need for training and support to participate as partners in assessment process, and in the planning, delivery, and evaluation of services, and provide that such training and support, including transportation assistance, advance discussions, and help with understanding written materials, will be made available.

xii. CONNECTION TO NATURAL SUPPORTS: The behavioral health system identifies and appropriately utilizes natural supports available from the child and parent's own network of associates, including friends and neighbors, and from community organizations, including service and religious organizations.

h. Overall, the Person-Centered Planning and Service Plan reflects the individual's strengths and preferences that meet the person's social, cultural, and linguistic needs and includes individualized goals and desired outcomes. Additionally, the planning process also identifies risk factors (including risks to member rights) and puts measures in place to minimize them with individual back-up plans and other strategies as needed.

2. Please describe the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of mental health and substance use services.

1. Single State Authority (SSA) and State Mental Health Authority (SMHA)

a. In addition to overseeing the MCOs that provide Medicaid-funded health care services, AHCCCS serves as the SSA on substance

use, and as the SMHA responsible for the state public mental health service delivery system administration. AHCCCS is the agency responsible for mental health and substance use and provides oversight, coordination, planning, administration, regulations, and monitoring of all facets of the public behavioral health system in Arizona.

b. Service Delivery System

c. Regardless of the type, amount, duration, scope, service delivery method, and population served, AHCCCS requires all MCOs ensure that their service delivery system:

i. Coordinate and provide access to high-quality health care services informed by evidence-based practice guidelines in a cost-effective manner,

ii. Coordinate and provide access to high-quality health care services that are culturally and linguistically appropriate, maximize personal and family voice and choice, and incorporate a trauma-informed care approach,

iii. Coordinate and provide access to preventive and health promotion services, including wellness services,

iv. Coordinate and provide access to comprehensive care coordination and transitional care across settings; follow-up from inpatient to other settings; participation in discharge planning, and facilitating transfer from the children's system to the adult system of health care,

v. Coordinate and provide access to chronic disease management support, including self-management support,

vi. Conduct behavioral health assessment and service planning following a Health Home model,

vii. Coordinate and provide access to peer and family delivered support services, based on member's needs, voice, and choice,

viii. Provide covered services to members in accordance with all applicable Federal and State laws, regulations, and policies,

ix. Coordinate and integrate clinical and non-clinical health care related needs and services across all systems,

x. Implement health information technology to link services, facilitate communication among treating professionals and between the health team and individual and family caregivers, and

1. Deliver services by providers that are appropriately licensed or certified, operating within their scope of practice, and registered as an AHCCCS provider.

d. AHCCCS further requires that at all MCOS work in partnership to meet, agree upon, and reduce to writing joint collaborative protocols with each county, district, or regional office of:

i. Administrative Office of the Courts,

ii. Juvenile Probation and Adult Probation,

iii. Arizona Department of Corrections and Arizona Department for Juvenile Corrections,

iv. Arizona Department of Child Safety (DCS),

v. Tribal Nations and Providers (Refer to this section above),

vi. The Veterans' Administration, and

vii. The county jails.

e. Division of Behavioral Health and Housing (DBHH)

i. The Division of Behavioral Health and Housing (DBHH), formerly the Division of Grants and Innovation (DGI), is the point of contact related to the pursuit, implementation and oversight of grants administered by the agency, including the MHBG and SUPTRS BG. The Integrated System of Care and Housing Divisions joined DBHH in Spring of 2023 to promote integration and fluidity in the fee-for-service and grant planning and implementation processes. Since then, the Office of Human Rights and the Justice Administrator also joined DBHH from other AHCCCS divisions for enhanced collaboration on the oversight, monitoring and administration of behavioral health programs and initiatives.

ii. DBHH is inclusive of grants-specific, and general behavioral health units. Additionally, the DBHH grants unit employes programmatic, financial, and compliance teams. Together, various DBHH units and teams work closely with each other to ensure effective communication, oversight, and implementation of all grants management for the agency. DBHH grants and behavioral health staff positions include the State Opioid Treatment Authority/Opioid Treatment Network, Women's Treatment Network, National Prevention Network and National Treatment Network representatives, Grant Administrators, and Grant Coordinators as well as Administrators for Housing, Crisis, and Justice initiatives.

iii. Administration of non-Title XIX/XXI programs

a. SUPTRS BG

i. The SUPTRS BG is used to plan, implement, and evaluate activities to prevent and treat substance use disorders. For treatment and recovery services, DBHH primarily leverages the ACC-RBHA contracts and TRBHA IGAs to provide access to care for substance use disorder. The SUPTRS BG supports primary prevention services through agreements with TRBHAs, state agencies, local and regional non-profits, coalitions. Grant funds are also used to provide early intervention services for HIV and tuberculosis disease in high-risk substance users. Arizona is not an HIV designated state, so there are not specific requirements that need to be met for SAMHSA. However, early intervention efforts remain in place in order to mitigate the high risk of transmission in the SUPTRS BG priority populations. SUPTRS BG funds are used to ensure access to interventions, treatment, and long-term recovery support services for (in order of priority):

1. Pregnant women (including teenagers) who use drugs by injection,

2. Pregnant women (including teenagers) who use substances,

3. Other persons who use drugs by injection,

4. Substance using women and teenagers with dependent children and their families, including females who are attempting to regain custody of their children, and

5. All other individuals with a substance use disorder, regardless of gender or route of use, (as funding is available).

ii. Behavioral health providers (contracted through the ACC-RBHAs and TRBHAs) are required to provide specialized, gender-specific treatment and recovery support services for females who are pregnant or have dependent children and their families in outpatient and residential treatment settings. Services are also provided to mothers who are attempting to regain custody of their children, and the family is treated as a unit. Providers must admit both mothers and their dependent children into treatment. The

following services are provided or arranged as needed:
1. Referral for primary medical care for pregnant females,
2. Referral for primary pediatric care for children,
3. Gender-specific substance use treatment, and
4. Therapeutic interventions for dependent children.
iii. Contractors must ensure the following issues do not pose barriers to access to obtaining substance use disorder treatment:
1. Childcare
2. Case management
3. Transportation
iv. The Contractors require any entity receiving funding from the SUPTRS BG for operating a treatment program for substance use disorders to follow procedures which address how the program:
1. Will, directly or through arrangements with other public or nonprofit private entities, routinely make available tuberculosis services as defined in [45 CFR 96.121] to each individual receiving treatment for such abuse,
2. In the case of an individual in need of such treatment who is denied admission to the program based on the lack of the capacity of the program to admit the individual, will refer the individual to another provider of tuberculosis services, and
3. Will implement infection control procedures designed to prevent the transmission of tuberculosis, including the following:
4. Screening of patients,
5. Identification of those individuals who are at high risk of becoming infected,
6. Meeting all State reporting requirements while adhering to Federal and State confidentiality requirements, including [42 CFR part 2], and
7. Will conduct case management activities to ensure that individuals receive such services.
8. Interim Services are required for those who meet the priority populations of pregnant women, women with dependent children, or intravenous drug users if there is a waitlist to engage in services. The purpose of interim services is to reduce the adverse health effects of substance use, promote the health of the members, and reduce the risk of transmission of disease. The minimum required interim services include:
9. Education that covers prevention of and types of behaviors which increase the risk of contracting HIV, Hepatitis C, and other sexually transmitted diseases,
10. Education that covers the effects of substance use on fetal development,
11. Risk assessment/screening,
12. Referrals for HIV, Hepatitis C, and tuberculosis screening and services, and
13. Referrals for primary and prenatal medical care.
b. MHBG
i. The MHBG is allocated to provide community mental health treatment services to adults with a Serious Mental Illness (SMI) designation, children with Serious Emotional Disturbance (SED), and individuals with an Early Serious Mental Illness (ESMI) including first episode psychosis (FEP). The program makes funding available throughout Arizona to provide community mental health services with the objective to support grantees in carrying out plans for providing comprehensive community mental health services.
ii. MHBG funds are used to provide treatment services in accordance with AHCCCS Medical Policy Manual (AMPM) 300-2B and AMPM 320-T1 and to ensure access to an integrated and comprehensive system of care, including employment, housing, case management, rehabilitation, dental, and health services as well as mental health services and supports.
iii. Adults with a Serious Mental Illness (SMI) designation includes persons aged 18 and older who have a diagnosable behavioral, mental, or emotional condition as defined by the American Psychiatric Association's Diagnostic and Statistical Manual (DSM) of Mental Disorders in addition to functional impairment that substantially interferes with, or limits, their ability to function in the community.
iv. Serious Emotional Disturbance (SED) includes persons up to age 18 who have diagnosable behavioral, mental, or emotional issues (as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM)). Their condition results in a functional impairment that substantially interferes with, or limits, a child's role or functioning in family, school, or community activities.
v. Early Serious Mental Illness (ESMI), including First Episode Psychosis (FEP), services are supported by the 10 percent set aside for ESMI/First Episode of Psychosis (FEP) and support evidence-based programs that provide treatment and support services for those who have experienced a first episode of psychosis within the past two years or individuals recently diagnosed with an SMI qualifying diagnosis. Psychosis is a brain condition that disrupts a person's thoughts and perceptions, making it difficult to differentiate between what is real and what is not. FEP Program models may include principles or core components identified by National Institute of Mental Health (NIMH) via the Recovery After an Initial Schizophrenia Episode (RAISE) initiative and practice a Coordinated Specialty Care model of early intervention.
vi. Five percent of the MHBG is set aside for crisis services to support an evidence-based crisis system. Arizona's crisis continuum of care services has gained national recognition for their innovative approach to behavioral health crisis services. The AHCCCS crisis care continuum encompasses a comprehensive range of services, including crisis telephone response, mobile crisis team intervention, facility-based stabilization (including observation and detox), and all other covered services available to any Arizona resident, regardless of insurance coverage. Ensuring recovery-oriented and person-focused care, the crisis services aim to stabilize individuals promptly, enabling them to return to their baseline of functioning.
vii. AHCCCS is the designated unit of the executive branch that is responsible for administering the MHBG. AHCCCS ensures the following performance requirements are met:
1. Subrecipients must submit a plan explaining how they will use MHBG funds to provide comprehensive, community mental health services to adults with serious mental illnesses and children with serious emotional disturbances,
2. Subrecipients to provide annual reports on their plans,

3. Subrecipients may distribute funds to local government entities and non-governmental organizations,
4. Subrecipients must ensure that community mental health centers provide such services as screening, outpatient treatment, emergency mental health services, and day treatment programs,
5. Subrecipients must comply with general federal requirements for managing grants. They must also cooperate in efforts by SAMHSA to monitor use of MHBG funds. For example, each year, CMHS conducts investigations (site visits) of at least ten grantees receiving MHBG funds. This is to assess how they are using the funds to benefit the population. These evaluations include careful review of the following:
6. How the grantees are tracking use of MHBG funds and their adult and child mental health programs,
7. Data and performance management systems,
8. Collaboration with consumers and the grantees' mental health planning council, and
9. Grantees receiving MHBG funds are required to form and support a state or territory mental health/behavioral health planning council.
10. Grantees receiving MHBG funds are required to form and support a state or territory mental health/behavioral health planning council.
c. AHCCCS DBHH also administers other non-Title XIX/XXI programs including but not limited to Projects for Assistance in Transition from Homelessness (PATH), State Opioid Response (SOR) Grants, State Pilot Grant Program for Treatment for Pregnant and Postpartum Women (PPW-PLT), and crisis programs.
f. As the SSA, AHCCCS DBHH convenes the Arizona Behavioral Health Planning Council (BHPC)
i. AHCCCS utilizes the Arizona BHPC to advise the state in planning and implementing a comprehensive community-based system of behavioral health and mental health Services.
g. AHCCCS also houses an Office of Individual and Family Affairs (OIFA)
i. The AHCCCS Office of Individual and Family Affairs (OIFA) is staffed by individuals and family members whose lives have been affected by substance use and/or mental health disorders. As a part of the Behavioral Health Planning Council (BHPC), OIFA is in a unique position to bring more voices of the community into the oversight process. In addition to the AHCCCS OIFA, each AHCCCS health plan is contractually required to have its own OIFA. The health plan OIFAs extend the reach of the BHPC to increase prospects for more responsive and accountable substance abuse and behavioral health services.
h. Although AHCCCS is the agency responsible for public behavioral health services, other state agencies are important partners in behavioral health prevention, treatment and recovery:
i. The Arizona Department of Health Services (ADHS) licensed behavioral health facilities, collects and reports opioid overdose data, purchases and distributes naloxone, and is responsible for many intersecting health issues for block grant priority populations (e.g. HIV, TB).
ii. The Attorney General's Office (AGO) is an integral partner is AHCCCS's adherence to the Synar Amendment (tobacco retail compliance). The AGO also administers the opioid settlement funds so the AHCCCS State Opioid Treatment Authority (SOTA) engages with the AGO to reduce silos and duplication.
iii. The Arizona Board of Behavioral Health Examiners establishes and maintains standard of qualifications and performance for licensed behavioral health professionals.
iv. The Arizona Department of Economic Security (DES) and Division of Developmental Disabilities (DDD) administer programs that intersect with the priority populations of the MHBG and SUPTRS BG.
v. The Arizona Department of Liquor Licenses and Control (DLLC) is a strong substance use prevention partner, as they conduct statewide alcohol retail compliance checks, retailer education, community/school/student alcohol prevention education, and more.
vi. The Governor's Office of Youth, Faith and Family (GOYFF) are a strong substance use prevention partner, as they administer a large portion of the SUPTRS primary prevention set aside.
vii. The Arizona Department of Corrections Rehabilitation and Reentry (ADCRR)
viii. Arizona Department of Education (ADE)
ix. Department of Child Safety (DCS)

3. Please describe how the public mental health and substance use services system is organized at the regional, county, tribal, and local levels. In the description, identify entities that provide mental health and substance use services, or contribute resources that assist in providing these services. This narrative must include a description of the current service system's attention to the MHBG and SUPTRS BG priority populations listed above under "Populations Served."

As outlined in the previous section, Arizona's public mental health and substance use service systems are administered statewide through contracts with Managed Care Organizations (ACC Plans). These organizations partner with integrated and specialty behavioral health providers to deliver services to members with ESMI, SMI, SED, SUD, including those in recovery. Regionally, three ACC-RBHAs—Arizona Complete Health North (Northern AZ), Mercy Care (Central AZ), and Arizona Complete Health South (Southern AZ)—each serve a distinct Geographic Service Area (GSA), providing behavioral health services for non-Title XIX/XXI members affected by ESMI, SMI, SED, and SUD. Additionally, AHCCCS collaborates with Tribes and Tribal Regional Behavioral Health Authorities (TRBHAs) through Intergovernmental Agreements (IGAs) to facilitate comprehensive behavioral health care for all eligible individuals assigned to tribal entities. Tribal governments may operate their own TRBHA by agreement with the State to support American Indian members. Current TRBHAs include the White Mountain Apache, Gila River, Pascua Yaqui, Navajo Nation, and Colorado River Indian Tribe. The range of entities offering mental health and substance use services is diverse, encompassing various provider types, specialties, and populations served.
For substance use treatment services and certain recovery services under the SUPTRS BG, the majority of providers fall under: subacute facilities to administer detox services, outpatient, integrated care, FQHCs, MAT/MOUD providers, and behavioral health residential facilities. Some examples of some unique or specialty programs for pregnant women and women with dependent

children include Hushabye Nursery, Arizona Women's Recovery Center, West Valley OBGYN, The Guidance Center, CODAC and their transitional living casitas and their Connie Hillman House. Recovery services and programs include peer support, employment support, Oxford House and Barbell Saves recovery program. The PWID population is served by 67 opioid treatment programs. There are 4 OTP programs that provide 24/7 access to care to provide immediate access to opioid treatment and connect to ongoing services. MOUD services may also be offered through Office Based Opioid Treatment (OBOT) programs. Another program option for PWID who are not yet ready for treatment is Sonoran Prevention Works who operates the statewide harm reduction program. SPW provides access to stigma-free services including street-based outreach, HIV and Hepatitis C testing and referrals, naloxone distribution and other overdose prevention resources and training, peer support, and syringe services programming (hypodermic syringes or any items used in the act of injection drug use are NOT funded by federal dollars). SPW is a partner that is uniquely posed to engaged positively and effectively with the PWID population and provide referrals to substance use and mental health treatment.

For substance use primary prevention, The SUPTRS BG supports programs and activities through agreements with TRBHAs, state agencies, local and regional non-profits, and coalitions. The majority of prevention efforts are administered through either 1) GOYFF with their Trauma Informed Substance Abuse Prevention Program (TISAPP), where they contract with over 25 local, county, or regional organizations that offer outreach, information dissemination, and education primarily to communities and individuals across the state, or 2) Matforce and the Substance Awareness Coalitions Leaders of Arizona (SACLAz) who contracts with approximately 25 community-based prevention coalitions across the state. AHCCCS works closely with these two entities, as well as the TRBHAs, DLLC, and other subrecipients to monitor the planning, implementation, and evaluation of prevention services.

The Mental Health Block Grant (MHBG) plays a critical role in supporting this system by funding community-based mental health treatment for specific priority populations. These include:

• Adults with Serious Mental Illness (SMI): Individuals aged 18 and older who have a diagnosable behavioral, mental, or emotional condition that significantly impairs their ability to function in the community.

• Children with Serious Emotional Disturbance (SED): Individuals under the age of 18 who experience behavioral, mental, or emotional challenges that interfere with their functioning in family, school, or community settings.

• Individuals with Early Serious Mental Illness (ESMI), including those experiencing First Episode Psychosis (FEP): These services are supported by a 10% set-aside of MHBG funds and follow evidence-based models such as Coordinated Specialty Care, incorporating principles from the National Institute of Mental Health's RAISE initiative.

• In addition to these targeted services, 5% of MHBG funds are reserved for crisis services. Arizona's crisis care continuum includes a robust and nationally recognized system of support, offering:

a. Crisis telephone response

b. Mobile crisis team interventions

c. Facility-based stabilization services, including observation and detox

d. Access to all other covered services for any Arizona resident, regardless of insurance status

e. This crisis system is designed to be recovery-oriented and person-focused, aiming to stabilize individuals quickly and help them return to their baseline level of functioning.

f. Together, AHCCCS and its contracted ACC-RBHAs ensure that MHBG resources are used effectively to support a responsive, integrated, and equitable behavioral health system across Arizona's regional, county, tribal, and local levels.

AHCCCS TRBHA partners tend to be tribal government organizations who have their own behavioral health services units from which to provide direct behavioral health prevention, treatment and recovery services. They may also have subcontracted or partnered behavioral health facilities within their tribal lands and jurisdiction as well as off-reservation placement options as indicated.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system, including state plans for addressing identified needs and gaps with MHBG/SUPTRS BG award(s)

Narrative Question

This narrative should describe your states needs assessment process to identify needs and service gaps for its population with mental or substance use disorders as well as gaps in the prevention system. A needs assessment is a systematic approach to identifying state needs and determining service capacity to address the needs of the population being served. A needs assessment can identify the strengths and the challenges faced in meeting the service needs of those served. A needs assessment should be objective and include input from people using the services, program staff, and other key community stakeholders. Needs assessment results should be integrated as a part of the state's ongoing commitment to quality services and outcomes. The findings can support the ongoing strategic planning and ensure that its program designs and services are well suited to the populations it serves. Several tools and approaches are available for gathering input and data for a needs assessment. These include use of demographic and publicly available data, interviews, and focus groups to collect stakeholder input, as well as targeted and focused data collection using surveys and other measurement tools.

Please describe how your state conducts needs assessments to identify behavioral health needs, determine adequacy of current services, and identify key gaps and challenges in the delivery of quality care and prevention services.

Grantees must describe the unmet service needs and critical gaps in the state's current systems identified during the needs assessment described above. The unmet needs and critical gaps of required populations relevant to each Block Grant within the state's behavioral health system, including for other populations identified by the state as a priority should be discussed. Grantees should take a data-driven approach in identifying and describing these unmet needs and gaps.

Data driven approaches may include utilizing data that is available through a number of different sources such as the **National Survey on Drug Use and Health (NSDUH)**, **Treatment Episode Data Set (TEDS)**, **National Substance Use and Mental Health Services Survey (N-SUMHSS)**, the **Behavioral Health Barometer**, **Behavioral Risk Factor Surveillance System (BRFSS)**, **Youth Risk Behavior Surveillance System (YRBSS)**, the CDC mortality data, and state data. Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention, treatment, and recovery support services planning. States with current Strategic Prevention Framework - Partnerships for Success discretionary grants are required to have an active SEOW.

This step must also describe how the state plans to address the unmet service needs and gaps identified in the needs assessment. These plans should reflect specific services and activities allowable under the respective Block Grants. In describing services and activities, grantees must also discuss their plan for implementation of these services and activities. Special attention should be made in ensuring each of the required priority populations listed above, and any other populations, prioritized by the state as part of their Block Grant services and activities are addressed in these implementation plans.

1. Please describe how your state conducts statewide needs assessments to identify needs for mental and substance use disorders, determine adequacy of current services, and identify key gaps and challenges in the delivery of quality care and prevention services.

Response-
The Arizona Health Care Cost Containment System (AHCCCS) utilizes several data feeds, surveys, systemic evaluations, as well as stakeholder forums to determine statewide need for services. AHCCCS works in tandem with the ACC Plans with Regional Behavioral Health Agreements (ACC-RBHAs) and Tribal Regional Behavioral Health Authorities (TRBHAs) to ensure efficient resource allocation that correlates system capacity with service demand. AHCCCS utilizes and continually works to enhance data driven decision-making processes when assessing prevention, intervention, treatment, and recovery needs for behavioral health disorders.

ACC Plan and ACC-RBHA Assessment Efforts
AHCCCS maintains active policies that allow for the assessment and monitoring of unmet needs at the contract level, in communities, and within specified populations either accessing or in need of behavioral health services statewide. The AHCCCS Contractor Operations Manual (ACOM) Policy 415 Provider Network Development and Management Plan - Periodic Network Reporting Requirements ensure that regular assessments of need are occurring. This policy applies to AHCCCS Complete Care (ACC) and ACC-RBHAs. The policy states that provider networks shall provide a foundation that supports an individual's needs as well as the membership in general. This policy establishes Contractor requirements for the submission of the Network Development and Management Plan and other periodic network reporting requirements allowing AHCCCS to assess and monitor both programmatic and financial activities. Specific requirements of activities contractors are required to manage and report on include, but are not limited to:
• Contractor's Workforce Development Plan

• Contractor's Value Based Purchasing/24/7 Access Points Report
• Evaluation of the prior year's Network Plan including: Actions proposed in the prior year's plan, network issues over the past year that required intervention, interventions taken to resolve network issues, barriers to the interventions, and evaluation of the effectiveness of the interventions.
• Contractor's current network gaps
• Contractor's network development steps for the coming year based upon its review of the prior year's Network Plan, current identified gaps, and any other priorities identified in the current plan
• Contractor's analysis demonstrating it has the capacity and the appropriate range of services adequate for the anticipated enrollment in its assigned service area
• Description of the integrated network design by GSA for the following populations: members undergoing substance use disorder treatment: Pregnant Women and/or Pregnant Women with Dependent Children, Persons who use drug by injection, Adults, and Children.
• General membership requiring access to the following types of substance use disorder treatment: Medication Assisted Treatment, Outpatient, Intensive Outpatient, Partial Hospitalization, and Residential Inpatient.
• A description of subcontracts for substance use treatment and recovery through the Substance Use Prevention, Treatment and Recovery Services (SUPTRS) Block Grant utilizing capacity data including wait list management methods for SUPTRS Block Grant Priority populations.

Some specific examples of needs assessments processes implemented by the ACC-RHBAs relating to the SUBG include:

AzCH North and South- The health plan monitors access through monthly gap analyses and tracks both existing and expanding SUD programming, including Medication for Opioid Use Disorder (MOUD) programs and State Opioid Response (SOR) initiatives.

Mercy Care – The health plan uses a multi-method approach which includes data analysis and trends of current SUBG network, stakeholder & provider engagement, provider pre-award risk assessment, and outcomes of the Independent Case Review. Provider pre-award risk assessment involves several evaluation criteria that contributes to the health plan ensuring providers that are selected to receive SUBG funding have the operational, financial, and programmatic/clinical experience with priority populations, which ensures funding decisions are data informed and responsive to community needs. The health plan also conducts stakeholder and provider meetings where regional and local need and gaps are identified. Mercy Care analyzes data on current SUBG subrecipient demographics and most used services. Quarterly, data analysis and trends are reviewed through a quarterly report of claims data that identifies how many individuals were served, demographics including pregnancy status, top 10 clinical services provided, and specific services received by age group. This type of data helps to inform trends of what is currently being provided within the SUBG network and what gaps still exist.

The National Survey on Drug Use and Health (NSDUH)

Prepared by the Substance Abuse and Mental Health Services Administration (SAMHSA), the NDSUH provides the underlying methodology used by AHCCCS to quantify the need for substance abuse treatment in Arizona. On an annual basis, prevalence information from the NSDUH compares census data, both actual and estimated, for the State of Arizona. The results outlined treatment needs based on race/ethnicity, gender, and age group for the state, and then for each county and/or sub-state planning area.

The Arizona Department of Health Services (ADHS) Data Dashboard

ADHS maintains an interactive data dashboard to provide timely data about the opioid epidemic in Arizona. The dashboard is a tool that ADHS, the Governor's Office of Youth, Faith, and Families (GOYFF), AHCCCS and others use to assess statewide impacts of opioid and other drugs. Data is displayed at multiple levels, across demographics, and over time, including tables, graphs, maps, and downloadable data files covering a variety of reporting and visualization needs.

AHCCCS Office of Data Analytics (AODA)

AHCCCS also relies on the results of data management and numerous qualitative surveys to determine need and direct resources accordingly. Data management on process-related performance measures occurs with contracted providers and partners reporting independent numbers no less than quarterly. The reports are then aggregated by the AODA within the Division of Managed Care (DMC). Data management and analysis on impact and outcome measures occur across the partner agencies. Sending this information to AHCCCS ensures a central location for consistent packaging and reporting to SAMHSA and for public dissemination. Qualitative surveys are critical to identifying potential service gaps, as they capture the human component and the effect a lack of services can have on a community which quantitative analysis cannot adequately determine.

Independent Case Review (ICR)

AHCCCS contracts annually with a professional consulting agency to conduct the Independent Case Review (ICR) to meet the independent peer review federal requirement of the SUBG grant. Each year member treatment case files from SUBG treatment providers under each ACC-RBHA are provided to AHCCCS and then to the consulting agency. Files are reviewed systematically by the consulting agency to assess the quality, appropriateness, and efficacy of SUBG-funded treatment services. The files that are reviewed by the contractor include intake documents, assessments, treatment plans, treatment services or referrals (HIV screening, peer support, case management, employment services, therapy, MAT services, etc.) and discharge paperwork. The contractor uses a validated case file review tool, which is reviewed annually, to assess if members were referred to appropriate services, provided knowledge of available services and whether the members utilized the services offered. Some specific examples of evaluation measures within the tool include: the timeliness of the assessment (within 45 days), presence of an individual service plan (ISP), timeliness of the ISP (within 90 days), use of certified peer support services and that the peer support specialist is "credentialed", whether telehealth was offered as a treatment option, if social (non-medical) determinants of health were assessed and when/how/if services were offered to the member throughout their time enrolled with the provider.

Additionally, the consulting agencies reviews for how many specific services (e.g. family therapy) were utilized throughout treatment and categorizes services offered/received for specific high-risk populations (e.g. pregnant/parenting women).

Additionally, focus groups are facilitated to allow members and providers to voice supplementary feedback including whether certain services were provided/available, the members experience while in treatment services and additional services that could have been beneficial to their treatment and recovery process.
Several other processes are implemented to continually assess needs and gaps for behavioral health services in Arizona. This includes professional needs assessments conducted by outside vendors (2021 Pregnant and Parenting Women Needs Assessment, 2022 Arizona Behavioral Health Needs for the Uninsured and Underinsured), reviews of data that AHCCCS compiles for required SAMHSA reporting (e.g. Table 10a, 10b, 5a, 5b), and monthly meetings with the Arizona Behavioral Health planning Council.
AHCCCS is currently considering and planning how best to conduct an updated comprehensive statewide substance use and mental health services needs assessment to assist in future and continued strategic planning of the SUBG and MHBG.
LMA NEEDS ASSESSMENT
AHCCCS finalized a statewide substance abuse prevention needs assessment in May 2025 that highlighted areas of needs in the current statewide primary prevention system structure. The assessment generated a community prevention inventory, conducted focus groups throughout AZ, conducted key informant interviews throughout AZ, conducted an online Substance Use Prevention Workforce survey, and synthesized secondary data analysis for a multitude of data sources.
To comprehensively assess Arizona's substance use prevention landscape, LeCroy & Milligan Associates (LMA) employed a mixed-methods approach grounded in SAMHSA's Strategic Prevention Framework (SPF). This framework emphasizes data-driven decision-making, stakeholder engagement, and contextual understanding of community needs. The methodology was designed to capture both quantitative and qualitative insights across diverse populations and regions.
The assessment was structured around four major themes:
1. Substance Use Trends – What is the prevalence and pattern of substance use across Arizona's demographic and geographic groups?
2. Current Prevention Efforts – What programs are in place, who do they serve, and where are the gaps?
3. Risk and Protective Factors – What influences substance use at individual, community, and systemic levels?
4. Prevention Needs – What strategies and resources are needed to strengthen Arizona's prevention infrastructure?
LMA analyzed state and national datasets to identify substance use prevalence, trends, and disparities. Sources included:
• Arizona Youth Survey (AYS)
• Arizona Department of Health Services (ADHS)
• Arizona Institutes for Higher Education (AZIHE)
• National Survey on Drug Use and Health (NSDUH)
• Youth Risk Behavior Survey (YRBS)
• Centers for Disease Control and Prevention (CDC)
• Arizona Department of Public Safety (DPS)
These datasets provided insights into substance use by age, gender, race/ethnicity, geography, and socioeconomic status.
LMA conducted a targeted literature review of best practices in prevention from 2019–2024 focused on:
• Trauma-informed care
• Youth engagement strategies
• Culturally responsive programming
• Technology-based interventions
• Policy and environmental approaches
A statewide workforce survey was distributed to Substance use prevention coalitions and organizations and school mental health professionals and nurses. The sample size was 314 respondents. LMA analyzed the data using descriptive statistics and thematic coding. Focus areas included workforce demographics, training history, service areas, preparedness, and perceived gaps. Ten listening sessions were held across Arizona, with a focus on rural and college populations. Participants included youth and college students, parents and educators, tribal community members, coalition leaders. There were 91 total participants.
These were in-person, 1.5-hour sessions, and $25 gift cards were offered as incentives. LMA analyzed the survey using thematic analysis of qualitative feedback.
Eight in-depth stakeholder interviews were conducted with coalition directors (including tribal-focused), college prevention leaders, tribal health program directors, and state education prevention specialists. These were 45–60 minute Zoom interviews and $25 gift card incentives were offered. LMA analyzed the interviews using thematic synthesis of expert perspectives.
Efforts were made to include high-risk and underserved groups, which often times are not reflected in generic data collection efforts and thus is a common limitation. This included rural and frontier populations, racial/ethnic minorities, LGBTQIA+ individuals, and tribal communities. AHCCCS also provided a stakeholder list, and LMA supplemented recruitment through outreach to coalitions, schools, and community organizations. Rural and tribal groups were prioritized for early survey distribution and guaranteed incentives.

Overall, quantitative data were analyzed using descriptive statistics to identify patterns and disparities. Qualitative data from sessions and interviews were coded thematically to extract insights on lived experiences, barriers, and recommendations. Triangulation of data sources ensured validity and depth of findings.

The needs assessment will be included within this application as an attachment and will be posted on the AHCCCS SUBG webpage.

Arizona Youth Survey
The Arizona Youth Survey (AYS) is administered every two years to a statewide sample of 8th, 10th, and 12th grade youth under the direction of the Arizona Criminal Justice Commission Statistical Analysis Center and in partnership with the Arizona State

University School of Criminology & Criminal Justice. Based on the nationally recognized Risk and Protective Factor model and the Communities That Care survey (Hawkins et al., 1992), the AYS assesses the prevalence and frequency of youth substance use, gang involvement, and other risky behaviors, and helps stakeholders to better understand the risk and protective factors that are correlated with these behaviors. The survey sample encompasses students in schools in all 15 Arizona counties. From the collected data, individual county results are published in separate reports. AHCCCS utilizes the AYS data on a state level, as well as promotes its use in local community planning. At the state level, at minimum, the AYS data is integrated throughout our statewide needs assessment, identifying salient risk factors across the state such as 30-day use, perceived risk, and family and peer attitudes, as well as protective factors such as sense of belonging, peer and parental disapproval of substance use, etc. At the local level, communities can receive reports at the county level or school district level, to identify the unique local conditions that influence substance use trends and issues in their community.

State Epidemiology Outcomes Workgroup (SEOW)
The Arizona Substance Abuse Partnership (ASAP) State Epidemiology Outcomes Workgroup (SEOW) was created in 2004 as a requirement of the Strategic Prevention Framework State Incentive Grant (SPF SIG) and continues to serve as an invaluable resource. The membership roster includes statisticians, data analysts, academics, holders of key datasets, other stakeholders from various state and federal agencies, tribal entities, private and non-profit substance abuse-related organizations, and universities. This group provides data management and analytics related to substance use and impacts within Arizona. The objective is data-driven analytics to inform decision-making to prevent, assess risks, evaluate treatments, and develop priorities. The analysis integrates, links, and associates data from multiple sources in Arizona for a comprehensive view of status and trends. AHCCCS membership and attendance at this group is necessary to ensure data reports and trends are incorporated into the planning of all substance abuse prevention, treatment, and recovery efforts. The Epidemiology Workgroup has been an integral part to AHCCCS' substance abuse prevention planning efforts, including the development and implementation of statewide needs assessments, strategic plans, and evaluation efforts.

As the designated unit of the executive branch that is responsible for administering the Community Mental Health Services Block Grant (MHBG), AHCCCS ensures the following performance requirements are met:
• Subrecipients must submit a plan explaining how they will use MHBG funds to provide comprehensive, community mental health services to adults with serious mental illness (SMI) designation, children with serious emotional disturbances (SED), and Early Serious Mental Illness (ESMI) including First Episode Psychosis (FEP)
• Subrecipients to provide annual reports on their plans.
• Subrecipients may distribute funds to local government entities and non-governmental organizations.
• Subrecipients must ensure that community mental health centers provide such services as screening, outpatient treatment, emergency mental health services, and day treatment programs.
• Subrecipients must comply with general federal requirements for managing grants. They must also cooperate in efforts by SAMHSA to monitor use of MHBG funds. For example, each year, CMHS conducts investigations (site visits) of at least ten grantees receiving MHBG funds. This is to evaluate how they are using the funds to benefit the population. These evaluations include careful review of the following:
o How the grantees are tracking use of MHBG funds and their adult and child mental health programs,
o Data and performance management systems,
o Collaboration with consumers and the grantees' mental health planning council, and
o Grantees receiving MHBG funds are required to form and support a state or territory mental health/behavioral health planning council.
• Grantees receiving MHBG funds are required to form and support a state or territory mental health/behavioral health planning council.

2. Please describe the unmet service needs and critical gaps in the state's current mental and substance use systems identified in the needs assessment described above. The description should include the unmet needs and critical gaps for the required populations specified under the MHBG and SUPTRS BG "Populations Served" above. The state may also include the unmet needs and gaps for other populations identified by the state as a priority.

Response-
Treatment - ICR
According to the SFY 2024 ICR report, only 3% of the chart reviews showed that members included family therapy in their treatment plan. Since we know that a support system is crucial for the members in the recovery process, integrating family therapy into the members treatment plan is an opportunity to better meet member's treatment and recovery needs. Although many members in treatment may choose not to involve family in their process for various reasons, there may be great opportunity, for those who are willing, to have facilitated support through family therapy or identify and engage a helpful family member to participate in the treatment and recovery process as a natural support.
Additionally, only 16% of charts had evidence of gender-specific treatment services. Increasing gender-specific treatment is valuable to address vulnerable, at-risk members including pregnant and parenting mothers. While some programs are specialized in treating SUD among pregnant and parenting mothers and provide a wide array of treatment services specific to women (e.g. prenatal and postnatal care, women's groups, child welfare systems navigation, parenting classes, etc.) other programs that are not women-specific may have opportunity to explore how to better address gender-specific needs.
According to member and provider focus groups captured in the ICR report, transportation was a barrier for members to get to their treatment service appointments. Although there are strategies in place to support member's transportation needs (e.g. telehealth, bus passes, transportation as a covered service), challenges remain. For example, there are many rural and remote areas

in Arizona where transportation options are more limited (no public transportation, no transportation provider available), or challenges that providers and members experience in arranging the covered transportation service. AHCCCS continues to research and address transportation issues to support improvements but it continues to be reported as a challenge.

Other Data Sources

Through discussions with ACC-RBHA and provider agencies, AHCCCS is also aware of the following unmet needs and service gaps that we hope to better address in the future as funding and capacity allows: access to recovery housing and affordable housing matched with employment support to address barriers to employment such as having a criminal record. Additional barriers include child sitting and childcare, stigma that hinders our highest priority populations from seeking care such as people who use drugs by injection, pregnant women, and parenting women, residential care, limited resources for outreach, care coordination for TB screening, addressing medical needs of uninsured individuals with SUD. Finally, ACC-RBHAs and providers have identified that the demand for MAT/MOUD services can surpass funding availability.

Prevention - Needs assessment data

The 2025 AHCCCS Prevention Needs Assessment, conducted by LeCroy & Milligan Associates, Inc., provides a comprehensive evaluation of Arizona's substance use prevention landscape. While the state has made notable progress in expanding coalitions and school-based programming, the assessment identifies unmet service needs and critical gaps which are highlighted below.

Access to prevention services remains highly uneven across Arizona. Rural, tribal, and border communities face significant barriers due to limited infrastructure, staffing shortages, and inconsistent program availability. Counties such as Mohave, Santa Cruz, and La Paz report thinly spread resources and a lack of structured activities for youth. Tribal communities, in particular, encounter challenges related to sovereignty, space constraints, and competing priorities, which limit their ability to host or sustain prevention programming (LeCroy & Milligan Associates, Inc., 2025, pp. 68–69).

Several demographic groups are disproportionately underserved by current prevention efforts. LGB youth, Spanish-speaking families, youth of color, out-of-school youth, and individuals residing in rural areas are significantly underrepresented. LGB youth face elevated risks due to minority stress and lack of affirming environments. Youth in non-English-speaking households often lack access to culturally relevant materials, and those not enrolled in traditional school settings—such as youth in juvenile detention or foster care—are frequently unreachable by school-based programs

The prevention workforce, particularly in rural and tribal regions, is under-resourced and undertrained. Many professionals report a lack of preparedness in key areas such as trauma-informed care, cultural responsiveness, and emerging drug trends like fentanyl and cannabis concentrates. According to the workforce survey, only 37% of respondents felt adequately equipped to address new challenges such as youth vaping and the influence of social media on substance use behaviors.

According to the needs assessment current prevention efforts often fail to reflect the cultural identities and languages of Arizona's diverse populations. There is a pressing need for bilingual resources, Indigenous healing practices, and community-driven models that resonate with local values and traditions. Without culturally responsive programming, prevention efforts risk being ineffective or inaccessible to key populations. There are current efforts in place that under the SUBG that support culturally relevant practices for some populations (e.g. Helping Enrich African American Lives (HEAAL coalition), Urban Indian Coalition of Arizona (UICA), TRBHAs, and Hispanic/Latino serving agencies), though it seems there are still many communities unreached by prevention efforts for various reasons which may include funding limitations, lack of capacity and/pr training, and need for strategic outreach and partnerships).

Many communities lack the physical and social infrastructure necessary to support effective prevention. This includes safe spaces for youth, reliable transportation, and recreational opportunities. Funding instability and staffing shortages further limit the sustainability of programming. Schools and coalitions in underserved areas struggle with limited training, misaligned messaging between home and school environments, and insufficient programmatic support.

Youth perceptions of substance use are shaped by legalization, normalization within households, and peer influence. Substances such as marijuana and vaping are often viewed as low-risk, undermining prevention messaging. Conflicting messages from family members and school personnel contribute to confusion and reduce the impact of educational efforts.

In relation to MHBG, the following areas were identified as needed enhancement: Standardized Process for SED Identification, Enhanced Capacity and Accessibility of Behavioral Health Services, Expanding Primary Care Workforce Capacity, Expanding Evidence-Based Practices for Adults with SMI and ESMI/FEP, and Crisis Intervention and Coordination.

3. Please describe how the state plans to address the unmet service needs and gaps identified in the needs assessment. These plans should reflect specific services and activities allowable under the respective Block Grants. In describing services and activities, grantees must also discuss plans for the implementation of these services and activities. Special attention should be made in ensuring each of the required priority populations and any other populations prioritized by the state as part of the Block Grant services and activities are addressed in the implementation plan.

Treatment and recovery

• Continue to allocate funds to the ACC-RBHAs based on regional factors identified in the data drive allocation methodology.

• Continue to review SOR vs SUBG service array and utilization to identify gaps and reduce duplication. Monitor the adherence to SUBG priority populations to ensure they are served first.

• Prioritize funding to SPW for the specific purpose of addressing the needs of the SUBG priority populations through outreach, support, referral, and engagement into services. This includes funding the SSP program to prioritize PWID, which involves reducing overdose death, reducing spread of infectious disease such as HIV and Hep C, and connecting to treatment services. Another specific focus of SPW under the SUBG will be to outreach, identify, and connect PWID and pregnant and parenting women with SUD into treatment and related services.

• Continue to monitor and address access to treatment for individuals in rural and tribal communities through outreach, care coordination, and other support services.

• RECOVERY
o Continue to promote the ACC-RBHAs and SUBG providers to address barriers to care for priority populations such as increasing utilization of the billable child sitting service, addressing transportation barriers,
o Continue to promote and utilize the Oxford House model for recovery housing.
o Add allowability of the ACC-RBHA SUBG networks to use SUBG to childcare (more formal/comprehensive than currently allowable on-site child sitting service) for women with dependent children engaging in SUD treatment.
o Continue to promote the certification, employment and utilization of certified Peer and Recovery Support Service (PRSS) professionals and their services as well as family engagement in treatment services.
• Continue and increase the implementation of programmatic site visits to subrecipients to identify unmet service needs and gaps that can be addressed with the SUBG, as well as strengths and limitations of the grant that we may draw upon or address as needed.
Prevention
• GOYFF TISAPP program
• Matforce/SACLAz coalition-based prevention cohort.
• DLLC – AHCCCS will sustain funding to DLLC to continue a focus on underage alcohol use and its negative impacts.
• TRBHAs – AHCCCS will continue to fund three TRBHAs with primary prevention funds: Gila River Indian Community, Pascua Yaqui Tribe, and the White Mountain Apache Tribe.
• Sustain funding to Institutes of Higher Education (IHEs)
• Promote addressing prevention at a younger age, such as elementary age children 11 and younger.
• SACLAz media campaign and toolkit was developed and implemented under SUBG funding from the American Rescue Plan Act (ARPA). The SACLAz media campaign and toolkit initiative provided statewide dissemination of diverse media messages educating youth and adults on the harmful impacts of underage alcohol, vaping, and marijuana. This included a message specifically targeted at parent-child conversations about substances. An educational toolkit on alcohol, vaping, and marijuana prevention was developed and implemented in schools. If funding is available, AHCCCS would plan to sustain the school-based educational toolkit component of this initiative.
• Promote parent prevention strategies, building prevention toolkits for parents, and promoting parent-child conversations about substances,
o Prevent Child Abuse AZ if funding is available, PAXIS PAX Tools for caregivers if funding is available.
• Continue and increase the implementation of programmatic site visits to subrecipients.

In relation to MHBG, The Arizona Health Care Cost Containment System (AHCCCS), has developed comprehensive plans to address the unmet service needs and gaps identified in the needs assessment. These plans include specific services and activities allowable under the respective Block Grants, with a focus on ensuring that each of the required priority populations and any other populations prioritized by the state are addressed in the implementation plan.
Standardized Process for SED Identification: AHCCCS has undertaken a thorough initiative to establish a statewide standardized procedure for the identification, referral, and assessment of children with Serious Emotional Disturbance (SED) over the past several years. The objective is to provide accessible interfaces for educational institutions and primary care providers, facilitating timely referrals for SED assessments and promoting early detection and service initiation for children identified as experiencing SED. To advance this initiative, AHCCCS has introduced the use of an electronic portal known as DUGless, which enables providers to submit member information for either SED identification or removal requests. Effective October 1, 2025, usage of the DUGless portal will be mandatory.
To submit an SED identification request within DUGless, providers are required to:
Locate the member in the Supplemental Data section of the portal;
Specify whether they are requesting SED identification (Yes) or removal (No);
Provide detailed member information including AHCCCS ID, first and last name, date of birth, effective date of SED identification, CALOCUS Level of Care Score (ranging from 1 to 6; use 99 for members under age 6 or for FFS members, specifically AIHP/TRBHA/FES, when CALOCUS is unavailable), and SED qualifying diagnosis.
The implementation of this SED identification process is designed to enhance the evaluation of member needs and support improved service delivery.
Enhanced Capacity and Accessibility of Behavioral Health Services: To address the increased need for behavioral health services, especially since the COVID-19 pandemic, AHCCCS has expanded the use of telehealth services. This expansion aims to increase access to behavioral health services in rural areas and for populations with limited transportation. Additionally, AHCCCS is developing crisis stabilization services for children and adolescents with an SED Identification in Northern Arizona, reducing the need for children to leave their geographic service area for treatment. The state is also contracting with National Wraparound Innovation Services to develop an Arizona Center of Excellence for serving children with an SED designation and their families.
Expanding Primary Care Workforce Capacity: Arizona faces a shortage of psychiatrists and other licensed mental health professionals, particularly in rural communities. To address this, AHCCCS is supporting the Arizona Pediatric Psychiatry Access Line (A-PPAL) in partnership with the University of Arizona. This initiative provides primary care providers with direct access to child and adolescent psychiatrists, enhancing the capacity to serve children designated with SED or symptoms of a first episode of psychosis.
Expanding Evidence-Based Practices for Adults with SMI and ESMI/FEP: AHCCCS is expanding evidence-based practices such as Assertive Community Treatment (ACT), Supportive Housing, and Peer Support for adults with Serious Mental Illness (SMI) and Early Serious Mental Illness/First Episode Psychosis (ESMI/FEP). The state is conducting a balance of state analysis to develop infrastructure and provide services that meet fidelity to criteria established by SAMHSA. Additionally, AHCCCS is partnering with ACC-RBHA's in Northern and Southern Arizona to expand development and monitor fidelity of Permanent Supportive Housing.

Crisis Intervention and Coordination: AHCCCS is committed to ensuring that the crisis continuum of care meets demand. The state is partnering with first responders, law enforcement, and healthcare professionals to provide crisis intervention training. Additionally, AHCCCS is working to improve integration and coordination between crisis services, mental health facilities, law enforcement, and social support programs for a more comprehensive crisis response approach.
These initiatives reflect Arizona's commitment to addressing the behavioral health needs of its residents, ensuring that all priority populations and other prioritized groups have access to necessary services and support.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Planning Tables

Table 1: Priority Area and Annual Performance Indicators

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Planning Tables

Table 2: SUPTRS BG Planned State Agency Budget for Two State Fiscal Years (SFY)

ONLY include funds budgeted by the executive branch agency (SSA) administering the SUPTRS BG. This includes only those activities that pass through the SSA to administer substance use primary prevention, substance use disorder treatment, and recovery support services for substance use disorder.

Planning Period Start Date: 7/1/2025 Planning Period End Date: 6/30/2027

Activity	Source of Funds							
	A. SUPTRS BG	B. Mental Health Block Grant	C. Medicaid (Federal State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare), etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. Bipartisan Safer Communities ACT Funds
1. Substance Use Disorder Prevention[a] and Treatment	$71,738,802.00		$171,086,800.00	$74,103,379.00	$8,753,434.00	$145,100.00	$0.00	
a. Pregnant Women and Women with Dependent Children (PWWDC)[b]	$7,001,554.00			$377,268.00				
b. All Other	$64,737,248.00		$171,086,800.00	$73,726,111.00	$8,753,434.00	$145,100.00		
2. Recovery Support Services[c]								
3. Primary Prevention[d]	$19,130,347.00							
4. Early Intervention Services for HIV[e]								
5. Tuberculosis								
6. Evidence-Based Practices For Early Serious Mental Illness including First Episode Psychosis (10 percent of total MHBG award)								
7. State Hospital								
8. Other Psychiatric Inpatient Care								
9. Other 24-Hour Care (Residential Care)								
10. Ambulatory/Community Non-24 Hour Care								
11. Crisis Services (5 percent Set-Aside)								
12. Other Capacity Building/Systems Development[f]								
13. Administration[g]	$4,782,587.00			$1,217,302.00				
14. Total	**$167,390,538.00**		**$342,173,600.00**	**$149,424,060.00**	**$17,506,868.00**	**$290,200.00**	**$0.00**	

[a] Prevention other than primary prevention.

[b] Grantees must plan expenditures for Pregnant Women and Women with Dependent Children in compliance with Women's Maintenance of Effort (MOE) over the two-year planning period.

[c] This budget category is mandated by Section 1243 of the Consolidated Appropriations Act, 2023 and includes an aggregate of planned expenditures allowable under the 2023 guidance, "Allowable Recovery Support Services (RSS) Expenditures through the SUBG and the MHBG." Only plan RSS for those in need of RSS from substance use disorder.

[d] Row 3 should account for the 20 percent minimum primary prevention set-aside of SUPTRS BG funds to be used for universal, selective, and indicated substance use prevention activities.

[e] The most recent AtlasPlus HIV data report published on or before October 1 of the federal fiscal year for which a state is applying for a grant is used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective SUPTRS BG allotments to establish one or more projects to provide early intervention services regarding the human immunodeficiency virus (EIS/HIV) at the sites at which individuals are receiving SUD treatment.

[f] Other Capacity Building/Systems development include those activities relating to substance use per **45 CFR §96.122 (f)(1)(v)**

[g] Per **45 CFR § 96.135** Restrictions on expenditure of the SUPTRS BG, the state involved will not expend more than 5 percent of the BG to pay the costs of administering the SUPTRS BG.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Planning Tables

Table 2: MHBG Planned State Agency Budget for Two State Fiscal Years (SFY)

States are asked to present their projected two-year budget at the State Agency level, including all levels of state and applicable federal funds to be expended on mental health and substance use services allowable under each Block Grant. When planning their budgets, states should keep in mind all statutory requirements outlined in the application Funding Agreement/Certifications and Assurances.

Table 2 addresses funds budgeted to be expended during State Fiscal Years (SFY) 2026 and 2027 (for most states, the 24-month period is July 1, 2025, through June 30, 2027).Table 2 includes columns to capture state planned budget of BSCA funds (MHBG only)

Include public mental health services provided by mental health providers or funded by the state mental health agency by source of funding.

Planning Period Start Date: Planning Period End Date:

Activity	Source of Funds							
	A. SUPTRS BG	B. Mental Health Block Grant	C. Medicaid (Federal State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare), etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. Bipartisan Safer Communities ACT Funds[a]
1. Substance Use Disorder Prevention and Treatment								
a. Pregnant Women and Women with Dependent Children (PWWDC)								
b. All Other								
2. Recovery Support Services								
3. Primary Prevention								
4. Early Intervention Services for HIV								
5. Tuberculosis								
6. Evidence-Based Practices For Early Serious Mental Illness including First Episode Psychosis (10 percent of total MHBG award)[b]								
7. State Hospital								
8. Other Psychiatric Inpatient Care								
9. Other 24-Hour Care (Residential Care)								
10. Ambulatory/Community Non-24 Hour Care								
11. Crisis Services (5 percent Set-Aside)[c]								
12. Other Capacity Building/Systems Development								
13. Administration								
14. Total		**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**

[a]The expenditure period for the 3rd and 4th allocations of Bipartisan Safer Communities Act (BSCA) supplemental funding will be from **September 30, 2024 through September 29, 2026** (3rd increment), **September 30, 2025 through September 29, 2027** (4th increment). Column H should reflect the state planned expenditure for this planning period (FY2026 and FY2027) [July 1, 2025 through June 30, 2027, for most states].

[b]Row 6 in Columns B and H: per statute, states are required to set-aside 10 percent of the total MHBG and BSCA awards for evidence-based practices for Early Serious Mental Illness (ESMI), including Psychotic Disorders.

[c]Row 11 in Columns B and H: per statute, states are required to set-aside 5 percent of the total MHBG and BSCA awards for Behavioral Health Crisis Services (BHCS) programs.

[d]Per statute, administrative expenditures for the MHBG and BSCA funds cannot exceed 5 percent of the fiscal year award.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Planning Tables

Table 3: Persons in Need of/Receiving SUD Treatment – Required for SUPTRS BG Only

This table allows states to present their estimated current need and baseline reach of the priority populations laid out in the SUPTRS BG statute. This information is intended to assist the state in demonstrating the unmet need of these populations that informs their plans for FY2026 - 2027. The estimates provided should represent the unmet need at the time of the application.

To complete the Aggregate Number Estimated in Need (Column A), please refer to the most recent edition of the **National Survey on Drug Use and Health** (NSDUH) or other federal/state data that describes the populations of focus in rows 1-5.

To complete the Aggregate Number in Treatment (Column B), please refer to the most recent edition of the **Treatment Episode Data Set** (TEDS) data prepared and submitted to the Behavioral Health Services Information System (BHSIS).

States should contact their federal points of contact for assistance in drawing these estimates from national and state survey data.

Estimates should utilize the most recent data from NSDUH, TEDS, and other data sources.

	A. Aggregate Number Estimated in Need of SUD Treatment	B. Aggregate Number in SUD Treatment
Pregnant Women	0	0
Women with Dependent Children	0	0
Individuals with a co-occurring M/SUD	0	0
Persons who inject drugs	0	0
Persons experiencing homelessness	0	0

Please provide an outline of how the state made these estimates, including data sources and values used for each row. For any cell which the state is

Page 1 of 182

unable to estimate the need or number in treatment, please provide an explanation for why these estimates could not be drawn.

Footnotes:

Planning Tables

Table 4: SUPTRS BG Planned Award Budget by Federal Fiscal Year

In addition to projecting planned budget by State Fiscal Year (Table 2b), states must project how they will use SUPTRS BG funds to provide authorized services as required by the SUPTRS BG regulations and expenditure categories. Therefore, Plan Table 4b must be completed for the SUPTRS BG awarded for Federal Fiscal Year (FFY) 2026 and FFY 2027. The totals for each FFY planning year should match the SUPTRS BG Final Allotments for the state in that award year.

Note: The FFY presented in the table is that of the award year, however states have up to two years to expend the award received. For example, the FFY 2026 award may be expended from October 1, 2025 through September 30, 2027.

Planning Period Start Date: 10/1/2025 Planning Period End Date: 9/30/2026

Expenditure Category	FFY 2026 SUPTRS BG Award
1 . Substance Use Disorder Prevention[a] and Treatment	$35,869,401.00
2 . Recovery Support Services[b]	$0.00
3 . Substance Use Primary Prevention[c]	$9,565,174.00
4 . Early Intervention Services for HIV[d]	$0.00
5 . Tuberculosis Services	$0.00
6 . Other Capacity Building/Systems Development[e]	$0.00
7 . Administration[f]	$2,391,293.00
8. Total	$47,825,868.00

[a]Prevention other than primary prevention. The amount in this row should reflect the planned budget for direct services during the planning period. Do not include budgeted funds for other capacity building/systems development, those are required to be presented in Row 6 of this table.

[b]This expenditure category is mandated by Section 1243 of the Consolidated Appropriations Act, 2023 and includes an aggregate of budget allowable under the 2023 guidance, "Allowable Recovery Support Services (RSS) Expenditures through the SUBG and the MHBG." Only present the estimated budget for RSS for those in need of RSS from substance use disorder. Do not include budgeted funds for other capacity building/systems development, those are required to be presented in Row 6 of this table.

[c]This row should reflect the state's planned budget of direct primary prevention activities that are intended to meet the SUPTRS BG 20 percent set aside. Activities include those used for universal, selective, and indicated substance use prevention activities. The budget for direct activities in this row should match the total budget planned in Table(s) 5a and 5b. Do not include budgeted funds for other capacity building/systems development, those are required to be presented in Row 6 of this table.

[d]The most recent AtlasPlus HIV data report published on or before October 1 of the federal fiscal year for which a state is applying for a grant is used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective SUPTRS BG allotments to establish one or more projects to provide early intervention services regarding the human immunodeficiency virus (EIS/HIV) at the sites at which individuals are receiving SUD treatment.

[e]Other Capacity Building/System Development include those activities relating to substance use per **45 CFR §96.122 (f)(1)(v)**. The amount presented here should reflect the total found in Planning Table 6 across treatment, recovery, and primary prevention.

[f]Per **45 CFR §96.135** Restrictions on expenditure of grant, the State involved will not expend more than 5 percent of the BG to pay the costs of administering the SUPTRS BG.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Planning Tables

Table 4: MHBG State Agency Planned Budget

Table 4 addresses the planned budget for MHBG. Please use this table to capture your estimated budget for MHBG-funded services and programs over a 24-month period (for most states, it is July 1, 2025 - June 30, 2027).

Planning Period Start Date: 7/1/2025 Planning Period End Date: 6/30/2027

MHBG-Funded Services	MHBG Funds Budgeted for This Item
1. Services for Adults	
1a. EBPs for Adults	
1b. Crisis Services for Adults	
1c. CSC/ESMI program for Adults	
1d. Other outpatient/ambulatory services for Adults	
1e. *Other Direct Services for Adults	
2. Subtotal of Services for Adults	0
3. Services for Children	
3a. EBPs for Children	
3b. Crisis Services for Children	
3c. CSC/ESMI program for Children	
3d. Other outpatient/ambulatory services for Children	
3e. *Other Direct Services for Children	
4. Subtotal of Services for Children	0
5. Other Capacity Building/Systems Development[a]	
6. Administrative Costs[b]	
7. *Any Other Cost	
8. Total MHBG Allocation[c]	**0**

Please provide brief explanation for services with an asterisk* below:

[a] This row for Other Capacity Building/Systems Development should be equal to the total of your planned budget in Table 6

[b] Administrative Costs should not exceed 5 percent of total MHBG allocation

[c] The total budget should be equal to your MHBG allocation for the next two years.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Planning Tables

Table 5a: SUPTRS BG Primary Prevention Planned Budget by Strategy and Institutes of Medicine (IOM) Categories

Planning Period Start Date: 10/1/2025 Planning Period End Date: 9/30/2026

Strategy	IOM Classification	FFY 2026 SUPTRS BG Award
1. Information Dissemination	Universal	$1,763,424
	Selective	$133,852
	Indicated	$0
	Unspecified	$0
	Total	**$1,897,276**
2. Education	Universal	$3,174,747
	Selective	$625,853
	Indicated	$144,726
	Unspecified	$0
	Total	**$3,945,326**
3. Alternatives	Universal	$401,444
	Selective	$67,312
	Indicated	$0
	Unspecified	$0
	Total	**$468,756**
4. Problem Identification and Referral	Universal	$114,093
	Selective	$7,037
	Indicated	$268
	Unspecified	$0
	Total	**$121,398**
	Universal	$2,531,207
	Selective	$374,099

5. Community-Based Processes	Indicated	$8,386
	Unspecified	$0
	Total	**$2,913,692**
6. Environmental	Universal	$218,725
	Selective	$0
	Indicated	$0
	Unspecified	$0
	Total	**$218,725**
7. Section 1926 (Synar)-Tobacco	Universal	$0
	Selective	$0
	Indicated	$0
	Unspecified	$0
	Total	**$0**
8. Other	Universal	$0
	Selective	$0
	Indicated	$0
	Unspecified	$0
	Total	**$0**
Total Prevention Budget		**$9,565,173**
Total Award [a]		**$47,825,868**
Planned Primary Prevention Percentage		**20.00%**

[a] Total SUPTRS BG Award is populated from Plan Table 4 SUPTRS BG Planned Award Budget by Federal Fiscal Year

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Planning Tables

Table 5b: SUPTRS BG Planned Primary Prevention Budget by Institutes of Medicine (IOM) Categories

States should identify the planned budget for primary prevention disaggregated by IOM Categories the state plans to prioritize with primary prevention set-aside dollars from the FFY 2026 and FFY 2027 SUPTRS BG allotments.

Planning Period Start Date: 10/1/2025 Planning Period End Date: 9/30/2026

Strategy	FFY 2026 SUPTRS BG Award
1. Universal Direct	
2. Universal Indirect	
3. Selective	
4. Indicated	
5. Column Total	**$0**
6. Total SUPTRS Award[a]	**$47,825,868**
7. Primary Prevention Percentage	**0.00%**

[a] Total SUPTRS BG Award is populated from Plan Table 4 SUPTRS BG Planned Award Budget by Federal Fiscal Year

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Planning Tables

Table 5c: SUPTRS BG Planned Primary Prevention Priorities

States should identify the categories of substances the state plans to prioritize with primary prevention set-aside dollars from the FFY 2026 SUPTRS BG award.

Planning Period Start Date: 10/1/2025 Planning Period End Date: 9/30/2026

Priority Substances	FFY 2026 SUPTRS BG Award
Alcohol	☑
Tobacco/Nicotine-Containing Products	☑
Cannabis/Cannabinoids	☑
Prescription Medications	☑
Cocaine	☑
Heroin	☑
Inhalants	☑
Methamphetamine	☑
Fentanyl or Other Synthetic Opioids	☑
Other	☐
Priority Populations	
Students in College	☑
Military Families	☑
American Indian/Alaska Native	☑
African American	☑
Hispanic	☑
Persons Experiencing Homelessness	☐
Native Hawaiian/Pacific Islander	☑
Asian	☑
Rural	☑

Footnotes:

Planning Tables

Table 6: SUPTRS BG Other Capacity Building/Systems Development Activities

Please enter the total amount of the SUPTRS BG budgeted for each activity described above, by treatment, recovery support services and primary prevention. In budgeting for each activity, states should break down the row budget by funds planned for SSA activities and those planned to be contracted out under other subrecipient contracts. States should plan their budgets on a single Federal Fiscal Year (FFY), specified in the table below.

Planning Period Start Date: 10/1/2025 Planning Period End Date: 9/30/2026

Activity	FFY 2026		
	A. SUPTRS Treatment	B. SUPTRS Recovery Support Services	C. SUPTRS Primary Prevention
1. Information Systems	$0.00	$0.00	$0.00
a. Single State Agency (SSA)	$0.00	$0.00	$0.00
b. All other subrecipient contracts	$0.00	$0.00	$0.00
2. Infrastructure Support	$0.00	$0.00	$0.00
a. Single State Agency (SSA)	$0.00	$0.00	$0.00
b. All other subrecipient contracts	$0.00	$0.00	$0.00
3. Partnerships, community outreach, and needs assessment	$0.00	$0.00	$0.00
a. Single State Agency (SSA)	$0.00	$0.00	$0.00
b. All other subrecipient contracts	$0.00	$0.00	$0.00
4. Planning Council Activities	$0.00	$0.00	$0.00
a. Single State Agency (SSA)	$0.00	$0.00	$0.00
b. All other subrecipient contracts	$0.00	$0.00	$0.00
5. Quality Assurance and Improvement	$0.00	$0.00	$0.00
a. Single State Agency (SSA)	$0.00	$0.00	$0.00
b. All other subrecipient contracts	$0.00	$0.00	$0.00
6. Research and Evaluation	$0.00	$0.00	$0.00

a. Single State Agency (SSA)	$0.00	$0.00	$0.00
b. All other subrecipient contracts	$0.00	$0.00	$0.00
7. Training and Education	$0.00	$0.00	$0.00
a. Single State Agency (SSA)	$0.00	$0.00	$0.00
b. All other subrecipient contracts	$0.00	$0.00	$0.00
8. Total	**$0.00**	**$0.00**	**$0.00**

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Planning Tables

Table 6: MHBG Other Capacity Building/Systems Development Activities

MHBG Plan 6 address MHBG funds to be expended on other capacity building /systems development during State Fiscal Year (SFY) 2026 and 2027 (for most states, the 24-month period is July 1, 2025, through June 30, 2027). This table includes columns to capture planned state budget for BSCA supplemental funds. Please use these columns to capture how much the state plans to expend over a 24-month period. Please document the planned uses of BSCA funds in the footnotes section.

MHBG Planning Period Start Date: MHBG Planning Period End Date:

Activity	A. MHBG[1]	B. BSCA Funds[2]
1. Information Systems		
2. Infrastructure Support		
3. Partnerships, Community Outreach, and Needs Assessment		
4. Planning Council Activities		
5. Quality Assurance and Improvement		
6. Research and Evaluation		
7. Training and Education		
8. Total	**$0.00**	**$0.00**

[1] The standard MHBG planned expenditures captured in column A should reflect the state planned budget for this planning period (SFYs 2026 and 2027) [**July 1, 2025 – June 30, 2027**, for most states].

[2] The expenditure period for the 3rd and 4th allocations of the Bipartisan Safer Communities Act (BSCA) funding is **September 30, 2024 – September 29, 2026** (3rd increment) and **September 30, 2025 – September 29, 2027** (4th increment). Column B should reflect the state planned budget for this planning period (SFYs 2026 and 2027) [**July 1, 2025, through June 30, 2027** for most states].

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Environmental Factors and Plan

1. Access to Care, Integration, and Care Coordination – Required for MHBG & SUPTRS BG

Narrative Question

Across the United States, significant proportions of adults with serious mental illness, children and youth with serious emotional disturbances, and people with substance use disorders do not have access to or do not otherwise access needed behavioral healthcare. **States should focus on improving the range and quality of available services and on improving the rate at which individuals who need care access it**. States have a number of opportunities to improve access, including improving capacity to identify and address behavioral health needs in primary care, increasing outreach and screening in a variety of community settings, building behavioral health workforce and service system capacity, and efforts to improve public awareness around the importance of behavioral health. When considering access to care, states should examine whether people are connected to services, and whether they are receiving the range of needed treatment and supports.

A venue for states to advance access to care is by **ensuring that protections afforded by MHPAEA are being adhered to in private and public sector health plans, and that providers and people receiving services are aware of parity protections**. SSAs and SMHAs can partner with their state departments of insurance and Medicaid agencies to support parity enforcement efforts and to boost awareness around parity protections within the behavioral health field. The following resources may be helpful: **The Essential Aspects of Parity: A Training Tool for Policymakers**; **Approaches in Implementing the Mental Health Parity and Addiction Equity Act: Best Practices from the States**.

The integration of primary and behavioral health care remains a priority across the country to ensure that people receive care that addresses their mental health, substance use, and physical health problems. People with mental illness and/or substance use disorders are likely to die earlier than those who do not have these conditions.[1] Ensuring access to physical and behavioral health care is important to address the physical health disparities they experience and to ensure that they receive needed behavioral health care. **States should support integrated care delivery in specialty behavioral health care settings as well as primary care settings**. States have a number of options to finance the integration of primary and behavioral health care, including programs supported through Medicaid managed care, Medicaid health homes, specialized plans for individuals who are dually eligible for Medicaid and Medicare, and prioritized initiatives through the mental health and substance use block grants or general funds. States may also work to advance specific models shown to improve care in primary care settings, including Primary Care Medical Homes; the Coordinated Care Model; and Screening, Brief Intervention, and Referral to Treatment.

Navigating behavioral health, physical health, and other support systems is complicated and many individuals and families require care coordination to ensure that they receive necessary supports in and efficient and effective manner. **States should develop systems that vary the intensity of care coordination support based on the severity and complexity of individual need**. States also need to consider different models of care coordination for different groups, such as High-Fidelity Wraparound and Systems of Care when working with children, youth, and families; providing Assertive Community Treatment to people with serious mental illness who are at a high risk of institutional placement; and connecting people in recovery from substance use disorders with a range of recovery supports. States should also provide the care coordination necessary to connect people with mental and substance use disorders to needed supports in areas like education, employment, and housing.

[1]Druss, B. G., Zhao, L., Von Esenwein, S., Morrato, E. H., & Marcus, S. C. (2011). Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. Medical care, 599-604.Avaiable at: **https://journals.lww.com/lww-medicalcare/Fulltext/2011/06000/Understanding_Excess_Mortality_in_Persons_With.11.aspx**

1. Describe your state's efforts to improve **access to care for mental disorders, substance use disorders, and co-occurring disorders**, including details on efforts to increase access to services for:

a) Adults with serious mental illness (SMI)

b) Adults with SMI and a co-occurring intellectual and developmental disabilities (I/DD)

c) Pregnant women with substance use disorders

d) Women with substance use disorders who have dependent children

e) Persons who inject drugs

f) Persons with substance use disorders who have, or are at risk for, HIV or TB

g) Persons with substance use disorders in the justice system

h) Persons using substances who are at risk for overdose or suicide

i) Other adults with substance use disorders

j) Children and youth with serious emotional disturbances (SED) or substance use disorders

k) Children and youth with SED and a co-occurring I/DD

l) Individuals with co-occurring mental and substance use disorders

RESPONSE -
Arizona has a comprehensive, integrated approach to improving access to care for individuals with mental disorders, substance use disorders (SUD), and co-occurring conditions. Arizona Health Care Cost Containment System (AHCCCS), who serves as the State Mental Health Agency, delivers services via Managed Care Organizations (MCOs), including AHCCCS Complete Care (ACC) plans, ACC Contractors with Regional Behavioral Health Agreements (ACC-RBHAs), the Arizona Long Term Care System (ALTCS), and Tribal Regional Behavioral Health Authorities (TRBHAs). These entities provide a full continuum of care that includes primary health services, behavioral health treatment, peer and family support, medication-assisted treatment, and crisis intervention. AHCCCS ensures that services are accessible to a wide range of populations, including adults with serious mental illness (SMI), individuals with co-occurring intellectual and developmental disabilities (I/DD), pregnant and parenting women with SUD, persons who inject drugs, individuals at risk for HIV or TB, justice-involved individuals, and those at risk for overdose or suicide. Children and youth with serious emotional disturbance (SED), including those with co-occurring I/DD, are also a priority. Services are delivered in integrated settings that address both physical and behavioral health needs, with a focus on recovery, person-centered care, and community integration.
The majority of AHCCCS members receive integrated health services through their chosen acute care program, one of seven AHCCCS Complete Care (ACC) plans throughout the state. Services include, but are not limited to, primary health care, mental health individual and group counseling, case management, psychiatric and psychologist services, peer support services, family support services, individual and group skills training, vocational training, substance use disorder treatment, medication for opioid use disorder (MOUD), and medication for the treatment of alcohol use disorder. The ACC Contractors with a Regional Behavioral Health Agreement (ACC-RBHAs) specifically serve individuals with a Serious Mental Illness (SMI) designation, Serious Emotional Disturbance (SED) and Early Serious Mental Illness (ESMI) including First Episode Psychosis (FEP) while also providing crisis, other grant-funded, and state-only funded services. Additionally, the Arizona Long Term Care System (ALTCS) program provides health insurance for individuals who are age 65 or older or who have a disability. American Indians and Alaska Natives (AI/AN) enrolled in AHCCCS or CHIP (KidsCare) may choose to receive their coverage through the American Indian Health Program (AIHP), Tribal ALTCS, or Tribal RBHAs (TRBHAs enter into Intergovernmental Agreements with AHCCCS for behavioral health care management) or one of the AHCCCS-contracted managed health plans. The core principles of AHCCCS' system of care are based on the concepts of recovery, member input, family involvement, person-centered care, communication, and commitment. AHCCCS MCOs are expected to demonstrate an unwavering commitment to these principles, while demonstrating creativity and innovation in their oversight and management of an integrated service delivery system. MCOs are required to develop and promote care integration activities, such as establishing integrated settings which serve members' primary care and behavioral health needs and encouraging member utilization of these settings. MCOs are also required to consider the entirety of the member population's health needs during network development and provider contracting to ensure member access to care, care coordination, and management, and to reduce duplication of services.

Arizona's model is based upon the premise that people want and deserve dignity, respect, integration, and safety. Based on four elements:
? Affording people dignity, compassion and respect
? Offering coordinated care, support or treatment
? Offering personalized care, support or treatment
? Supporting people to recognize, as well as develop, their strengths and abilities enables them to live a fulfilling and independent life.

To ensure that individuals with lived experience have a voice in system design, AHCCCS mandates that all contracted health plans maintain an Office of Individual and Family Affairs (OIFA). These offices mirror the AHCCCS OIFA and ensure that peer and family perspectives are represented in decision-making at every level—from the state agency to health plans and providers.

To support these efforts, AHCCCS leverages federal funding through the Mental Health Block Grant (MHBG) and Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUPTRS BG). Collaborative block grant funding and respective supplemental allocations have facilitated the expansion of innovative initiatives, such as the Arizona Peer and Family Career Academy. To address the growing demand for behavioral health services and workforce accessibility, the Academy provides comprehensive professional development and advanced training for Peer Recovery Support Specialists and Family Support Professionals. This ensures that these specialized providers receive targeted instruction to support individuals affected by mental health disorders, substance use disorders, and co-occurring conditions. Additionally, the Arizona Peer and Family Career Academy developed and implemented a training program for clinical supervisors, as required by AHCCCS, for those overseeing these unique service providers. This initiative not only reinforces the behavioral health workforce but also enhances the quality and effectiveness of services for individuals with complex needs. In addition, enhanced support for justice- involved individuals with mental disorders, substance use disorders, and co-occurring disorders have been provided through the services of justice navigation providers, court liaisons, and coordinated care before and after release. AHCCCS also supports the expansion of Permanent Supported Housing programs in rural Northern and Southern Arizona geographic service areas increasing access to

evidence-based Permanent Supportive Housing (PSH) models for serving persons experiencing homelessness, persons with behavioral health needs including mental illness or substance use disorders (SUD) and co-occurring disorders premised on: 1) access to and availability of both affordable housing subsidies and capacity, and, 2) individualized wrap around housing focused supportive services to support housing placement, stability and coordination with member's other service goals and resources.

Through SUPTRS BG Arizona has shifted the culture in the treatment of pregnant and postpartum parents by raising awareness, providing training to providers serving this population, improving referral pathways to local and culturally responsive programming, and coordinating with other state and local agencies to create a multi-systemic collaborative approach necessary to serve this population. Projects such as the Arizona Women's Recovery Center Childcare Initiative support retention in SUD treatment for women/families with childcare needs by connecting families with meaningful age-appropriate childcare or activities and specialty residential programs for maternal health, pregnancy care, SUD treatment and recovery support services to pregnant and parenting women.
SUPTRS BG also leverages funding to reach underserved populations through mobile outreach efforts such as the Intensive Treatment Systems Mobile Methadone Van, which delivers services directly to high-risk individuals in jails, shelters, and syringe distribution sites.

Additional efforts include covering child sitting and childcare for women with dependent children seeking SUD treatment services, covering transportation, and telehealth. The use of certified peer support specialists in the AZ behavioral health also improves access to care and retention in care by offering support by someone who has been in their shoes and can help them navigate their treatment and recovery journey.
Both AHCCCS and the ACC-RBHAs conduct secret shopper calls to SUBG providers to assess how providers respond when a priority population member seeking care, assess compliance to block grant requirements and address any access to care issues.

MHBG has strategically leveraged funding to strengthen delivery systems and service provision through effective implementation across the state of Arizona, with a particular focus on rural communities.
In relation to children identified with serious emotional disturbance (SED), improvements have been made to the AHCCCS SED identification process. The state recognized that the previous approach, which required lengthy and complex documentation, imposed unnecessary administrative burdens and could result in delayed access to care due to avoidable errors or incomplete submissions. Consequently, the process was streamlined to facilitate easier submission of SED identification requests by providers. This revision not only reduced paperwork but also improved the accuracy and timeliness of assessments, enabling children to receive essential services more promptly. These enhancements aim to improve access to care for children and youth with SED and co-occurring intellectual and developmental disabilities (I/DD).
Furthermore, children and adolescents with SED benefit from the Arizona Pediatric Psychiatry Access Line, which provides psychiatric consultation services in rural regions. The establishment of child and adolescent crisis stabilization units in Northern Arizona has further mitigated notable deficiencies within the rural behavioral health infrastructure.
Supplemental grant funding has also been leveraged for developing additional First Episode Psychosis (FEP) treatment programs, including a unit dedicated to providing mobile FEP services in two rural Arizona counties, as well as expanded outreach and training initiatives for ESMI/FEP service providers in these areas. To reduce barriers to care, AHCCCS has recently issued clarifications and technical assistance to contractors regarding ESMI identification and utilization of ESMI funds, with the objective of minimizing obstacles during this clinically critical intervention period.
Arizona's behavioral health system is grounded in the belief that all individuals deserve dignity, respect, and the opportunity to live fulfilling lives. The state's model emphasizes coordinated, personalized care that builds on individual strengths and promotes long-term recovery and independence. Through these targeted efforts and systemic innovations, Arizona continues to reduce barriers and expand access to care for all residents affected by mental health and substance use challenges.

2. Describe your efforts, alone or in partnership with your state's department of insurance and/or Medicaid system, to advance **parity enforcement and increase awareness of parity protections** among the public and across the behavioral and general health care fields.

RESPONSE -
Arizona Health Care Cost Containment System (AHCCCS) serves as both the Single State Agency (SSA) and the State Medicaid Agency for Arizona. In response to the Centers for Medicare & Medicaid Services' (CMS) Medicaid Mental Health Parity Final Rule (March 30, 2016), AHCCCS has taken significant steps to strengthen access to mental health and substance use disorder (MH/SUD) services for Medicaid beneficiaries. This rule ensures that MH/SUD services are covered comparably to physical health services.
To support enforcement, AHCCCS issued the AHCCCS Contractor Operations Manual (ACOM), Policy 110 (www.azahcccs.gov/Shared/Downloads/ACOM/PolicyFiles/100/110.pdf)– Mental Health Parity, which outlines contractor requirements for compliance with the Mental Health Parity and Addiction Equity Act of 2008. These requirements include conducting parity analyses, identifying applicable conditions, and defining MH/SUD benefits. AHCCCS contracts with Mercer Government Human Services Consulting to provide technical assistance in assessing compliance. Parity requirements apply whenever any portion of a benefit is delivered through a managed care organization (MCO). The 2022-2023 AHCCCS Delivery System Integration information outlines that all members have equitable coverage for physical, behavioral, children's rehabilitative or long term care services. https://www.azahcccs.gov/shared/Downloads/2022_Delivery_SystemIntegration_10012022.pdf
The Covered Behavioral Health Services Guide (CBHSG) (https://www.azahcccs.gov/PlansProviders/Downloads/MedicalCodingResources/AHCCCSCoveredBHServicesManual.pdf) , also serves as a resource for general information regarding behavioral health services and commonly used billing codes.
AHCCCS also monitors contractor compliance through regular reporting, technical reviews, and corrective action plans when

necessary. These oversight mechanisms ensure that parity is not only a policy but a practice embedded in service delivery.
In terms of public and provider awareness, AHCCCS promotes parity protections through educational materials, provider training, and community outreach. These efforts are integrated into broader initiatives such as the AHCCCS Delivery System Integration, which ensures equitable coverage for physical, behavioral, children's rehabilitative, and long-term care services. AHCCCS also supports member-facing resources and provider toolkits to increase understanding of parity rights and responsibilities.
For individuals dually eligible for Medicare and Medicaid, AHCCCS contracts with Medicare Advantage Dual Special Needs Plans (D-SNPs) that are affiliated with AHCCCS Complete Care (ACC) Medicaid health plans. This alignment promotes enrollment in a single, integrated plan, simplifying access to services and improving care coordination for over 180,000 Arizonans.
Despite these efforts, parity implementation faces challenges, particularly due to a shortage of trained behavioral health professionals. According to the October 2022 Arizona Department of Health Services Biennial Report, 82 of Arizona's 126 Primary Care Areas are designated as medically underserved. The Health Resources and Services Administration also designates much of Arizona as a Health Professional Shortage Area in behavioral health, with approximately 40% of Arizonans living in a Mental Health Professional Shortage Area.
To address these gaps, AHCCCS collaborates with the Arizona Department of Health Services and other stakeholders through the Arizona Health Improvement Plan (AzHIP) 2021–2025. This plan includes strategies to:
· Expand access to remote behavioral health services (e.g., telehealth, virtual support groups).
· Increase public awareness and utilization of mental health resources.
· Train frontline staff in evidence-based suicide prevention.
· Build a diverse, culturally competent behavioral health workforce by reducing barriers to education, aligning curricula with community needs, and prioritizing tribal and underserved populations.
AHCCCS remains actively engaged in these initiatives to ensure that all Arizonans—regardless of geography or payer—receive integrated, equitable care that honors the principles of mental health parity

3. Describe how the state supports the provision of **integrated services and supports for individuals with co-occurring mental and substance use disorders**, including screening and assessment for co-occurring disorders and integrated treatment that addresses substance use disorders as well as mental disorders.

Arizona has a rich tradition of addressing both mental health and substance use needs in an integrated system of care. The AHCCCS Medical Policy Manual (AMPM) and the AHCCCS Contractor Operations Manual (ACOM) provide mandates to support the integration of medical and behavioral health services throughout the lifespan. AMPM Chapter 200 - Behavioral Health Practice Tools encompasses policies related to the use of quality assessment and best practice to strengthen the capacity of Arizona's Behavioral Health System in response to the needs of children, adolescents, and young adults. Links to assessment tools, guidance on their utilization, and additional resources are provided as attachments to the policies and utilized by both primary care and behavioral health providers. The primary Behavioral Health Practice Tool utilized for the screening and assessment of co-occurring mental health and substance use disorders for individuals under 18 years of age in Arizona is the Child and Adolescent Level of Care Utilization System (CALOCUS). The CALOCUS dimensional rating system is used to determine the intensity of a child or adolescent's service needs on 7 levels over 6 dimensions: Risk of Harm, Functional Status, Comorbidity, Recovery Environment, Resiliency and Treatment History, and Treatment Acceptance and Engagement (scored with 2 scales - A. for the Child/Adolescent and B. for the parents/primary caregivers). AMPM Policy 220 - Child and Family Team - https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/200/220.pdf describes universal Child and Family Team (CFT) practice in the AHCCCS System of Care, indicators contributing to a child's and family's complexity of needs, how the essential CFT practice activities are implemented on a continuum based on individualized needs, and how the CALOCUS is utilized in the AHCCCS System of Care. This policy outlines requirements in procedure for CFT practice consisting of nine activities:
1. Engagement of the Child and Family.
2. Immediate Crisis Stabilization.
3. Strengths, Needs, and Culture Discovery (SNCD).
4. CFT Formation/Coordination of CFT Practice.
5. Service Plan Development.
6. Ongoing Crisis Planning.
7. Service Plan Implementation.
8. Tracking and Adapting.
9. Transition.
AMPM Behavioral Health Practice Tool 220, Attachment B provides a table matrix to describe how the CFT practice may be implemented for children and families with varying needs and service intensity levels. While the CALOCUS suggests a level of service intensity, the CFT identifies the specific services and supports that will best meet the identified needs. Service planning should always be individualized, family driven, culturally competent and flexible. Children are resilient and families are adaptable and strong, and therefore, as their needs vary over time, service intensity will adjust to correspond with these changes. Policy 220 additionally outlines transition planning for youth adjudicated and sentenced to the Arizona Department of Juvenile Corrections, their release to the community, or entering/leaving foster care specific to behavioral health, including SUD, services. Additionally outlines are requirements for the transition planning of any child involved in behavioral health care to the adult behavioral health system when the child reaches age 16.
AMPM Chapter 300 - Medical Policy For Covered Services and 320 - Services with Special Circumstances encompass all policies related to the provision of medical and behavioral health, including substance use disorder, and integrated services. AMPM Policy 320-O - Behavioral Health Assessments, Service, and Treatment Planning https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/300/320-O.pdf specifies provisions for Behavioral Health Assessments Service and Treatment Planning and requires the contractors to ensure assessments, service, and treatment planning

are conducted in compliance with the Adult Behavioral Health Services Delivery System including that they are conducted by an individual within their scope of practice, incorporate the concept of a integrated "team" established for each member receiving behavioral health services, and an indication of agreement or disagreement with the service plan and awareness of the right to appeal if not in agreement with the service plan. Specialized requirements are in place and outlined for individuals with a SMI designation within this policy. The policy provides specific details regarding comprehensive behavioral health assessment including an evaluation of the member's: 1) Presenting concerns, 2) Information on the strengths and needs of the member and his/her/their family, 3) Behavioral health treatment, 4) Medical conditions and treatment, 5) Sexual behavior and, if applicable, sexual abuse, 6) Substance abuse, if applicable, 7) Living environment, 8) Educational and vocational training, 9) Employment, 10) Interpersonal, social, and cultural skills, 11) Developmental history, 12) Criminal justice history, 13) Public (e.g., unemployment, food stamps, etc.) and private resources (e.g., faith based, natural supports, etc.), 14) Legal status (e.g., presence or absence of a legal guardian) and apparent capacity (e.g., ability to make decisions or complete daily living activities), 15) Need for special assistance, and 16) Language and communication capabilities. ii. Additional components of the assessment shall include: 1) Risk assessment of the member, 2) Mental status examination of the member, 3) A summary of impressions, and observations, 4) Recommendations for next steps, 5) Diagnostic impressions of the qualified clinician, 6) Identification of the need for further or specialty evaluations, and 7) Other information determined to be relevant. In alignment with SAMHSA's Evidence-Based Practice, Arizona utilizes the American Society of Addition Medicine (ASAM) Criteria level of care assessment tool that provides clinicians with a structured interview for assessing and caring for individuals with addictive, substance-related and co-occurring conditions. In the event of positive results, the information shall be shared with the providers involved with the member's care if the member has authorized sharing of protected health information. To assist in decision-making and treatment planning, AHCCCS provides an ASAM to AHCCCS Level of Care Crosswalk https://www.azahcccs.gov/PlansProviders/Downloads/CurrentProviders/ASAM_AHCCCS0_LevelOfCareCrosswalk.pdf identifying the ASAM Level of Care Title, Number, and Description with the AHCCCS Facility Type/Level of Care Title, Code, and detailed Description. In situations when a specific assessment is duplicated, the results of such assessments shall be discussed collaboratively with any other provider that may have completed an assessment to address clinical implications for treatment needs in addition to the differences being addressed within the "team" with participation of providers within and outside of behavioral health as indicated.

AHCCCS MCOs are required to develop processes to identify Health Homes within their network and assign members with an SMI designation, including those with co-occurring SMI and substance use conditions, to a Health Home within five days of enrollment. The assigned Health Home is responsible for either directly providing, or coordinating the provision of, all medically necessary health care services. In order to treat the whole person, the Health Home is also responsible to provide or coordinate a range of integrated, recovery-focused services to members, such as medication services, counseling for mental health and/or substance use disorder treatment, medical management, case management, transportation, peer and family support services, and health and wellness groups. Additionally, to support continuity of care and ensure coordination across systems, the Health Home is required to ensure timely follow-up and continuing care post-crisis engagement. AHCCCS MCOs are additionally required to maintain and execute policies and procedures describing the implementation of comprehensive and coordinated delivery of integrated physical and behavioral health services, including administrative and clinical integration of health care service delivery. Integration strategies and activities are expected to focus on improving individual health outcomes, enhance care coordination (including care coordination for Medication Assisted Treatment (MAT), and increase member satisfaction.

a. Please describe how this system differs for youth and adults.

RESPONSE -

AHCCCS has established an integrated system of care to support individuals with co-occurring mental health and substance use disorders. The system addresses the needs of both youth and adults, recognizing that these groups benefit from different approaches.

For youth, services are provided through a Child and Family Team (CFT) model, which incorporates family involvement, developmentally appropriate strategies, and coordination with sectors such as education, juvenile justice, and child welfare. Youth with Serious Emotional Disturbance (SED) or Early Serious Mental Illness (ESMI), including First Episode Psychosis (FEP), receive care that includes trauma-informed methods, early childhood screenings, and family support options. These services are often accessible within school and community environments to promote continuity.

The primary Behavioral Health Practice Tool used in Arizona for screening and assessing co-occurring mental health and substance use disorders in those under 18 is the Child and Adolescent Level of Care Utilization System (CALOCUS). The CALOCUS uses a dimensional rating approach to assess the level of service need for children and adolescents across seven levels and six areas: Risk of Harm, Functional Status, Comorbidity, Recovery Environment, Resiliency and Treatment History, and Treatment Acceptance and Engagement (evaluated using two scales: one for the Child/Adolescent and another for parents/primary caregivers).

AMPM Policy 220 - Child and Family Team (https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/200/220.pdf) details universal Child and Family Team practice in the AHCCCS System of Care, factors influencing child and family complexity, how CFT activities are individualized based on need, and the utilization of CALOCUS. The policy outlines procedures for nine core CFT activities:

1.Engagement of the Child and Family
2.Immediate Crisis Stabilization
3.Strengths, Needs, and Culture Discovery (SNCD)
4.CFT Formation/Coordination of CFT Practice

5.Service Plan Development
6.Ongoing Crisis Planning
7.Service Plan Implementation
8.Tracking and Adapting
9.Transition
Attachment B of AMPM Behavioral Health Practice Tool 220 provides a table describing implementation of CFT practice for children and families with varying needs and levels of service intensity. While CALOCUS suggests a service intensity level, the CFT determines the specific services and supports required. Service plans should be individualized, family driven, culturally competent, and flexible. Service intensity is adjusted according to changes in children's or families' needs over time. Policy 220 also describes transition planning for youth involved with the Arizona Department of Juvenile Corrections, those re-entering the community, or entering/leaving foster care regarding behavioral health, including substance use disorder services. The policy also establishes requirements for transitioning any child involved in behavioral health care to the adult system once they reach age 16.
Adults receive support through the Adult Recovery Team (ART) model, which emphasizes recovery-focused planning, peer support, and collaboration with adult-serving systems such as housing, employment, and the criminal justice system. Individuals with Serious Mental Illness (SMI) or co-occurring disorders have access to a comprehensive range of services, including medication-assisted treatment (MAT), vocational training, and integrated primary and behavioral health care.
MPM Chapter 300 - Medical Policy For Covered Services and Chapter 320 - Services with Special Circumstances collectively govern medical and behavioral health policies, encompassing substance use disorder and integrated services. AMPM Policy 320-O - Behavioral Health Assessments, Service, and Treatment Planning (link) delineates requirements for assessments, service provision, and treatment planning, mandating that these activities are conducted in alignment with the Adult Behavioral Health Services Delivery System. Assessments must be performed by qualified individuals within their scope of practice and employ an integrated team approach, incorporating agreement or disagreement with the service plan and acknowledging the right to appeal. The policy also outlines specialized processes for individuals with an SMI designation.
Comprehensive behavioral health assessments should include evaluation of: 1) presenting concerns; 2) strengths and needs of the individual and their family; 3) behavioral health treatment history; 4) medical conditions and treatments; 5) sexual behavior and potential sexual abuse; 6) substance use; 7) living environment; 8) educational and vocational training; 9) employment status; 10) interpersonal, social, and cultural skills; 11) developmental history; 12) criminal justice involvement; 13) public and private resource utilization; 14) legal status and decision-making capacity; 15) need for special assistance; and 16) language and communication abilities. Additional components include risk assessment, a mental status examination, summary impressions and recommendations, diagnostic impressions from a qualified clinician, identification of further evaluation needs, and other relevant information.
Consistent with SAMHSA's Evidence-Based Practice, Arizona utilizes the American Society of Addiction Medicine (ASAM) Criteria level of care assessment tool, supporting clinicians in evaluating and treating individuals with substance use and co-occurring conditions. When positive results occur, they are shared with authorized providers involved in the individual's care. AHCCCS offers an ASAM to AHCCCS Level of Care Crosswalk (link), which outlines the relationship between ASAM and AHCCCS levels of care. If duplicate assessments arise, findings are collaboratively reviewed among relevant providers to address clinical implications and differences within the multidisciplinary team.
AHCCCS Managed Care Organizations (MCOs) are required to establish procedures for identifying Health Homes within their networks and assigning members with an SMI designation, including those with co-occurring substance use conditions, to a Health Home within five days of enrolment. The designated Health Home assumes responsibility for directly providing or coordinating all medically necessary health care services and delivering a range of integrated, recovery-oriented supports, including medication management, mental health and substance use counselling, medical care management, case management, transportation, peer and family support, and health and wellness programs. They must also ensure timely follow-up and continuity of care after crisis intervention. Managed Care Organizations (MCOs) are required to implement and uphold comprehensive policies and procedures that support the delivery of integrated physical and behavioral health services, with a focus on both administrative and clinical alignment. These integration efforts are designed to advance health outcomes, improve care coordination—including medication-assisted treatment (MAT)—and elevate member satisfaction.

b. Does your state provide evidence-based integrated treatment for co-occurring disorders (IT-COD), formerly known as IDDT? Please explain.

RESPONSE -
Yes, AHCCCS provides evidence-based integrated treatment for co-occurring disorders (IT-COD), formerly known as IDDT. The Arizona Health Care Cost Containment System (AHCCCS) offers comprehensive integrated health care services for individuals with co-occurring mental and substance use disorders through Managed Care Organizations (MCOs). These services include primary health care, mental health counseling, case management, psychiatric and psychologist services, peer support services, family support services, skills training, vocational training, substance use disorder treatment, and medication for opioid and alcohol use disorders.
AHCCCS MCOs are expected to demonstrate creativity and innovation in their oversight and management of an integrated service delivery system. They are required to develop and promote care integration activities, such as establishing integrated settings that serve members' primary care and behavioral health needs and encouraging member utilization of these settings 1. Additionally, AHCCCS supports integrated systems of care for individuals and families with co-occurring mental and substance use disorders, including management, funding, and payment strategies that foster co-occurring

capability.
The core principles of AHCCCS' system of care are based on concepts of recovery, member input, family involvement, person-centered care, communication, and commitment. This integrated approach ensures that individuals receive comprehensive care that addresses both their mental health and substance use disorders effectively. Some specific evidence-based practices used in Arizona for integrated treatment of co-occurring disorders:
1. Assertive Community Treatment (ACT): This model focuses on individuals with severe and persistent mental illness that seriously impairs their functioning in community living. It involves a multidisciplinary team approach to coordinating care across multiple systems, such as social services, housing services, and health care.
2. High-Fidelity Wraparound: This model is used when working with children, youth, and families. It provides intensive care coordination and support based on the severity and complexity of individual needs.
3. Screening, Brief Intervention, and Referral to Treatment (SBIRT): This model is shown to improve care in primary care settings by identifying and addressing behavioral health needs early.
4. Trauma-Informed Care: This approach includes screening for Adverse Childhood Events (ACEs), referral processes for children that screen positive, and the use of evidence-based practices and trauma-informed services.
5. Permanent Supported Housing (PSH): This model serves persons experiencing homelessness, persons with behavioral health needs including mental illness or substance use disorders, and co-occurring disorders. It focuses on providing both affordable housing and individualized wrap-around housing-focused supportive services.
6. Intensive Treatment Systems Mobile Methadone Van: This initiative conducts outreach to high-risk opioid use touchpoints such as jails, syringe distribution locations, homeless shelters, and substance use disorder treatment programs. It aims to build trust and establish relationships with underserved populations.
7. Arizona-Pediatric Psychiatry Access Line: This initiative expands access to pediatric psychiatric resources throughout the state, particularly in rural and underserved areas.
8. Forensic Assertive Community Treatment (FACT): This model addresses the unique needs of people diagnosed with serious mental illness who have had involvement with the criminal justice system. It aims to reduce recidivism and assist members with high needs through an array of integrated, community-based services, resources, and supports.
9. Medical Assertive Community Treatment (MACT): This model is similar to ACT but includes individuals with significant medical comorbid conditions. It provides integrated care for the unique challenges presented by the combination of these conditions.

c. How many IT-COD teams do you have? Please explain.

RESPONSE - Arizona does not have a specific number of teams classified solely as IT-COD teams. Instead, the state uses a comprehensive, integrated approach to deliver care for individuals with co-occurring mental health and substance use disorders. The Arizona Health Care Cost Containment System (AHCCCS), which serves as the State Mental Health Agency, provides these services through Managed Care Organizations (MCOs), including AHCCCS Complete Care (ACC) plans, ACC-RBHAs, ALTCS, and TRBHAs. These entities offer a full continuum of care—including behavioral health treatment, primary care, peer support, and crisis services—ensuring that integrated treatment is available system-wide rather than through isolated teams.

d. Do you monitor fidelity for IT-COD? Please explain.

RESPONSE -
Arizona Health Care Cost Containment System (AHCCCS) mandates that Managed Care Organizations (MCOs) comply with fidelity standards for Integrated Treatment for Co-Occurring Disorders (IT-COD). This compliance is ensured through multiple mechanisms, such as the implementation of evidence-based practices and the use of fidelity monitoring tools. For example, the Assertive Community Treatment (ACT) model—applied for individuals with severe and persistent mental illness—adheres to fidelity criteria established by the Substance Abuse and Mental Health Services Administration (SAMHSA).
Furthermore, the Targeted Investment (TI) Program provides support to providers in delivering integrated and coordinated care at the provider level. As part of this program, participating providers are required to complete the Integrated Practice Assessment Tool (IPAT) annually, which evaluates their integration level according to the SAMHSA Levels of Integrated Care continuum.
Additionally, AHCCCS requires MCOs to submit an annual Provider Case Management Plan, detailing how the contractor intends to implement and monitor provider case management standards and caseload ratios for both adult and pediatric populations.
These quality assurance measures are designed to ensure ongoing fidelity monitoring and maintenance for IT-COD, thereby promoting the delivery of high-quality, integrated care to individuals with co-occurring disorders.
Under AHCCCS guidelines, MCOs must also provide an annual Provider Case Management Plan. This plan describes the strategies for implementing and monitoring provider case management standards and managing caseload ratios for both adults and children. It encompasses performance outcomes, lessons learned, and targeted improvement strategies.
Moreover, AHCCCS Targeted Investment (TI) Program supports providers in the delivery of integrated and coordinated care. As part of TI Program requirements, providers are obligated to complete the IPAT assessment annually to determine their integration level along the SAMHSA Levels of Integrated Care continuum. The TI Program incentivizes providers to implement and sustain various protocols, policies, and systems that facilitate person-centered integrated care.
The establishment of co-located, integrated clinics—where primary care and behavioral health services are delivered jointly to justice-involved individuals—has been another significant outcome supported by the TI Program. Providers participating in the TI Program have reported improvements in service quality and coordination stemming from enhanced

communication protocols between primary care and behavioral health teams.
Collectively, these initiatives ensure that fidelity data is systematically reported and monitored, advancing the provision of high-quality, integrated care for persons with co-occurring disorders.

e. Do you have a statewide COD coordinator? ○ Yes ◉ No

4. Describe how the state **supports integrated behavioral health and primary health care**, including services for individuals with mental disorders, substance use disorders, co-occurring M/SUD, and co-occurring SMI/SED and I/DD. Include detail about:

a) Access to behavioral health care facilitated through primary care providers

b) Efforts to improve behavioral health care provided by primary care providers

c) Efforts to integrate primary care into behavioral health settings

d) How the state provides integrated treatment for individuals with co-occurring disorders

RESPONSE - The AHCCCS Medical Provider Manual (AMPM) dedicates a full chapter to Care Coordination Requirements for primary care providers, member transitions, member transfers between facilities, coordination of care with other government agencies, children's rehabilitative services care coordination and service plan management, provider case management, and behavioral health crisis services and care coordination.

AMPM Policy 510 - Primary Care Providers https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/500/510.pdf outlines the care coordination responsibilities of primary care providers for "ongoing treatment coordination" including behavioral health services. When a primary care provider has initiated medication management services for a member to treat a behavioral health disorder, the Contractor provider policies and procedures shall address guidelines for referral to a behavioral health provider, specific guidelines for transfer of a member with a Serious Mental Illness (SMI) designation for ongoing treatment coordination, notifying entities of the transfer, the transfer/sharing of medical records, transition of prescription services including notification of the individual's current medications ensuring that the member does not run out of prescribed medication prior to the first appointment with a behavioral health provider, and monitoring activities to ensure that members are appropriately transitioned for care.
AMPM Policy 541 - Coordination of Care with Other Government Agencies
https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/500/541.pdf establishes Contractor requirements for maintaining collaborative relationships with other government entities that delivers services to members and their families, ensuring access to services, and coordinating care with consistent quality. Contractors are responsible for ensuring collaboration with government agencies, including but not limited to involvement in the member's Child and Family Team (CFT) or Adult Recovery Team (ART). In serving high needs children, adolescents and families involved with the Arizona Department of Child Safety, contractors are mandated to ensure that a behavioral risk assessment is performed that identifies the behavioral health needs of the child, and the child's parents and family or caregivers, that is based on the Arizona Vision - 12 Guiding Principles; coordinate behavioral health services, activities, and AHCCCS Behavioral Health System Practice Tools: Transition to Adulthood, Unique Behavioral Health Services for Needs of Children, Youth and Families involved with DCS, and CFT, Working with the Birth Through Five Population and Psychiatric and Psychotherapeutic Best Practices for Children: Birth Through Five Years of Age. AHCCCS considers the removal of a child from his/her home to the protective custody of the DCS to be an urgent behavioral health or physical need and at risk for negative emotional consequences and future physical and behavioral health disorders. As such, the policy outlines specific care coordination activities in AHCCCS' Rapid Response Process in these instances. Other government agencies with specific contractor case coordination requirements include: Arizona Department of Child Safety Arizona Families FIRST (Families in Recovery Succeeding Together) Program which provides expedited access to substance use treatment for parents/families/caregivers referred by DCS and that "substance use disorder treatment for families involved with DCS shall be family centered, provide sufficient support services, and shall be provided in a timely manner to promote permanency for children, stability for families, to protect the health and safety of abused/neglected children and promote economic security for families." The policy outlines care coordination with the Arizona Department of Education, Schools, or Other Local Educational Authorities to ensure that behavioral health providers collaborate with schools and help a child achieve success in school, including provision of appropriate behavioral health services in school settings; the Arizona Department of Economic Security to ensure behavioral health providers coordinate member care with Arizona Early Intervention Program; the Arizona Department of Economic Security/Rehabilitation Services Administration requiring a Interagency Service Agreement (ISA) to be in place to provide specialty employment supports for members determined to have a SMI; and Courts and Corrections to ensure that behavioral health providers are collaborating and coordinating care for members with behavioral health needs (including substance use disorders and co-occurring disorders) involved in the Arizona Department of Corrections, Arizona Department of Juvenile Corrections, Administrative Office of the Court, and the County Jail System. Coordination requirements include assimilation of information and recommendations contained in probation or parole case places when developing the service plan and ensuring that the behavioral health provider evaluates and participates in transition planning prior to release and arranging/coordinating the person's behavioral health care upon release.
AMPM Policy 570 - Provider Case Management https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/500/570.pdf establishes requirements for provider case management (including care coordination activities) for behavioral health providers. AHCCCS covers provider case management as a supportive service intended to improve treatment outcomes and meet individuals' Service or Treatment Plan goals. Examples of case management activities include but are not limited to:

1. Assistance in maintaining, monitoring, and modifying behavioral health services.
2. Assistance in finding necessary resources other than behavioral health services.
3. Coordination of care with the individual/Health Care Decision Maker (HCDM), designated representative (DR), healthcare providers, family, community resources, and other involved supports including educational, social, judicial, community, and other State agencies.
4. Coordination of care activities related to continuity of care between levels of care (e.g. inpatient to outpatient care) and across multiple services (e.g. personal care services, nursing services, and family counseling) and providers.
5. Assisting individuals in applying for Social Security benefits when using the SSI/SSDI Outreach, Access, and Recovery (SOAR) approach.
6. Outreach and follow-up of crisis contacts and missed appointments.
Provider case managers are responsible for monitoring the individual's current needs, services, and progress through regular and ongoing contact with the individual. The frequency and type of contact is determined during the treatment planning process, and is adjusted as needed, considering clinical need and individual preference, though generally falls within one of the following categories 1. Assertive Community Treatment (ACT) Case Management (Adult): One component of a comprehensive model of treatment based upon fidelity criteria developed by the Substance Abuse and Mental Health Services Administration. ACT case management focuses upon individuals with severe and persistent mental illness that seriously impairs their functioning in community living, in conjunction with a multidisciplinary team approach to coordinating care across multiple systems (e.g. social services, housing services, health care).
2. High Needs Case Management (Children/Adolescents): Focuses upon providing case management and other support and rehabilitation services to children with complex needs and multiple systems involvements for whom less intensive case management would likely impair their functioning. Children with high service intensity needs who require the assignment of a high needs case manager are identified as:
a. Children 0 through five years of age with two or more of the following:
i. Other agency involvement; specifically: Arizona Early Intervention Program (AzEIP), DCS, and/or DDD, and/or
ii. Out of home placement for behavioral health treatment (within past six months), and/or
iii. Psychotropic medication utilization (two or more medications), and/or
iv. Evidence of severe psycho-social stressors (e.g. family member serious illness, disability, death, job loss, eviction), and
b. Children six through 17 years of age: CALOCUS level of 4, 5, or 6.

3. Medium Level of Intensity Case Management (Adult): Focuses upon individuals for whom less intensive case management would likely impair their functioning. Supportive case management provides assistance, support, guidance and monitoring in order to achieve maximum benefit from services. Caseloads may include individuals with an SMI designation as well as individuals with a general mental health condition or substance use disorder as clinically indicated.
4. Low Level of Intensity Case Management (Adult): Focuses on individuals who have largely achieved recovery and who are maintaining their level of functioning. Case management involves careful monitoring of the individual's care and linkage to service. Caseloads may include both individuals with an SMI designation as well as individuals with a general mental health condition or substance use disorder as clinically indicated.
In addition to the levels of Case Management as listed above, Forensic Assertive Community Treatment Teams (FACT) function in Maricopa County to address the unique needs of people diagnosed with SMI and have had involvement with the criminal justice system. The goal of the FACT teams is to reduce recidivism and assist members with high needs through an array of integrated, community based services, resources, and supports.
The FACT team utilizes evidence-based practices to:
? Identify and engage members with complex, high needs.
? Remove barriers to services and supports.
? Address the whole person and provide a full range of community-based services and supports wherever and whenever they are needed.
? Reduce hospitalizations and contact with the criminal-justice system, improve health outcomes and help establish and strengthen natural community supports.
FACT team staff have experience in psychiatry, nursing, social work, rehabilitation services, substance-abuse interventions, employment support, independent-living skills and housing. A key member of the team is a peer support person who has lived experience with behavioral health challenges and prior interaction with the criminal justice system likened to the members served. The team assists members with adhering to treatment plans, activities of daily living, employment-related services, finding and maintaining affordable housing, budgeting, obtaining benefits, and engaging in community activities through delivering services in accordance with SAMHSA evidence-based practices (EBP/s).
AHCCCS/Maricopa County also offers Medical Assertive Community Treatment Teams (MACT). The difference between a regular ACT team and the MACT team is that the individuals not only have a diagnosis of a SMI but also have significant medical comorbid conditions. MACT employees have experience in Psychiatry (Behavioral Health Medical Provider), nursing, social work, rehabilitation services, and licensed substance use specialists who provide individual and group counseling, interventions/supports, employment support, independent living skills and housing supports. The MACT team additionally employs a Primary Care Medical Provider and closely monitors the medical and physical condition of the member along with their behavioral
health condition providing integrated care for the unique challenges the combination of these conditions can present.

AMPM Policy 590 - Behavioral Health Crisis Services and Care Coordination
https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/500/590.pdf is applicable to all Arizona residents regardless

of Medicaid enrollment or eligibility and establishes requirements related to the behavioral health crisis system for Title XIX/XXI and Non-Title XIX/XXI eligible members. The ACC-RBHA Contractor is responsible for the full continuum of crisis services to all individuals in their respective service areas to prevent a potentially dangerous condition, episode, or behavior. Crisis services include crisis telephone response, mobile crisis response, and facility-based stabilization (including observation and detoxification) and all other associated covered services delivered by crisis service providers. Additionally, the ACC-RBHA Contractor is responsible for all related telephonic crisis system follow-up activities, non-emergency transportation to remediate a crisis, and transportation provided by mobile crisis teams to a crisis stabilization facility. The ACCRBHA Contractor shall collect, report, and analyze crisis system data as an important element in evaluating the service, efficiency, sufficiency, and quality of the crisis delivery system. For AHCCCS-enrolled members, the health plan of enrollment is responsible for coordinating medically necessary services and care provided to members after the initial 24 hours of a crisis episode, or discharge from a crisis stabilization setting, whichever occurs first, covering all emergency transportation and non-emergent transportation from crisis receiving facilities. Ongoing stabilization services and related covered services are the responsibility of the member's health plan of enrollment, regardless of whether the services are provided within or outside the health plan's Geographic Service Area (GSA).

For AHCCCS enrolled members, the ACC-RBHA Contractor shall ensure notification is provided to the member's plan of enrollment, providers (e.g., TRBHA, health home, Primary care provider, if known), and other appropriate parties when an enrolled member engages with the crisis system. This notification shall occur within 24 hours of an enrolled member first engaging in the crisis system, seven days a week, 365 days a year, including weekends and holidays. The ACC-RBHA Contractor shall develop and maintain effective systems to ensure notifications of an enrolled member's interaction with the crisis system include, at a minimum: 1. Enrolled member demographic information (e.g., name, date of birth, AHCCCS ID, health plan of enrollment). 2. Nature of reason for contacting crisis. 3. Acuity level. 4. Final outcome or disposition of the crisis event. 5. Summary of interventions and clinical recommendations related to the need for any follow up and continuing services.

The ACC-RBHA Contractor shall ensure individuals receive a Post-Crisis Care Plan which includes information related to the individual's needs post-crisis and interventions to meet these needs including access to services, prescription medications, and referrals as clinically indicated. For enrolled members, the Post-Crisis Care Plan shall be provided to the member's health plan of enrollment so that subsequent services can be initiated. The member's health plan of enrollment shall ensure that post crisis care coordination and service delivery occur when an enrolled member engages in crisis services, with the objective to address the member's ongoing needs and ensure resolution of the crisis. Refer to AMPM Policy 1040 for outreach and engagement requirements and ACOM policy 417 for general behavioral health appointment standards. Care coordination shall occur between the member's health plan of enrollment, the ACC-RBHA Contractor, crisis providers and, if applicable, TRBHAs serving the member. TRBHAs are responsible for care coordination as outlined in their Intergovernmental Agreement (IGA). The Contractor shall have policies establishing post-crisis care coordination expectations that shall provide for: 1. Transfer of medical records of services received during a crisis episode, including prescriptions. 2. Tracking of admission, discharge, and re-admissions, including admission setting (e.g., emergency departments, inpatient and outpatient hospitals, detoxification, residential). 3. Requirements for follow-up directly with the individual, within 72 hours, when discharged from a crisis setting to ensure: a. Immediate assessment of the individual's needs, identification of the supports and services that are necessary to meet those needs, and connecting the individual to appropriate services, including a plan for suicide prevention and safety, as appropriate, and b. Provide solution-focused and recovery-oriented interventions designed to avoid unnecessary hospitalization, incarceration, or placement in a more restrictive setting. 4. Engagement of peer and family support services when responding to post-crisis situations, as preferred and identified by enrolled members. 5. The provision of ongoing care in an expedient manner, in accordance with the timeliness expectations specified in ACOM Policy 417. The Contractor shall regularly evaluate post-crisis care coordination activities and work to improve internal and external collaboration efforts. Care coordination activities shall include use of Health Information Technology (HIT), as available, to improve member outcomes.

MCOs are required to submit an annual Provider Case Management Plan that addresses how the Contractor will implement and monitor provider case management standards and caseload ratios for adult and child individuals. The Provider Case Management Plan includes performance outcomes, lessons learned, and strategies targeted for improvement. MCOs must also ensure that provider sites where provider case management services are delivered have regular and ongoing member and/or family participation in decision making, quality improvement, and enhancement of customer service.

AHCCCS' Division of Fee for Service Management (DFSM) has been targeting improvement in care coordination within the tribal health care delivery system. This has included, but is not limited to, the establishment of the American Indian Medical Home, investing in the Health Information Exchange to implement notifications related to admissions, discharges and transfers (ADTs), and working to coordinate with TRBHAs regarding Emergency Department (ED) and inpatient admissions for care management follow-ups. AHCCCS has also implemented its American Indian Medical Home Program (AIMH) for IHS/638 facilities for enhanced primary care case management and care coordination, as well as the implementation of Care Coordination Agreements between IHS/638 facilities and non-IHS/638 facilities to improve the delivery system for American Indians by increasing access to care and strengthening the continuity of care. The American Indian Medical Home (AIMH) Program is for American Indian/Alaska Native (AI/AN) members enrolled in the American Indian Health Program (AIHP). The AIMH Program is the first of its kind in the nation and was brought to fruition through a robust partnership between AHCCCS and tribal leadership. The AIMH Program supports Primary Care Case Management (PCCM), diabetes education, and care coordination for its AIHP enrolled members.

5. Describe how the state **provides care coordination**, including detail about how care coordination is funded and how care coordination models provided by the state vary based on the seriousness and complexity of individual behavioral health needs. Describe care

coordination available to:

a) Adults with serious mental illness (SMI)

b) Adults with substance use disorders

c) Adults with SMI and I/DD

d) Children and youth with serious emotional disturbances (SED) or substance use disorders

e) Children and youth with SED and I/DD

Arizona delivers care coordination through a fully integrated system managed by the Arizona Health Care Cost Containment System (AHCCCS), which oversees Medicaid services statewide. Care coordination is guided by policies outlined in the AHCCCS Medical Policy Manual (AMPM) and the AHCCCS Contractor Operations Manual (ACOM), ensuring that behavioral health and physical health services are integrated across the lifespan. Funding for care coordination is supported through Medicaid capitation payments, federal block grants (MHBG and SUPTRS BG), and state general funds.
Care coordination models vary based on the seriousness and complexity of individual behavioral health needs. These models include Health Homes, Child and Family Teams (CFTs), Assertive Community Treatment (ACT) teams, and cross-system collaboration with the Division of Developmental Disabilities (DDD). The following outlines care coordination approaches for specific populations:

a. Adults with Serious Mental Illness (SMI)
Adults with an SMI designation are assigned to a Health Home within five days of enrollment. Health Homes are responsible for coordinating all medically necessary services, including behavioral health, physical health, and social supports. Services include:
• Medication management
• Counseling and therapy
• Case management
• Peer and family support
• Transportation
• Health and wellness programs
For individuals with high complexity, ACT teams provide intensive, multidisciplinary, community-based services. These teams are tailored to individuals with frequent hospitalizations, co-occurring disorders, or housing instability. Care coordination is funded through Medicaid, MHBG, and state general funds.

b. Adults with Substance Use Disorders (SUD)
Care coordination for adults with SUD is guided by the American Society of Addiction Medicine (ASAM) Criteria, which determines the appropriate level of care. AHCCCS provides a crosswalk aligning ASAM levels with Arizona-specific facility types and services. MCOs ensure that assessments and treatment planning are conducted by qualified professionals and coordinated across providers.
Funding sources include Medicaid, SABG, and state general funds. Coordination models vary by severity:
• Mild to moderate SUD: Outpatient services with case management
• Severe or co-occurring conditions: Residential treatment or integrated care teams
SUBG funds support services for non-Medicaid eligible individuals and harm reduction efforts, including mobile methadone vans and peer outreach.

c. Adults with SMI and Intellectual/Developmental Disabilities (I/DD)
Arizona employs enhanced care coordination for adults with dual diagnoses of SMI and I/DD. Health Homes coordinate services across behavioral health and developmental systems, often in collaboration with DDD. Key components include:
• Individualized service planning
• Crisis response
• Permanent Supportive Housing (PSH)
• Employment services
• Adaptive communication supports
• Legal guardianship coordination
Funding is braided across Medicaid Title XIX, MHBG, and state general funds. The complexity of this population necessitates cross-agency collaboration and specialized residential placements.

d. Children and Youth with Serious Emotional Disturbances (SED) or SUD
Arizona utilizes the Child and Adolescent Level of Care Utilization System (CALOCUS) to assess service intensity. The Child and Family Team (CFT) model is central to care coordination, ensuring services are:
• Family-driven
• Culturally competent
• Responsive to changing needs
CFTs engage in nine core activities, including crisis stabilization, service planning, and transition planning. For youth with SUD, ASAM criteria guide treatment planning. Funding includes Medicaid, MHBG, SABG, and state appropriations. Coordination is critical during transitions such as foster care entry/exit or juvenile justice involvement.

e. Children and Youth with SED and I/DD

Care coordination for children and youth with both SED and I/DD involves collaboration between AHCCCS, DDD, and behavioral health providers. The CFT process is adapted to include developmental specialists and address unique needs. CALOCUS determines service intensity, while care plans incorporate:

• Behavioral interventions
• Habilitation services
• Educational supports
• Transition planning beginning at age 16
•

Funding sources include Medicaid, MHBG, and state general funds.

6. Describe how the state supports the provision of **integrated services and supports for individuals with co-occurring mental and substance use disorders**, including screening and assessment for co-occurring disorders and integrated treatment that addresses substance use disorders as well as mental disorders. Please describe how this system differs for youth and adults.

RESPONSE - Arizona has a rich tradition of addressing both mental health and substance use needs in an integrated system of care. The AHCCCS Medical Policy Manual (AMPM) and the AHCCCS Contractor Operations Manual (ACOM) provide mandates to support the integration of medical and behavioral health services throughout the lifespan. AMPM Chapter 200 - Behavioral Health Practice Tools encompasses policies related to the use of quality assessment and best practice to strengthen the capacity of Arizona's Behavioral Health System in response to the needs of children, adolescents, and young adults. Links to assessment tools, guidance on their utilization, and additional resources are provided as attachments to the policies and utilized by both primary care and behavioral health providers. The primary Behavioral Health Practice Tool utilized for the screening and assessment of co-occurring mental health and substance use disorders for individuals under 18 years of age in Arizona is the Child and Adolescent Level of Care Utilization System (CALOCUS). The CALOCUS dimensional rating system is used to determine the intensity of a child or adolescent's service needs on 7 levels over 6 dimensions: Risk of Harm, Functional Status, Comorbidity, Recovery Environment, Resiliency and Treatment History, and Treatment Acceptance and Engagement (scored with 2 scales - A. for the Child/Adolescent and B. for the parents/primary caregivers). AMPM Policy 220 - Child and Family Team - https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/200/220.pdf describes universal Child and Family Team (CFT) practice in the AHCCCS System of Care, indicators contributing to a child's and family's complexity of needs, how the essential CFT practice activities are implemented on a continuum based on individualized needs, and how the CALOCUS is utilized in the AHCCCS System of Care. This policy outlines requirements in procedure for CFT practice consisting of nine activities:

1. Engagement of the Child and Family.
2. Immediate Crisis Stabilization.
3. Strengths, Needs, and Culture Discovery (SNCD).
4. CFT Formation/Coordination of CFT Practice.
5. Service Plan Development.
6. Ongoing Crisis Planning.
7. Service Plan Implementation.
8. Tracking and Adapting.
9. Transition.

AMPM Behavioral Health Practice Tool 220, Attachment B provides a table matrix to describe how the CFT practice may be implemented for children and families with varying needs and service intensity levels. While the CALOCUS suggests a level of service intensity, the CFT identifies the specific services and supports that will best meet the identified needs. Service planning should always be individualized, family driven, culturally competent and flexible. Children are resilient and families are adaptable and strong, and therefore, as their needs vary over time, service intensity will adjust to correspond with these changes. Policy 220 additionally outlines transition planning for youth adjudicated and sentenced to the Arizona Department of Juvenile Corrections, their release to the community, or entering/leaving foster care specific to behavioral health, including SUD, services. Additionally outlines are requirements for the transition planning of any child involved in behavioral health care to the adult behavioral health system when the child reaches age 16.

AMPM Chapter 300 - Medical Policy For Covered Services and 320 - Services with Special Circumstances encompass all policies related to the provision of medical and behavioral health, including substance use disorder, and integrated services. AMPM Policy 320-O - Behavioral Health Assessments, Service, and Treatment Planning https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/300/320-O.pdf specifies provisions for Behavioral Health Assessments Service and Treatment Planning and requires the contractors to ensure assessments, service, and treatment planning are conducted in compliance with the Adult Behavioral Health Services Delivery System including that they are conducted by an individual within their scope of practice, incorporate the concept of a integrated "team" established for each member receiving behavioral health services, and an indication of agreement or disagreement with the service plan and awareness of the right to appeal if not in agreement with the service plan. Specialized requirements are in place and outlined for individuals with a SMI designation within this policy. The policy provides specific details regarding comprehensive behavioral health assessment including an evaluation of the member's: 1) Presenting concerns, 2) Information on the strengths and needs of the member and his/her/their family, 3) Behavioral health treatment, 4) Medical conditions and treatment, 5) Sexual behavior and, if applicable, sexual abuse, 6) Substance abuse, if applicable, 7) Living environment, 8) Educational and vocational training, 9) Employment, 10) Interpersonal, social, and cultural skills, 11) Developmental history, 12) Criminal justice history, 13) Public (e.g., unemployment, food stamps, etc.) and private resources (e.g., faith-based, natural supports, etc.), 14) Legal status (e.g., presence or absence of a legal guardian) and apparent capacity (e.g., ability to make decisions or complete daily living activities), 15) Need for special

assistance, and 16) Language and communication capabilities. ii. Additional components of the assessment shall include: 1) Risk assessment of the member, 2) Mental status examination of the member, 3) A summary of impressions, and observations, 4) Recommendations for next steps, 5) Diagnostic impressions of the qualified clinician, 6) Identification of the need for further or specialty evaluations, and 7) Other information determined to be relevant. In alignment with SAMHSA's Evidence-Based Practice, Arizona utilizes the American Society of Addition Medicine (ASAM) Criteria level of care assessment tool that provides clinicians with a structured interview for assessing and caring for individuals with addictive, substance-related and co-occurring conditions. In the event of positive results, the information shall be shared with the providers involved with the member's care if the member has authorized sharing of protected health information. To assist in decision-making and treatment planning, AHCCCS provides an ASAM to AHCCCS Level of Care Crosswalk https://www.azahcccs.gov/PlansProviders/Downloads/CurrentProviders/ASAM_AHCCCS0_LevelOfCareCrosswalk.pdf identifying the ASAM Level of Care Title, Number, and Description with the AHCCCS Facility Type/Level of Care Title, Code, and detailed Description. In situations when a specific assessment is duplicated, the results of such assessments shall be discussed collaboratively with any other provider that may have completed an assessment to address clinical implications for treatment needs in addition to the differences being addressed within the "team" with participation of providers within and outside of behavioral health as indicated.

AHCCCS MCOs are required to develop processes to identify Health Homes within their network and assign members with an SMI designation, including those with co-occurring SMI and substance use conditions, to a Health Home within five days of enrollment. The assigned Health Home is responsible for either directly providing, or coordinating the provision of, all medically necessary health care services. In order to treat the whole person, the Health Home is also responsible to provide or coordinate a range of integrated, recovery-focused services to members, such as medication services, counseling for mental health and/or substance use disorder treatment, medical management, case management, transportation, peer and family support services, and health and wellness groups. Additionally, to support continuity of care and ensure coordination across systems, the Health Home is required to ensure timely follow-up and continuing care post-crisis engagement. AHCCCS MCOs are additionally required to maintain and execute policies and procedures describing the implementation of comprehensive and coordinated delivery of integrated physical and behavioral health services, including administrative and clinical integration of health care service delivery. Integration strategies and activities are expected to focus on impro ving individual health outcomes, enhance care coordination (including care coordination for Medication Assisted Treatment (MAT), and increase member satisfaction.

7. Describe how the state supports the provision of **integrated services and supports for individuals with co-occurring mental and intellectual/developmental disorders (I/DD)**, including screening and assessment for co-occurring disorders and integrated treatment that addresses I/DD as well as mental disorders. Please describe how this system differs for youth and adults.

RESPONSE - In Arizona, the state's Medicaid agency, AHCCCS, in partnership with the Division of Developmental Disabilities (DDD), has developed a multi-layered and evolving system of care to support individuals with co-occurring mental health and intellectual or developmental disabilities (I/DD). This system is grounded in principles of integration, person-centered planning, and health equity, and it is designed to meet the unique and often complex needs of both youth and adults.
For individuals with co-occurring I/DD and mental health conditions, Arizona's approach begins with early identification and comprehensive assessment. Behavioral health providers across the state are equipped with access to a specialized I/DD Course Library through the Relias training platform. This library includes over 100 courses, many of which are CEU-eligible, and is designed to build provider competency in recognizing and treating co-occurring conditions. A structured Training Plan—"Intellectual & Developmental Disabilities Essential Knowledge for Behavioral Health Providers"—includes coursework on trauma-informed care, cognitive behavioral therapy for individuals with I/DD, and integrated care strategies
The National Center for START Services® (NCSS) at the University of New Hampshire (UNH) Institute on Disability and AHCCCS collaborated from November 1, 2023, to September 30, 2024. NCSS provided training aimed to enhance the capacity of Arizona professionals working with people with intellectual and developmental disabilities and mental health needs (IDD-MH) in both the adult and youth populations. AHCCS was interested in building the capacity of community professionals in the mental health aspects of intellectual and developmental disabilities. The largest group of professionals targeted were Care Coordinators/Case Managers.
To ensure that screening and assessment are developmentally appropriate and culturally responsive, Arizona uses tools such as the Child and Adolescent Level of Care Utilization System (CALOCUS) for youth (ages 6 to up to age 18). This tool evaluates service intensity needs across multiple domains, including risk of harm, functional status, and recovery environment. It is embedded within the Child and Family Team (CFT) model, which guides service planning and coordination for youth with complex behavioral health needs
For adults, the system transitions to the Adult Recovery Team (ART) model, which emphasizes recovery-oriented planning, peer support, and coordination with housing, employment, and justice systems. Adults with I/DD and co-occurring mental health conditions may also receive services through the Arizona Long Term Care System (ALTCS), which provides access to integrated physical and behavioral health care, including crisis services, medication management, and supported employment. All SAMHSA EBP such as ACT, SE, COS, and PSH are available to all members, including those with I/DD.
Arizona's managed care organizations, such as Mercy Care, play a critical role in delivering integrated services. These organizations work closely with DDD and community-based providers to ensure that services are accessible, flexible, and tailored to individual needs. Each member is assigned a Care Manager who conducts annual screenings for health-related social needs (HRSN) such as housing instability, food insecurity, and social isolation. These screenings are conducted using the Closed Loop Referral System (CLRS), which connects members to community-based organizations for wraparound support
The state also supports residential treatment options for youth with co-occurring disorders. Programs like Desert River provide short-term, intensive behavioral health services for children with developmental disabilities and complex behavioral needs. These

facilities use applied behavioral analysis and trauma-informed interventions to stabilize youth and prepare them for reintegration into the community
To address systemic barriers, such as workforce shortages and service fragmentation, Arizona has invested in technical assistance, fidelity monitoring, and network development. The state's 2021 ARPA Mental Health Block Grant Plan outlines efforts to expand provider capacity and ensure fidelity to evidence-based practices such as Assertive Community Treatment (ACT) and Supported Employment

In summary, Arizona's system for individuals with co-occurring I/DD and mental health conditions is built on a foundation of integrated care, provider training, and individualized service planning. The system distinguishes between youth and adults through developmentally appropriate models—CFT for children and ART for adults—and ensures continuity through structured transition planning. Through these efforts, the state aims to reduce disparities, improve outcomes, and support individuals in achieving their highest level of independence and community inclusion.

8. Please indicate areas of **technical assistance needs** related to this section.

No technical assistance needs at time

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Environmental Factors and Plan

2. Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI) – 10 percent set aside – Required for MHBG

Narrative Question

Much of the mental health treatment and recovery service efforts are focused on the later stages of illness, intervening only when things have reached the level of a crisis. While this kind of treatment is critical, it is also costly in terms of increased financial burdens for public mental health systems, lost economic productivity, and the toll taken on individuals and families. There are growing concerns among individuals and family members that the mental health system needs to do more when people first experience these conditions to prevent long-term adverse consequences. Early intervention is critical to treating mental illness as soon as possible following initial symptoms and reducing possible lifelong negative impacts such as loss of family and social supports, unemployment, incarceration, and increased hospitalizations *[Note: MHBG funds cannot be used for primary prevention activities. States cannot use MHBG funds for prodromal symptoms (specific group of symptoms that may precede the onset and diagnosis of a mental illness) and/or those who are not diagnosed with SMI or SED].* The duration of untreated mental illness, defined as the time interval between the onset of symptoms and when an individual gets into appropriate treatment, has been a predictor of outcomes across different mental illnesses. Evidence indicates that a prolonged duration of untreated mental illness may be a negative prognostic factor. However, earlier treatment and interventions not only reduce acute symptoms but may also improve long-term outcomes.

The working definition of an Early Serious Mental Illness is "An early serious mental illness or ESMI is a condition that affects an individual regardless of their age and that is a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-5TR (APA, 2022). For a significant portion of the time since the onset of the disturbance, the individual has not achieved or is at risk for not achieving the expected level of interpersonal, academic, or occupational functioning. This definition is not intended to include conditions that are attributable to the physiologic effects of a substance use disorder, are attributable to an intellectual/developmental disorder or are attributable to another medical condition. The term ESMI is intended for the initial period of onset."

States may implement models that have demonstrated efficacy, including the range of services and principles identified by the Recovery After an Initial Schizophrenia Episode **(RAISE)** initiative.Utilizing these principles, regardless of the amount of investment, and by leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, states should move their system to address the needs of individuals experiencing first episode of psychosis (FEP). RAISE was a set of federal government- sponsored studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP. The RAISE studies, as well as similar early intervention programs tested worldwide, consist of multiple evidence-based treatment components used in tandem as part of a Coordinated Specialty Care (CSC) model, and have been shown to improve symptoms, reduce relapse, and lead to better outcomes.

States shall expend not less than 10 percent of the MHBG amount the State receives for carrying out this section for each fiscal year to support evidence-based programs that address the needs of individuals experiencing early serious mental illness, including psychotic disorders, regardless of the age of the individual at onset. In lieu of expending 10 percent of the amount, the state receives under this section for a fiscal year as required, a state may elect to expend not less than 20 percent of such amount by the end of such succeeding fiscal year.

Please respond to the following items:

1. Please name the evidence-based model(s) for ESMI, including psychotic disorders, that the state implemented using MHBG funds including the number of programs for each.

Model(s)/EBP(s) for ESMI	Number of programs
Navigate	6.00
OnTrack	3.00
Acceptance and Commitment Therapy (ACT)	9.00
Cognitive Behavior Therapy for psychosis (CBTp)	9.00

Cognitive Enhancement Therapy (CET)	9.00
Somatic Experiencing	9.00

2. Please provide the total budget/planned expenditure for ESMI for FY 26 and FY 27 (only include MHBG funds).

FY2026	FY2027
2,304,884.90	2,304,884.90

3. Please describe the status of billing Medicaid or other insurances for ESMI services. How are components of the model currently being billed? Please explain.

RESPONSE
The Arizona Health Care Cost Containment System (AHCCCS), has established a robust and evolving billing framework to support Early Serious Mental Illness (ESMI) services. This structure is designed to ensure timely, integrated care for individuals experiencing early psychosis or related conditions.

AHCCCS employs a multi-funding strategy that includes Medicaid (Title XIX/XXI), Non-Title XIX/XXI (NTXIX), and the Mental Health Block Grant (MHBG). These funding sources are applied based on individual eligibility and the nature of the services provided.
For Medicaid-eligible individuals, services are billed directly to Medicaid using standard codes aligned with the Coordinated Specialty Care (CSC) model, such as NAVIGATE and OnTrackNY. Covered services include case management, counseling, family education, medication management, peer support, supported employment and education, and primary care coordination.
For individuals who are uninsured or not eligible for Medicaid, AHCCCS utilizes MHBG and NTXIX funds. These services are tracked through quarterly reporting by the ACC-RBHAs and include specific codes like S9485 for per diem crisis stabilization. Clear distinctions are maintained between Medicaid and grant-funded encounters.
Community Psychiatric Supportive Treatment Programs offer structured, medically supervised services such as behavioral health counseling, skills training, medication support, and peer recovery support. Key billing codes include:
H0036: Face-to-face services (15-minute units)
H0037: Per diem billing for supportive treatment programs
H2041: Coordinated specialty care for first episode psychosis (requires AHCCCS approval)
Billing limitations include one per diem code per member per day, bundled meal costs, separate transportation billing, and non-overlapping education hours. Group services are exempt from size limits if the ratio is 1:20 or less.

AHCCCS conducts regular technical assistance meetings with providers and finance teams to refine billing practices, clarify policies, and ensure accurate reimbursement for all CSC model components. Ongoing discussions also address code attribution, such as the appropriate use of S9485, reflecting the agency's commitment to compliance and effective service delivery.

4. Please provide a description of the programs that the state funds to implement evidence-based practices for those with ESMI.

AHCCCS mandates the Coordinated Specialty Care (CSC) model as the foundational framework for all evidence-based practices (EBP) implemented in early serious mental illness (ESMI), including First Episode Psychosis (FEP). Currently, providers have adopted two CSC model programs: NAVIGATE and OnTrackNY. In addition to the CSC foundation, the following EBPs are integrated within programs across the state: Acceptance and Commitment Therapy (ACT), Cognitive Behavioral Therapy for psychosis (CBTp), Cognitive Enhancement Therapy (CET), Cognitive Remediation, Personal Medicine, Certified Clinical Trauma Specialist–Individual (CCTSI), Dialectical Behavior Therapy (DBT), Eye Movement Desensitization and Reprocessing (EMDR), Family Therapy Model, Motivational Interviewing (MI), Peer Support, Solution-Focused Brief Therapy (SFBT), Systemic Family Therapy, and Somatic Experiencing.
AHCCCS employs ACC-Regional Behavioral Health Agreements (ACC-RBHAs) for the selection and fidelity oversight of FEP programs within each geographic service area (GSA). In Northern Arizona, Arizona Complete Health - Complete Care Plan Northern Region serves as the contracted ACC-RBHA, overseeing Mohave Mental Health Center, Southwest Behavioral and Health Services, and The Guidance Center. In Central Arizona, Mercy Care is the contracted ACC-RBHA, selecting Horizon Health and Wellness and Valleywise Health as FEP providers. In Southern Arizona, Arizona Complete Health - Complete Care Plan Southern Region is the contracted ACC-RBHA, with Banner (EPICenter) and Intermountain Center for Human Development (ICHD) designated as FEP providers. Descriptions of each program are provided below.

Mohave Mental Health Center (MMHC) is in Mohave County, Arizona and serves the communities and surrounding areas of Kingman, Bullhead City, and Lake Havasu City, AZ and was established as an FEP provider in October of 2017. MMHC accepts individuals between the ages of 12-30 and utilizes the CSC model by utilizing NAVIGATE in addition to other EBP as determined clinically applicable to meet each member's needs. Although MMHC does not provide PCP services on site, their case managers coordinate with local Federally Qualified Health Centers to ensure integrated and effective continuum of care in relation to primary care services. Their assigned FEP personnel consist of a clinical director and 2 Behavioral Health Technicians. Members can

receive medication management/psychiatric services at each clinic via tele-health or in-person appointments.
Southwest Behavioral and Health Services (SBWH) is in Mohave County and Yavapai County, Arizona and serves the communities and surrounding areas of Kingman, Bullhead City, Lake Havasu City and Prescott Valley, AZ and was established as an FEP provider in October of 2024. SBWH accepts individuals between the ages of 15-40 and utilize the CSC model by utilizing NAVIGATE in addition to other EBP as determined clinically applicable to meet each member's needs. Although SBWH does not provide PCP services on site, their case managers coordinate with local Federally Qualified Health Centers to ensure an integrated and effective continuum of care in relation to primary care services. Their assigned FEP personnel consist of a Peer Support Specialist and a Prescriber. Members can receive medication management/psychiatric services at each clinic via tele-health or in-person appointments.
The Guidance Center (TGC), located in Flagstaff, AZ, serves the Coconino County region and was established as an FEP provider in October of 2017. TGC accepts individuals between the ages of 12-30 and implements the CSC model by utilizing NAVIGATE. Although TGC does not provide PCP services on site, they do coordinate with local Federally Qualified Health Centers to ensure integrated and effective continuum of care in relation to primary care services. TGC's FEP personnel consist of a program manager, therapist, Behavioral Health Medical Practitioner, and (2) FEP care managers.

Banner Early Psychosis Intervention Center (EPICenter) is in Tucson, AZ, and was established in 2010. The center was developed based on the CSC model using NAVIGATE programming. Banner EPICenter operates as a five-year program providing evidence-based, intensive, stage-specific treatment, including wraparound services for adolescents and young adults (aged 15 to 35) who are in the early stages of psychotic illness. The program has three primary functions: (a) early detection, (b) acute care during and immediately after a psychiatric crisis, and (c) recovery-focused continuing care. These include interventions intended to help young people maintain or regain their social, academic, and career paths during the initial 2-5 years after illness onset. Since 2015, Banner EPICenter has operated within the Banner University Whole Health Clinic (WHC), an integrated facility offering both primary and behavioral health services. The FEP team includes three psychologists, two psychology externs, a specialized recovery coordinator, a peer support specialist, and a communication specialist.
Intermountain Center for Human Development (ICHD), based in Tucson, delivers services through both satellite offices and rural clinicians in Cochise, Santa Cruz, and Yuma Counties. ICHD became an FEP (First Episode Psychosis) provider in October 2021 and began accepting referrals in January 2022. Established on the CSC (Coordinated Specialty Care) model, ICHD offers NAVIGATE programming to individuals. Comprehensive wraparound resources are available for clients aged 15-25 who have experienced a psychotic episode within the previous year. Treatment typically lasts between 12 and 18 months, with duration tailored to individual needs. ICHD collaborates with community partners to educate and promote early detection of psychosis, supporting timely identification and connection to specialized services. Referral pathways are developed with inpatient facilities, emergency departments, schools, crisis intervention programs, and the criminal justice system. Integrated health clinics providing both FEP and primary care are operational in Pima, Cochise, and Yuma Counties, with plans to establish primary care services in Santa Cruz County. The FEP team includes a clinical director, four clinicians, two outreach engagement specialists, a care coordinator, peer support staff, a behavioral health medical provider (BHMP), and a family nurse practitioner (FNP), ensuring comprehensive and integrated onsite service delivery.
The Valleywise Health First Episode Center manages two facilities serving Maricopa County, the most populous county in Arizona, with a third location currently under development. Plans are also being considered to introduce mobile FEP services to extend coverage to Pinal and Gila counties. All locations deliver care to individuals aged 15-25 who have received a qualifying diagnosis within the past two years. Each center implements the CSC model and integrates OnTrackNY programming to alter the typical progression associated with primary psychotic disorder diagnoses. The program emphasizes member education regarding their diagnosis and provides tools and resources to help address the disruptions that psychosis symptoms may cause in adolescents and young adults. Valleywise Health FEP programs employ evidence-based strategies such as Shared Decision Making, Cognitive Enhancement Therapy, mindfulness meditation, integrated and primary care, among others.
The West Valley facility, established in Avondale, AZ in February 2017, was the first Valleywise Health site to offer FEP services, staffed by a clinical director, clinical coordinator, medical assistant, patient services specialist, peer support specialist, program assistant, rehabilitation specialist, and team specialist. The East Valley location in Mesa, AZ, began providing FEP services in November 2022 and is staffed by a clinical director, clinical coordinator, peer support specialist, two team specialists, and a rehabilitation specialist.
Horizon Health and Wellness (HHW) operates multiple locations in Gila and Pinal counties. HHW serves individuals aged 15-25 who have received a qualifying diagnosis within the past two years. The organization implements the CSC model and utilizes OnTrack NY programming to address primary psychotic disorders. The program provides education about diagnoses and information on tools and resources to support individuals managing symptoms of psychosis. The HHW team includes skills trainers, team leaders, peer support specialists, clinicians, psychiatrists, recovery coaches, employment and education specialists, nurses, medical assistants, and community liaisons to offer services throughout these remote counties.

5. Does the state monitor fidelity of the chosen EBP(s)? (●) Yes ( ) No

6. Does the state or another entity provide trainings to increase capacity of providers to deliver interventions related to ESMI? (●) Yes ( ) No

7. Explain how programs increase access to essential services and improve client outcomes for those with an ESMI.

RESPONSE
AHCCCS implements an integrated model of health care, combining coverage of medical and behavioral health under one managed care health plan. Contracted health plans coordinate and pay for physical and behavioral health care services delivered by more than 104,000 health care providers to more than two million Arizonans. Three of the seven AHCCCS Complete Care Plans

are designated as ACC - Regional Behavioral Health Agreements (ACC-RBHAs) which are fully integrated health plans for acute and behavioral health services for members with ESMI/FEP, serious emotional disturbance (SED), and serious mental illness (SMI). The ACC-RBHAs are responsible for the coordination of care for members with behavioral health needs which includes those with ESMI and FEP. AHCCCS Complete Care encourages consistent coordination between both medical and behavioral health providers within the same network, reducing fragmentation and leading to better overall health outcomes for members.

In addition to the requirements for providers to implement EBP for FEP, the integration of physical, dental, and behavioral health under one plan for children in foster care, helps to ensure these children, who are at increased risk for psychosis, have access to comprehensive individualized treatment and integrated care. The earlier children in foster care, especially those who may be experiencing psychosis, receive integrated physical and behavioral health care, the better their health outcomes may be.

Further, the use of Child and Family Teams (CFT) for children and Adult Recovery Teams (ART) for adults ensure that children, youth, and young adults with psychosis receive integrated health care through the use of EBPs, not just for the treatment of early psychosis but for their other mental health needs as well as physical health.

The State of Arizona utilizes the Coordinated Specialty Care (CSC) model as the foundation of all acceptable EBPs to be utilized for the 10 percent set-aside of ESMI/FEP programs. The Northern and Southern regions of Arizona utilize NAVIGATE programming and Central Arizona utilizes OnTrackNY; continual training and consultation from appointed EBP programs are provided to ensure all staff are adequately trained with the most current information. In conjunction with NAVIGATE and OnTrackNY, provider programs also report utilizing the following EBP: Acceptance and Commitment Therapy (ACT), Cognitive Behavior Therapy (CBT) for psychosis, Cognitive Enhancement Therapy (CET), Cognitive Remediation, Personal Medicine, Certified Clinical Trauma Specialist–Individual (CCTSI), Dialectical behavior therapy (DBT), EMDR and Family Therapy Model, Motivational Interviewing (MI), Peer support, Solution-focused brief therapy (SFBT), Systemic Family Therapy, and Somatic Experiencing.

AHCCCS understands how imperative it is to utilize the CSC model for FEP and ESMI populations for the best quality of care; to ensure this is accomplished, consistent monitoring of EBP training and recertification initiatives has been implemented. Utilization is monitored through deliverables set forth in contracts and policies.

CSC is an evidence-based model studied and shown effectively in the Recovery After an Initial Schizophrenia Episode (RAISE) project. CSC focuses on offering psychotherapy, medication management, family education and support, case management, supported education and employment, in a recovery-oriented manner, with an emphasis on shared decision making. Each member works with the team of specialists and the family as much as possible and appropriate to create an individualized treatment plan that works best for the individual. Each team of specialists is composed of professionals to meet the key roles and functions, although the staffing in each program may vary based on local needs.

8. Please describe the planned activities in FY2026 and FY2027 for your state's ESMI programs.

For Fiscal Years 2026 and 2027, AHCCCS will maintain comprehensive oversight and strengthen partnerships with ACC-Regional Behavioral Health Agreements (RBHAs) and contracted providers in support of our ESMI programs. ACC-RBHAs are required to submit detailed ESMI and FEP grant proposals to the MHBG team for evaluation. These narrative plans are intended to be comprehensive, focusing on infrastructure enhancement, service delivery, and program expansion. The plans also encompass outreach initiatives targeting specific populations both at the RBHA and provider levels.
Each grant proposal must include a framework to identify quantifiable ESMI objectives, which should be iteratively refined until all program aims are thoroughly articulated. Furthermore, the plan delineates the methodologies and data sources used to identify FEP populations—such as children within school systems, individuals at risk of suicide, and those residing in rural or homeless settings. Plans address infrastructure development, direct services, expansion strategies, full utilization of MHBG FEP funding, and mechanisms for expenditure monitoring. Additional components involve targeted outreach, suicide prevention efforts for FEP-eligible individuals, and person-centered care oversight. Templates are provided to help outline provider-specific initiatives and clearly defined metrics for goal achievement.
AHCCCS remains committed to rigorous oversight of Coordinated Specialty Care (CSC) model implementation and to continuous evaluation of Evidence-Based Practice (EBP) training and recertification initiatives, ensuring the consistent availability of all essential CSC components—case management, group counseling, family education, individual therapy, medication management, peer support, primary care, supported employment/education, and statewide accessibility for individuals diagnosed with ESMI or FEP.
For the upcoming federal fiscal year, AHCCCS continues to collaborate closely with all ACC-RBHAs to achieve initial certification or recertification in an approved EBP, such as NAVIGATE and/or OnTrackNY. Additionally, AHCCCS is proactively partnering with ACC-RBHAs to enhance and broaden ESMI/FEP services, with a particular focus on rural and frontier regions, while also executing planned expansions within the central area of Arizona.

9. Please list the diagnostic categories identified for each of your state's ESMI programs.

RESPONSE -
In accordance with the Arizona Health Care Cost Containment System (AHCCCS) Medical Policy Manual (AMPM) Policy 320-T1, the following diagnostic categories are recognized as qualifying under Early Serious Mental Illness (ESMI) and First Episode Psychosis (FEP) programs. These categories exclude conditions primarily attributable to the physiological effects of a substance use disorder (SUD), intellectual or developmental disabilities, or other medical conditions:
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

i. Depressive Disorders with Psychotic Features
All individuals currently served through Arizona's ESMI/FEP programs have diagnoses that fall within the categories listed above.

10. What is the estimated incidence of individuals experiencing first episode psychosis in the state?

To estimate the incidence of individuals experiencing first episode psychosis in the state, AHCCCS utilized two primary data sources: internal deliverables from ACC-Regional Behavioral Health Agreements (ACC-RBHAs) and projections from the OnTrackNY interactive tool.
• According to the OnTrackNY tool, the estimated number of new active individuals receiving services per year is 276, while the projected number of incident cases approached is 553.
• In comparison, AHCCCS deliverable data for fiscal year 2022 reported 150 new active individuals receiving services and 462 incident cases approached.
These estimates suggest that the annual incidence of individuals experiencing first episode psychosis in Arizona likely falls within the range of 462 to 553 individuals approached, with 150 to 276 individuals actively entering services.

11. What is the state's plan to outreach and engage those experiencing ESMI who need support from the public mental health system?

RESPONSE -
The Arizona Health Care Cost Containment System (AHCCCS) employs a comprehensive outreach and engagement strategy tailored for individuals experiencing Early Serious Mental Illness (ESMI). Through its integrated health care model—which unifies medical and behavioral health services under a single managed care plan—AHCCCS ensures that outreach and engagement activities are systematically incorporated across the entire continuum of care.
AHCCCS maintains contracts with ACC-Regional Behavioral Health Authorities (ACC-RBHAs), responsible for monitoring fidelity of ESMI programs within their designated Geographic Service Areas (GSAs). These entities implement a range of outreach and engagement initiatives targeting individuals with ESMI, including community education, provider training, and campaigns to raise awareness about available services.
The outreach strategy for early serious mental illness is multi-faceted, aiming to optimize awareness, engagement, and ease of access to care for affected individuals. Central elements of this approach include community involvement, educational programming, collaborative partnerships, and focused communication efforts.
Ongoing community engagement and educational activities form a core part of the outreach process. Organizations coordinate public meetings, professional training sessions, and informational events. These activities aim both to elevate public awareness and to strengthen relationships with key partners such as schools, local organizations, and referral sources, thereby facilitating timely identification and connection of individuals to appropriate resources.
Media and digital outreach serve as essential components, involving collaboration with media outlets to produce radio segments and digital advertising. These strategies enhance the dissemination of information, guiding the public to specialized online platforms featuring resources, success stories, and guidance on accessing services, which helps reach diverse populations across multiple geographic regions.
Collaboration with providers and community stakeholders bolsters the outreach infrastructure. Regular communication—including direct discussions, clinical case reviews, and formal presentations—ensures transparency regarding program goals and referral mechanisms. This intersectoral cooperation supports prompt identification and referral of eligible individuals.
Targeted communications further reinforce the outreach strategy. Leveraging data such as location, diagnosis, age, and behavioral health claims, organizations can proactively identify potential participants. Direct contact through email and mailed materials ensures prospective members receive vital information about available resources and referral processes, promoting timely service access.
Continual education and stakeholder engagement remain priorities within the strategy. Frequent sharing of program updates and provision of specialized training to professionals—such as educators, correctional officers, crisis responders, and healthcare staff—ensure stakeholders are prepared to recognize and support those at risk for early serious mental illness.
Strengthening and maintaining referral networks is also recognized as vital. Efforts focus on building relationships with healthcare and educational entities, with particular attention to rural and homeless populations. By integrating digital outreach, print materials, and community-based activities, the strategy seeks to connect individuals efficiently to needed care and support.
Together, these coordinated actions constitute a robust framework designed to improve visibility, accessibility, and enrollment in early serious mental illness services, thereby ensuring that individuals in need receive timely, comprehensive support.

12. Please indicate area of technical assistance needs related to this section.

No technical assistance needs a this time.

Footnotes:

Environmental Factors and Plan

3. Person Centered Planning (PCP) – Required for MHBG, Requested for SUPTRS BG

Narrative Question

States must engage adults with a serious mental illness or children with a serious emotional disturbance and their caregivers in making health care decisions, including activities that enhance communication among individuals, families, caregivers, and treatment providers. Person-centered planning (PCP) is a process through which individuals develop their plan of service based on their chosen, individualized goals to improve their quality of life. The PCP process may include a representative who the person has freely chosen, and/or who is authorized to make personal or health decisions for the person. The PCP team may include family members, legal guardians, friends, caregivers and others that the person or his/her representative wishes to include. The PCP should involve the person receiving services and supports to the maximum extent possible, even if the person has a legal representative. The PCP approach identifies the person's strengths, goals, preferences, needs and desired outcome. The role of state and agency workers (for example, options counselors, support brokers, social workers, peer support workers, and others) in the PCP process is to enable and assist people to identify and access a unique mix of paid and unpaid services to meet their needs and provide support during planning. The person's goals and preferences in areas such as recreation, transportation, friendships, therapies, home, employment, education, family relationships, and treatments are part of a written plan that is consistent with the person's needs and desires.

In addition to adopting PCP at the service level, for PCP to be fully implemented it is important for states to develop systems which incorporate the concepts throughout all levels of the mental health network. PCP resources may be accessed from **https://acl.gov/news-and-events/announcements/person-centered-practices-resources**

1. Does your state have policies related to person centered planning? (●) Yes ( ) No

2. If no, describe any action steps planned by the state in developing PCP initiatives in the future.

N/A

3. Describe how the state engages people with SMI and their caregivers in making health care decisions, and enhances communication.

RESPONSE -
AHCCCS has implemented person-centered planning for all populations that we serve. This has been a collaborative effort and partnership with the individuals we serve, family members, advocates, and community stakeholders.
Arizona's model is based upon the premise that people want and deserve dignity, respect, inclusion, and safety. Based on four elements:
? Affording people dignity, compassion and respect
? Offering coordinated care, support or treatment
? Offering personalized care, support or treatment
? Supporting people to recognize, as well as develop their strengths and abilities in order to enable them to live a fulfilling and independent life.
An essential part of person-centered planning is that the person drives the process. They are the experts of their own lives and are at the center of the "person-centered planning" process. It is essential to gather their input, hear their voice and choice of treatment/services, who they want involved in their treatment planning process, and ensure access to care is timely and efficient.
Person-Centered Planning is based upon a foundation of Person-Centered Thinking (PCT), which inspires and guides respectful listening leading to actions, resulting in individuals who:
? Have positive control over the life they desire and find satisfying
? Are recognized and valued for their contributions to their journey toward recovery and to their families, people of support and their community/ies
? Are supported by a network of relationships, both natural and paid, within their community
? Are offered employment opportunities, education, vocational training, and opportunities to work/not work depending on an individual's unique needs and choices
The person-centered planning process also ensures that cultural and linguistic needs are identified and addressed. Person-centered planning includes a description of how care and services are delivered in a culturally competent, family/member centered manner and are responsive to diverse cultural and ethnic backgrounds.
The AHCCCS Medical Policy Manual (AMPM) Policy 320-O: Behavioral Health Assessments and Treatment Service Planning https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/300/320-O.pdf specifies provision for Behavioral health assessment, services and/or treatment planning for individuals we serve. Including outlining additional requirements for individuals with SMI designations. Provider case managers are responsible for monitoring the member's current needs, services, and progress through regular and ongoing contact. Treatment plans are to be reviewed and updated annually at a minimum or based on individual needs.
Linguistic needs are defined as providing services in a person's primary or preferred language, including sign language, and the provision of interpretation and translation services. Written materials are critical to obtaining services and the conversion of

written materials from English into the person's preferred language while maintaining the original intent also occurs.
Examples include:
? Treatment Planning Documents
? Member Handbooks
? Provider Directories
? Consent Forms
? Appeal and Grievance Notices
? Denial and Termination Notices

4. Describe the person-centered planning process in your state.

Arizona's Medicaid agency, the Arizona Health Care Cost Containment System (AHCCCS), has established a comprehensive and person-centered approach to service planning across its long-term care, developmental disabilities, and behavioral health systems. This approach ensures that individuals receiving services are actively involved in shaping their care, with a focus on dignity, autonomy, and community integration.

Person-centered service planning is a foundational requirement for all members enrolled in the Arizona Long Term Care System (ALTCS). The process begins with a thorough assessment of the member's functional needs and results in the development of a Person-Centered Service Plan (PCSP). This written plan outlines both paid and unpaid supports—including behavioral health services—that are important to and for the member. It incorporates the member's strengths, preferences, cultural and linguistic needs, and personal goals. The PCSP also identifies potential risks, including those affecting member rights, and includes contingency strategies to mitigate those risks. ALTCS case managers play a critical role in facilitating this process. They assess needs, identify barriers, and support members in creating a life aligned with their values and aspirations. The planning process is standardized to ensure consistency in documentation and promotes meaningful conversations that inform goal development and service delivery.

Support Coordinators within the Division of Developmental Disabilities (DDD) are trained in person-centered planning and apply this approach to empower individuals with developmental disabilities. The planning process emphasizes the member's voice and choice, fostering independence and self-determination. Support Coordinators assist individuals in identifying their goals and ensuring that services are responsive to their needs and preferences, enabling them to live the life they choose.

AHCCCS' Adult System of Care (ASOC) provides a continuum of coordinated services for adults with behavioral health challenges. The system is guided by Nine Principles of Recovery, which include respect, empowerment, community integration, and hope. These principles promote recovery by building partnerships, addressing cultural and linguistic needs, and supporting individuals in defining their own success. The planning process is collaborative, involving individuals served, their families, advocates, and service providers in shared decision-making. The Nine Principles of Recovery components are outlined below:
1. RESPECT: Respect is the cornerstone. Meet the person where they are without judgment, with great patience and compassion.

2. PERSONS IN RECOVERY CHOOSE SERVICES AND ARE INCLUDED IN PROGRAM DECISIONS AND PROGRAM DEVELOPMENT EFFORTS: A person in recovery has choice and a voice. Their self-determination in driving services, program decisions, and program development is made possible, in part, by the ongoing dynamics of education, discussion, and evaluation, thus creating the "informed consumer" and the broadest possible palette from which choice is made. Persons in recovery should be involved at every level of the system, from administration to service delivery.

3. FOCUS ON INDIVIDUAL AS A WHOLE PERSON, WHILE INCLUDING AND/OR DEVELOPING NATURAL SUPPORTS: A person in recovery is held as nothing less than a whole being: capable, competent, and respected for their opinions and choices. As such, focus is given to empowering the greatest possible autonomy and the most natural and well-rounded lifestyle. This includes access to and involvement in the natural supports and social systems customary to an individual's social community.

4. EMPOWER INDIVIDUALS TAKING STEPS TOWARDS INDEPENDENCE AND ALLOWING RISK TAKING WITHOUT FEAR OF FAILURE: A person in recovery finds independence through exploration, experimentation, evaluation, contemplation, and action. An atmosphere is maintained whereby steps toward independence are encouraged and reinforced in a setting where both security and risk are valued as ingredients promoting growth.

5. INTEGRATION, COLLABORATION, AND PARTICIPATION WITH THE COMMUNITY OF ONE'S CHOICE:
A person in recovery is a valued, contributing member of society and, as such, is deserving of and beneficial to the community. Such integration and participation underscores one's role as a vital part of the community, the community dynamic being inextricable from the human experience. Community service and volunteerism is valued.

6. PARTNERSHIP BETWEEN INDIVIDUALS, STAFF, AND FAMILY MEMBERS/NATURAL SUPPORTS FOR SHARED DECISION MAKING WITH A FOUNDATION OF TRUST: A person in recovery, as with any member of a society, finds strength and support through partnerships. Compassion-based alliances with a focus on recovery optimization bolster self-confidence, expand understanding in all participants, and lead to the creation of optimum protocols and outcomes.

7. PERSONS IN RECOVERY DEFINE THEIR OWN SUCCESS: A person in recovery – by their own declaration – discovers success, in part, by quality of life outcomes, which may include an improved sense of well-being, advanced integration into the community,

and greater self-determination. Persons in recovery are the experts on themselves, defining their own goals and desired outcomes.

8. STRENGTHS-BASED, FLEXIBLE, RESPONSIVE SERVICES REFLECTIVE OF AN INDIVIDUAL'S CULTURAL PREFERENCES: A person in recovery can expect and deserves flexible, timely, and responsive services that are accessible, available, reliable, accountable, and sensitive to cultural values and more. A person in recovery is the source of his/her own strength and resiliency. Those who serve as supports and facilitators identify, explore, and serve to optimize demonstrated strengths in the individual as tools for generating greater autonomy and effectiveness in life.

9. HOPE IS THE FOUNDATION FOR THE JOURNEY TOWARDS RECOVERY: A person in recovery has the capacity for hope and thrives best in associations that foster hope. Through hope, a future of possibility enriches the life experience and creates the environment for uncommon and unexpected positive outcomes to be made real. A person in recovery is held as boundless in potential and possibility.
In addition, Arizona/AHCCCS collaborated with the child, family, and others to provide services that are tailored to meet the needs of children with serious emotional disturbances and their caregivers. The goal is to ensure that services are provided to the child and family in the most appropriate setting, in a timely manner, in accordance with the best practices and respecting the child, family and their cultural heritage.

For children with serious emotional disturbances, AHCCCS has developed Twelve Principles that guide behavioral health service delivery. These principles emphasize collaboration with families, functional outcomes, accessibility, cultural respect, and stability. Service plans are developed through joint assessments involving families and multi-agency teams, ensuring that services are tailored to the child's unique strengths and needs. The planning process also anticipates transitions and crises, providing strategies to maintain stability and continuity of care. The twelve principles are described in detail below:

1. COLLABORATION WITH THE CHILD AND FAMILY: Respect for and active collaboration with the child and parents is the cornerstone to achieving positive behavioral health outcomes. Parents and children are treated as partners in the assessment process, and the planning, delivery, and evaluation of behavioral health services, and their preferences are taken seriously.

2. FUNCTIONAL OUTCOMES: Behavioral health services are designed and implemented to aid children to achieve success in school, live with their families, avoid delinquency, and become stable and productive adults. Implementation of the behavioral health services plan stabilizes the child's condition and minimizes safety risks.

3. COLLABORATION WITH OTHERS: When children have multi-agency, multi-system involvement, a joint assessment is developed and a jointly established behavioral health services plan is collaboratively implemented. Client centered teams plan and deliver services. Each child's team includes the child and parents and any foster parents, any individual important in the child's life who is invited to participate by the child or parents. The team also includes all other persons needed to develop an effective plan, including, as appropriate, the child's teacher, DCS and/or DDD caseworker, and the child's probation officer. The team (a) develops a common assessment of the child's and family's strengths and needs, (b) develops an individualized service plan, (c) monitors implementation of the plan, and (d) makes adjustments in the plan if it is not succeeding.

4. ACCESSIBLE SERVICES: Children have access to a comprehensive array of behavioral health services, sufficient to ensure that they receive the treatment they need. Plans identify transportation the parents and child need to access behavioral health services, and how transportation assistance will be provided. Behavioral health services are adapted or created when they are needed but not available.

5. BEST PRACTICES: Competent individuals who are adequately trained and supervised provide behavioral health services. They are delivered in accordance with guidelines adopted by ADHS that incorporate evidence-based "best practice." Behavioral health service plans identify and appropriately address behavioral symptoms that are reactions to death of a family member, abuse or neglect, learning disorders, and other similar traumatic or frightening circumstances, substance abuse problems, the specialized behavioral health needs of children who are developmentally disabled, maladaptive sexual behavior, including abusive conduct and risky behavior, and the need for stability and the need to promote permanency in class member's lives, especially class members in foster care. Behavioral Health Services are continuously evaluated and modified if ineffective in achieving desired outcomes.

6. MOST APPROPRIATE SETTING: Children are provided behavioral health services in their home and community to the extent possible. Behavioral health services are provided in the most integrated setting appropriate to the child's needs. When provided in a residential setting, the setting is the most integrated and most home-like setting that is appropriate to the child's needs.

7. TIMELINESS: Children identified as needing behavioral health services are assessed and served promptly.

8. SERVICES TAILORED TO THE CHILD AND FAMILY: The unique strengths and needs of children and their families dictate the type, mix, and intensity of behavioral health services provided. Parents and children are encouraged and assisted to articulate their own strengths and needs, the goals they are seeking, and what services they think are required to meet these goals.

9. STABILITY: Behavioral health service plans strive to minimize multiple placements. Service plans identify whether a class member is at risk of experiencing a placement disruption and, if so, identify the steps to be taken to minimize or eliminate the risk. Behavioral health service plans anticipate crises that might develop and include specific strategies and services that will be employed if a crisis develops. In responding to crises, the behavioral health system uses all appropriate behavioral health services to help the child remain at home, minimize placement disruptions, and avoid the inappropriate use of the police and criminal justice system. Behavioral health service plans anticipate and appropriately plan for transitions in children's lives, including transitions to new schools and new placements, and transitions to adult services.

10. RESPECT FOR THE CHILD AND FAMILY'S UNIQUE CULTURAL HERITAGE: Behavioral health services are provided in a manner that respects the cultural tradition and heritage of the child and family. Services are provided in Spanish to children and parents whose primary language is Spanish.

11. INDEPENDENCE: Behavioral health services include support and training for parents in meeting their child's behavioral health needs, and support and training for children in self-management. Behavioral health service plans identify parents' and children's need for training and support to participate as partners in assessment process, and in the planning, delivery, and evaluation of services, and provide that such training and support, including transportation assistance, advance discussions, and help with understanding written materials, will be made available.

12. CONNECTION TO NATURAL SUPPORTS: The behavioral health system identifies and appropriately utilizes natural supports available from the child and parents' own network of associates, including friends and neighbors, and from community organizations, including service and religious organizations.

Across all systems, AHCCCS fosters a person-centered planning environment that is transparent, flexible, and responsive. The planning process is a living document that evolves with the individual's needs and goals. By centering services around the person, Arizona ensures that individuals have full access to community living, meaningful support, and the opportunity to lead self-directed lives.

5. What methods does the SMHA use to encourage people who use the public mental health system to develop Psychiatric Advance Directives (for example, through resources such as **A Practical Guide to Psychiatric Advance Directives**)?

The Arizona State Mental Health Authority (SMHA), through the Arizona Health Care Cost Containment System (AHCCCS), employs a multifaceted approach to encourage individuals who utilize the public mental health system to develop Psychiatric Advance Directives (PADs). These efforts are guided by the provisions outlined in the AHCCCS Medical Policy Manual (AMPM) Policy 640 – Advance Directives.
Under Policy 640, AHCCCS mandates that adult members—and when incapacitated, their legally authorized family members or surrogates as defined in A.R.S. §36-3231—receive comprehensive written information regarding Advance Directives. This includes a clear explanation of the member's rights under Arizona law, the provider's policies regarding the implementation of those rights, and any limitations due to conscientious objections. Providers must also describe applicable state laws, inform members of their right to file complaints with the Arizona Department of Health Services (ADHS) Division of Licensing Services, and outline procedures for follow-up when a member regains capacity.

To ensure consistent access to this information, providers are required to deliver it at key points of care, including at enrollment, upon admission to hospitals or nursing facilities, and when initiating services with home health agencies, hospices, or personal care providers. These requirements align with federal regulations under 42 CFR 489.102(e) and 42 U.S.C. § 1396a(w)(2).

In addition to these regulatory measures, Arizona's Regional Behavioral Health Authorities (RHBAs) offer supplemental resources and educational materials to support the development of PADs. Providers are expected to integrate these resources into their standard practices, thereby reinforcing the importance of proactive treatment planning.

A cornerstone of Arizona's strategy is the widespread use of the Wellness Recovery Action Plan (WRAP), an evidence-based, self-directed tool that empowers individuals to manage their mental health and maintain autonomy during periods of crisis. Section 5 of the WRAP serves as a Psychiatric Advance Directive, enabling individuals to identify early warning signs, designate trusted supporters, communicate treatment preferences, and outline helpful and unhelpful interventions. This approach not only promotes self-determination but also ensures that care remains aligned with the individual's values and goals, even when they are unable to advocate for themselves.

Together, these methods reflect Arizona's commitment to person-centered care and align with national best practices, such as those outlined in SAMHSA's A Practical Guide to Psychiatric Advance Directives. By embedding PAD education and planning into routine care, the SMHA fosters a culture of empowerment, preparedness, and respect for individual choice.

6. Please indicate areas of technical assistance needs related to this section.

No technical assistance needs at this time

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Environmental Factors and Plan

4. Program Integrity – Required for MHBG & SUPTRS BG

Narrative Question

There is a strong emphasis on ensuring that Block Grant funds are expended in amanner consistent with the statutory and regulatory framework. This requires that the federal government and the states have a strong approach to assuring program integrity. Currently, the primary goals of the federal government's program integrity efforts are to promote the proper expenditure of Block Grant funds, improve Block Grant program compliance nationally, and demonstrate the effective use of Block Grant funds

While some states have indicated an interest in using Block Grant funds for individual co-pays deductibles and other types of co-insurance for behavioral health services, states are reminded of restrictions on the use of Block Grant funds outlined in **42 U.S.C. § 300x–5** and **42 U.S.C § 300x-31**, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under **42 U.S.C. § 300x-55(g)**, there are periodic site visits to MHBG and SUPTRS BG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services made available to adults with SMI and children with SED and SUPTRS BG funds can only be used for individuals with or at risk for SUD. The 20% minimum primary prevention set-aside of SUPTRS BG funds should be used for universal, selective, and indicated substance use prevention. Guidance on the use of block grant funding for co-pays, deductibles, and premiums can be found at: **http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf**. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The MHBG and SUPTRS BG resources are to be used to support, not supplant, services that will be covered through private and public insurance. In addition, the federal government and states need to work together to identify strategies for sharing data, protocols, and information to assist Block Grant program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SUPTRS BG funds are allocated to support evidence-based substance use primary prevention, treatment and recovery programs, and activities for adults with SMI and children with SED.

States traditionally have employed a variety of strategies to procure and pay for behavioral health services funded by the MHBG and SUPTRS BG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered mental health and SUD benefits; (3) ensuring that consumers of mental health and SUD services have full confidence in the confidentiality of their medical information; and (4) monitoring the use of mental health and SUD benefits in light of utilization review, medical necessity, etc. Consequently, states may have to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

Please respond to the following items:

1. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers? (●) Yes ( ) No

2. Does the state provide technical assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards? (●) Yes ( ) No

3. Does the state have any activities related to this section that you would like to highlight?

RESPONSE - AHCCCS OIG Program Integrity

The Office of Inspector General (OIG) is responsible for program integrity for the Arizona Health Care Cost Containment System (AHCCCS). It exists to prevent, detect, and recover improper payments due to Medicaid fraud, waste, and abuse. OIG works closely with federal and state partners, including the Medicaid Fraud Control Unity (MFCU) of the Arizona Attorney General, the Federal Bureau of Investigations (FBI), Drug Enforcement Agency (DEA), Health and Human Services (HHS) OIG, local police and law enforcement agencies, county prosecutors, contracted health plans, and other state agencies.

All suspected fraud, waste, or abuse must be reported to the AHCCCS OIG. The OIG is responsible for handling all reports of fraud, waste, and abuse of the AHCCCS program. Absolutely anyone can report Arizona Medicaid fraud, waste, or abuse without restrictions and reporters may remain anonymous. Information regarding OIG and how to report suspected fraud is available at:

https://www.azahcccs.gov/Fraud/ReportFraud/.

AHCCCS ACOM Policy 103 - 'Fraud, Waste, and Abuse'
https://www.azahcccs.gov/shared/Downloads/ACOM/PolicyFiles/100/103.pdf outlines the corporate compliance requirements including the reporting responsibilities for alleged fraud, waste and/or abuse involving AHCCCS program funds regardless of the source. This Policy also addresses additional responsibilities regarding compliance with broader program integrity regulatory and programmatic requirements. AHCCCS has a comprehensive Corporate Compliance Program to achieve the goals of preventing and detecting fraud, waste, and abuse of the program. The program ensures Contractor compliance with applicable laws, rules, regulations, and contract requirements. Continued collaboration efforts include regularly scheduled meetings held to share information with RBHAs and TRBHAs regarding their Corporate Compliance Program that includes all program integrity activities.

To report suspected fraud by an AHCCCS medical provider, please call in Maricopa County: 602-417-4045, outside of Maricopa County: 888-ITS-NOT-OK or 888-487-6686.
To report suspected fraud by an AHCCCS member, please call in Maricopa County: 602-417-4193, outside of Maricopa County: 888-ITS-NOT-OK or 888-487-6686.
Provider and member fraud can be reported online at https://www.azahcccs.gov/Fraud/ReportFraud/onlineform.aspx.
Questions can also be emailed to the AHCCCS OIG at AHCCCSFraud@azahcccs.gov.

AHCCCS contracts with three AHCCCS Complete Care Contractors with a Regional Behavioral Health Agreement (ACC-RBHAs): Mercy Care and Arizona Complete Health South and Arizona Complete Health North, for the provision of SAMHSA Mental Health Block Grant (MHBG) and Substance Use Block Grant (SUBG) services and funding. These Contracts delineate the requirements of the ACC-RBHAs, including their responsibilities for implementing and monitoring subcontractors who are the providers of direct care services and treatment. Notwithstanding any relationship(s) the ACC-RBHA may have with any subcontractor, the ACC-RBHA maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of the Contract. ACC-RBHAs subcontract with providers in their Geographic Service Area (GSA) to ensure members may access services within their communities. Provider networks must meet access-to-care standards for the populations served. The AHCCCS Division of Behavioral Health and Housing (DBHH) meets with ACC-RBHAs monthly. These meetings are called by AHCCCS DBHH Program Administrators and Coordinators. Necessary updates and/or technical assistance are provided within these meetings.

AHCCCS additionally holds Intergovernmental Agreements (IGAs) with three (3) Tribal Regional Behavioral Health Authorities (TRBHAs): Gila River, White Mountain Apache, and Pascua Yaqui, for the provision of MHBG and SUBG services and funding. The IGAs ensure that services and treatment funded under the federal block grants meet the legal requirements of the respective block grant. The TRBHAs are responsible for implementing and monitoring direct care services and treatment and for the development and implementation of primary substance abuse prevention services. Both the MHBG and SUBG teams meet with the ACC-RBHA's and TRBHAs on a monthly and as-needed basis and either AHCCCS or the ACC-RBHA's/TRBHAs can request to convene a meeting. Necessary updates and/or technical assistance are provided within these meetings.

Contracts/IGAs are updated and amendments are executed on a scheduled and as needed basis to revise and implement reporting, monitoring, evaluation, and compliance requirements. The Non-Title XIX/XXI contracts with the ACC-RBHAs are updated annually, amendments executed by October 1 each year. This contract amendment is facilitated by the AHCCCS Division of Managed Care (DMC) (formerly Division of Health Care Services), Contracts Unit, reviewed and revised by all pertinent AHCCCS divisions and subject matter experts. Once suggested contract revisions are completed by AHCCCS, they are posted for public comment opportunity. Public comments are received, reviewed, and addressed by AHCCCS prior to contract execution. The IGAs are updated on a 5-year cadence. The IGA updates are negotiated between the AHCCCS Division for Fee for Service Management (DFSM) and the TRBHAs. The latest update occurred in 2021 and DBHH provided requested revisions related to SUBG and MHBG. NTXIX/XXI Contracts and IGAs are posted on the AHCCCS website at the links below.
ACC-RBHA NTXIX/XXII Contracts
https://www.azahcccs.gov/Resources/OversightOfHealthPlans/SolicitationsAndContracts/contracts.html

AHCCCS-TRBHA IGAs
https://www.azahcccs.gov/Resources/OversightOfHealthPlans/SolicitationsAndContracts/TRBHA.html

ACC-RBHAs are required to align their programs and activities with the following AHCCCS System Values:

1. Timely access to care
2. Culturally competent and linguistically appropriate care
3. Identification of the need for and the provision of comprehensive care coordination for physical and behavioral health service delivery
4. Integration of clinical and non-clinical health care related services
5. Education and guidance to providers on service integration and care coordination
6. Provision of disease/chronic care management including self-management support
7. Provision of preventive and health promotion and wellness services
8. Adherence with the Adult Behavioral Health Service Delivery System Nine Guiding Principles and the Arizona Vision and 12 Principles for Children Behavioral Health Service Delivery

9. Promotion of evidence-based practices through innovation
10. Expectation for continuous quality improvement
11. Improvement of health outcomes
12. Containment and/or reduction of health care costs without compromising quality
13. Engagement of member and family members at all system levels
14. Collaboration with the greater community
15. Maintenance, rather than delegation of, key operational functions to ensure integrated service delivery
16. Commitment to system transformation
17. Implementation of health information technology to link services and facilitate improved communication between treating professionals, and between the health team, the member, and member caregivers
18. Integration of the delivery of physical and behavioral health care as an essential part of improving the overall health of members

Within AHCCCS, many divisions collaborate to ensure compliance with block grant program integrity responsibilities. The DBHH provides ultimate oversight and management of evidence-based, person-centered programming and service delivery in addition to fiscal responsibility of MHBG and SUBG grant dollars. DMC, DFSM, the Office of the Director (OOD), the Division of Community Advocacy & Intergovernmental Relations (DCAIR), also play an integral role in the ongoing monitoring for programmatic and fiscal compliance, including promoting the proper expenditure of block grant funds, improving block grant program compliance, and demonstrating the overall effective use of block grant funds. ACC-RBHAs and TRBHAs are required to ensure they and their subcontractors are fulfilling all reporting requirements and deliverables outlined in their contract/IGA.

Operational Reviews

AHCCCS conducts annual MHBG/SUBG Operational Reviews (ORs) of ACC-RBHAs to determine if the Contractors satisfactorily meet AHCCCS's requirements as specified in Contract, AHCCCS policies, Arizona Revised Statute, the Arizona Administrative Code and 42 CFR Part 438, Managed Care; Increase AHCCCS knowledge of the Contractors' operational encounter processing procedures; provide technical assistance and identify areas where improvements can be made, as well as identifying areas of noteworthy performance and accomplishments; review progress in implementing recommendations made during prior reviews; determine if the Contractor is in compliance with its own policies and to evaluate the effectiveness of those policies and procedures; perform Contractor oversight as required by the CMS in accordance with AHCCCS' 1115 Waiver; and Provide information to an External Quality Review Organization (EQRO) for its use as described in 42 CFR 438.364. Operational Reviews can be found on the AHCCCS website: https://www.azahcccs.gov/Resources/OversightOfHealthPlans/OpReviews.html

Led by DFSM and assisted by DBHH and other pertinent divisions, AHCCCS conducts biennial OR with the TRBHAs block grant services. Block grant requirements, prohibitions, and deliverables are outlined in the TRBHA IGAs. During the OR, records of members who received block grant services are reviewed according to the prospective grant requirements to ensure the expenditure of funds on services for the priority population and intervention and prevention services, that the services meet the legal requirements of the grant, and that they are being utilized as the payor of last resort. Findings are discussed, plans are put in place if needed, and AHCCCS provides regular technical assistance to ensure regulatory utilization of grant dollars including reviewing reports and deliverables, monitoring and reviewing spend, providing technical assistance and training to the TRBHAs as needed, and conducting routine finance meetings.

Reporting Requirements

Regular deliverable submissions to AHCCCS by each ACC-RBHA and TRBHA are required and analyzed to ensure program integrity efforts are met. These include at a minimum: annual Independent Case Reviews; annual MHBG and SUBG Activities and Expenditures Plans and Reports; quarterly Grievance and Appeal reporting; and annual/quarterly/monthly Financial Reporting. A brief description of each is provided below:

1. AHCCCS oversees the Independent Case Reviews (ICRs) to meet the Independent Peer Review requirement of the block grant to ensure the quality and appropriateness of treatment services and indications of treatment outcomes. An ICR interdisciplinary team from an independent agency completes case reviews.
2. ACC-RBHAs and TRBHAs must provide information regarding MBHG and SUBG activities and expenditures outlining use of funds, strategies for monitoring expenditures, and make adjustments in a timely manner to best meet the needs of the community.
3. ACC-RBHAs and TRBHAs must for all members, subcontractors, and providers administer all Grievances and Appeal System processes competently, expeditiously, and equitably. ACC-RBHAs and TRBHAs are required to report provider claim disputes, member grievances, SMI Grievances and SMI Appeals as delineated in Arizona Administrative Code Title 9, Chapter 21, Article 4.
4. ACC-RBHAs and TRBHAs are required to submit financial statements and reporting packages, which must comply with contractual requirements for management of federal block grant funds.

Both AHCCCS and the ACC-RBHAs conduct secret shopper calls to SUBG providers to assess how providers respond when a priority population member seeking care, assess compliance to block grant requirements and address any program integrity issues identified through the calls.

AHCCCS and the ACC-RBHAs may also conduct site visits and programmatic visits to block grant subrecipients to review how the program is functioning and ensure compliance with federal and state rules and regulations. Corrective Action Plan tools are available for use according to the AHCCCS compliance escalation standard work process.

Policies and Procedures

In addition to the Contracts/IGAs, multiple policies and procedures are developed and implemented for ACC-RBHAs and TRBHAs to ensure operational and programmatic compliance and appropriate service delivery. Two priority manuals are the AHCCCS Contractor Operations Manual (ACOM) and the AHCCCS Medical Policy Manual (AMPM). Policies within these manuals are written in collaboration within multiple divisions at AHCCCS with revisions completed as needed due to Federal or State legislation, contractual requirements, operational changes, monitoring requirements, benefit coverage, etc. All applicable policies are incorporated by reference in the Contracts/IGAs.
Several noteworthy policies are outlined below which relate to ACC-RBHA grant services and funding; member and provider notifications; and access to care requirements (this is not an all-inclusive list):
ACOM Policy 103, Fraud, Waste, and Abuse
ACOM Policy 323, RBHAs Title XIX/XXI Reconciliation and Non-Title XIX/XXI Profit Limit
ACOM Policy 404, Contractor Website and Member Information
ACOM Policy 406, Member Handbook and Provider Directory
ACOM Policy 416, Provider Information
ACOM Policy 436, Provider Network Requirements
ACOM Policy 444, Notice of Appeal Requirements (SMI Appeals)
ACOM Policy 446, Grievances and Investigations Concerning Persons with Serious Mental Illness
ACOM Policy 448, Housing
AMPM 300-2B AHCCCS Covered Non-Title XIX XXI Behavioral Health Services
AMPM 310-B, Title XIX/XXI Behavioral Health Services Benefit
AMPM 320-T1 Block Grants and Discretionary Grants
AMPM 310-V, Prescription Medications-Pharmacy Services
AMPM 320-V, Behavioral Health Residential Facilities
AMPM 320-T1, Block Grants and Discretionary Grants
AMPM 580, Behavioral Health Referral and Intake Process
AMPM 650, Behavioral Health Provider Requirements for Assisting Individuals with Eligibility Verification and Screening, Application for Public Health Benefits Provider Eligibility
AMPM 960, Quality of Care Concerns
AMPM 961, Incident, Accident, and Death Reporting
AMPM 962, Reporting and Monitoring of Seclusion and Restraint
AMPM 963, Peer and Recovery Support Service Provision Requirements
AMPM 964, Credentialed Parent Family Support Requirements
AMPM 1040, Outreach, Engagement, Re-Engagement and Closure for Behavioral Health

Contractors, providers, and members have full access to the ACOM, AMPM, and other Guides and Resources via the AHCCCS website https://www.azahcccs.gov . Policies are made available to stakeholders for a 45-day Tribal Consultation/Public Comment period. Revision memos that accompany each policy revision explain the changes and notification of changes is sent via email. AHCCCS additionally hosts the AHCCCS Managed Care Organization (MCO) Update Meetings with contracted health plans, state agencies, and TRBHAs every other month or as needed. AHCCCS also conducts quarterly Tribal Consultation meetings to consult with tribes, Indian Health Service, tribal health programs operated under P.L. 93-638, and urban Indian health programs in Arizona regarding policy and programmatic changes that may significantly impact members. Individualized communication with each ACC-RBHA formally occurs during regular meetings with AHCCCS to review issues, concerns, and new information. If an improvement plan is established, oversight and communication between AHCCCS and the perspective ACC-RBHA or TRBHA occurs more frequently.

ACC-RBHAs and TRBHAs are responsible for ensuring that its subcontractors are notified when modifications are made to AHCCCS guidelines, policies, and manuals. In the event of a modification to AHCCCS Policy, guidelines, and manuals and are required to issue a notification of the change to its affected subcontractors within 30 calendar days of the published change and ensure amendment of any affected subcontracts. ACC-RHBAs are also contractually required to hold semi-annual provider forums to improve communication between the Contractor and providers and to provide such general information, technical assistance, and/or address issues.

4. Please indicate areas of technical assistance needs related to this section.

No technical assistance needs at this time.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Environmental Factors and Plan

5. Primary Prevention – Required for SUPTRS BG

Narrative Question

SUPTRS BG statute requires states to spend a minimum of 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment which programs (A) educate and counsel the individuals on substance use and substance use disorders; and (B) provide for activities to reduce the risk of substance use and substance use disorders by the individual. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SUPTRS BG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must serve both the general population and sub-groups that are at high risk for substance use. The program must include, but is not limited to, the following strategies:

1. ***Information dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, misuse and substance use disorders on individuals families and communities.
2. ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. ***Alternative programs*** that provide for the participation of priority populations in activities that exclude alcohol, tobacco, and other drug use.
4. ***Problem identification and Referral*** that aims at identification of those who have engaged in illegal/age-inappropriate use of tobacco or alcohol, and those individuals who have engaged in initial use of illicit drugs, in order to assess if the behavior can be addressed by education or other interventions to prevent further use.
5. ***Community-based processes*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. ***Environmental strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the use of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that serve populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Assessment

1. Does your state have an active State Epidemiological and Outcomes Workgroup (SEOW)? (●) Yes ( ) No

2. Does your state collect the following types of data as part of its primary prevention needs assessment process? (check all that apply):

- **a)** ☑ Data on consequences of substance-using behaviors
- **b)** ☑ Substance-using behaviors
- **c)** ☑ Intervening variables (including risk and protective factors)
- **d)** ☐ Other (please list)

3. Does your state collect needs assesment data that include analysis of primary prevention needs for the following population groups? (check all that apply)

- **a)** ☑ Children (under age 12)
- **b)** ☑ Youth (ages 12-17)
- **c)** ☑ Young adults/college age (ages 18-26)
- **d)** ☐ Adults (ages 27-54)
- **e)** ☑ Older adults (age 55 and above)
- **f)** ☑ Rural communities

i) ☐ Other (please list)

4. Does your state use data from the following sources in its primary prevention needs assesment? (check all that apply):

a) ☐ Archival indicators (Please list)

b) ☑ National survey on Drug Use and Health (NSDUH)

c) ☑ Behavioral Risk Factor Surveillance System (BRFSS)

d) ☑ Youth Risk Behavioral Surveillance System (YRBS)

e) ☐ Monitoring the Future

f) ☐ Communities that Care

g) ☑ State-developed survey instrument

h) ☐ Other (please list)

5. Does your state use needs assessment data to make decisions about the allocation of SUPTRS BG primary prevention funds? ◉ Yes ○ No

a) If yes, (please explain in the box below)

AHCCCS recently (2025) contracted with LeCroy & Milligan Associates (LMA) to complete a comprehensive Statewide Prevention Needs Assessment to evaluate the current state of substance use prevention efforts across Arizona. This assessment was conducted to inform strategic decision-making and ensure that prevention initiatives are responsive to the evolving needs of communities throughout the state.

Upon reviewing the findings, AHCCCS determined that many of the identified needs are already being addressed through existing funding mechanisms. However, to maximize impact and ensure equitable access to prevention services, AHCCCS has identified key strategic priorities that will guide future planning and resource allocation.

The first priority focuses on expanding and diversifying the prevention workforce. AHCCCS recognizes the importance of recruiting and retaining qualified professionals, particularly in rural areas where access to services is limited. The second priority emphasizes strengthening equity and reach in programming. AHCCCS is committed to prioritizing funding for high-need and under-reached populations, including rural communities. To better serve these groups, improving prevention messaging and education represents the third strategic priority. Youth-developed social media campaigns are recommended to amplify peer-to-peer messaging, as well as training for school staff to help them recognize and respond to new substance use trends and devices.

The fourth priority centers on promoting systemic coordination and cross-sector collaboration. AHCCCS is reviewing these recommendations to put plans and funding allocations in place to build a more responsive, effective prevention system that addresses the root causes of substance use and promotes the health and well-being of all Arizonans.

b) If no, please explain how SUPTRS BG funds are allocated:

Narratve Question

SUPTRS BG statute requires states to spend a minimum of 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment which programs (A) educate and counsel the individuals on substance use and substance use disorders; and (B) provide for activities to reduce the risk of substance use and substance use disorders by the individual. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SUPTRS BG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must serve both the general population and sub-groups that are at high risk for substance use. The program must include, but is not limited to, the following strategies:

1. ***Information dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, misuse and substance use disorders on individuals families and communities.
2. ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. ***Alternative programs*** that provide for the participation of priority populations in activities that exclude alcohol, tobacco, and other drug use.
4. ***Problem identification and Referral*** that aims at identification of those who have engaged in illegal/age-inappropriate use of tobacco or alcohol, and those individuals who have engaged in initial use of illicit drugs, in order to assess if the behavior can be addressed by education or other interventions to prevent further use.
5. ***Community-based processes*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. ***Environmental strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the use of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that serve populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Capacity Building

1. Does your state have a statewide licensing or certification program for the substance use primary prevention workforce? ○ Yes ◉ No

a) If yes, please describe.

N/A

2. Does your state have a formal mechanism to provide training and technical assistance to the substance use primary prevention workforce? ◉ Yes ○ No

a) If yes, please describe mechanism used.

To strengthen Arizona's substance use prevention infrastructure, the Arizona Health Care Cost Containment System (AHCCCS) leverages national and regional resources to provide targeted technical assistance (TA) and training to its prevention workforce. Two key partners in this effort are the Prevention Technology Transfer Center (PTTC) and the Strategic Prevention Technical Assistance Center (SPTAC), both supported by the Substance Abuse and Mental Health Services Administration (SAMHSA).

The PTTC Network offers a wide range of professional development opportunities, including webinars, certification programs, and skill-building workshops. These resources are designed to enhance the capacity of prevention professionals in areas such as cultural competence, trauma-informed care, and emerging substance use trends. In Arizona, PTTC trainings have been accessed by both community-based coalitions and school-based mental health professionals, helping to standardize best practices across diverse settings.

The SPTAC provides specialized TA focused on culturally responsive prevention strategies, particularly for American Indian and Alaska Native populations. AHCCCS utilizes SPTAC guidance to ensure that prevention programming is inclusive and reflective of tribal values, traditions, and community priorities. This includes integrating Indigenous healing practices and supporting tribal sovereignty in program design and delivery.

To complement these TA efforts, AHCCCS conducted a statewide Workforce Survey as part of its 2025 Prevention Needs

Assessment. The survey gathered input from over 300 prevention professionals, including coalition members, school nurses, and mental health providers. Respondents identified key training gaps in areas such as LGB affirming practices, fentanyl awareness, and culturally specific communication. The survey also revealed disparities in workforce readiness, with rural and tribal staff often managing large geographic areas with limited support.

In addition to the survey, AHCCCS facilitated listening sessions and stakeholder interviews to further understand local challenges and opportunities. These sessions highlighted the need for peer-led models, bilingual resources, and stronger interagency coordination.

Together, the PTTC, SPTAC, and AHCCCS's community engagement strategies form a comprehensive approach to building a more skilled, equitable, and responsive prevention workforce across Arizona.

3. Does your state have a formal mechanism to assess community readiness to implement prevention strategies? (●) Yes ( ) No

a) If yes, please describe mechanism used.

At the state level, the AHCCCS SUBG-funded prevention system follows and implements the Strategic Prevention Framework (SPF) model, which includes the development and implementation of a statewide needs assessment at least every 3-5 years. The most recent Prevention Needs Assessment, finalized in June of 2025. Which highlighted community readiness by Expand and Support the Prevention Workforce
Building a robust and sustainable prevention workforce is essential. This includes offering competitive salaries, service stipends for rural and tribal areas, and clear career pathways. Additionally, peer-led and community health worker models should be supported to enhance local engagement and cultural relevance. Advance Equity in Program Access and Delivery Prevention efforts must be inclusive and responsive to the needs of underserved populations. Funding should prioritize programs that serve Indigenous youth, LGB individuals, disconnected youth, and rural communities. Expanding bilingual resources and integrating culturally specific practices—such as Indigenous healing traditions—will help ensure programs are accessible and effective. Strengthen Prevention Messaging and Education a coordinated statewide campaign is needed to raise awareness about the risks of vaping, marijuana, alcohol, and fentanyl. Parent toolkits should be developed to support early conversations at home, and youth-led social media initiatives should be encouraged to increase relevance and reach. Training for school personnel is also critical to help them identify and respond to emerging substance use trends. Promote Cross-Sector Collaboration and System Integration Interagency planning groups should be convened to align efforts across education, public health, juvenile justice, and behavioral health sectors. Prevention should be embedded into school wellness programs, behavioral health screenings, and higher education initiatives. Partnerships with tribal governments, colleges, and community organizations are key to developing innovative, place-based approaches. Advance Early Intervention and Mental Health Supports, prevention should be integrated into behavioral health screenings and restorative practices in schools. Investments in early childhood and parenting programs can help build protective factors from a young age. Expanding access to youth development opportunities statewide will further support early intervention. Invest in Data Infrastructure and Evaluation Capacity to ensure continuous improvement, technical assistance and mini-grants should be provided to enhance local data collection and analysis. Community-based participatory research should be promoted to elevate local voices and ensure relevance. Findings should be shared through accessible formats such as dashboards, infographics, and tailored briefs.

Another related deliverable for the directly-contracted primary prevention contractors is a workforce development plan. Required annually, providers plan their staff development and trainings to ensure, at minimum, that they meet the contract requirements for trainings for prevention providers. Providers often choose to bolster their readiness and capacity by adding optional trainings, or trainings that are required or promoted by their agency. Since there is often turnover in the behavioral health field, including prevention, these are critical plans to ensure that new staff are supported in their development and readiness to deliver prevention services.

Narratve Question

SUPTRS BG statute requires states to spend a minimum of 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment which programs (A) educate and counsel the individuals on substance use and substance use disorders; and (B) provide for activities to reduce the risk of substance use and substance use disorders by the individual. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SUPTRS BG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must serve both the general population and sub-groups that are at high risk for substance use. The program must include, but is not limited to, the following strategies:

1. ***Information dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, misuse and substance use disorders on individuals families and communities.
2. ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. ***Alternative programs*** that provide for the participation of priority populations in activities that exclude alcohol, tobacco, and other drug use.
4. ***Problem identification and Referral*** that aims at identification of those who have engaged in illegal/age-inappropriate use of tobacco or alcohol, and those individuals who have engaged in initial use of illicit drugs, in order to assess if the behavior can be addressed by education or other interventions to prevent further use.
5. ***Community-based processes*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. ***Environmental strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the use of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that serve populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Planning

1. Does your state have a strategic plan that addresses substance use primary prevention that was developed within the last five years? (●) Yes ( ) No

If yes, please attach the plan in WebBGAS

Plan will be attached

2. Does your state use the strategic plan to make decisions about use of the primary prevention set-aside of the SUPTRS BG?

- [x] Yes
- [ ] No
- [ ] Not applicable (no prevention strategic plan)

3. Does your state's prevention strategic plan include the following components? (check all that apply):

- **a)** [x] Based on needs assessment datasets the priorities that guide the allocation of SUPTRS BG primary prevention funds
- **b)** [x] Timelines
- **c)** [x] Roles and responsibilities
- **d)** [x] Process indicators
- **e)** [x] Outcome indicators
- **f)** [ ] Not applicable/no prevention strategic plan

4. Does your state have an Advisory Council that provides input into decisions about the use of SUPTRS BG primary prevention funds? (●) Yes ( ) No

- **a)** Does the composition of the Advisory Council represent the demographics of the State? (●) Yes ( ) No

5. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SUPTRS BG primary prevention funds? (●) Yes ( ) No

a) If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based?

AHCCCS SUBG prevention staff make decisions about appropriate strategies to be implemented with SUPTRS BG primary prevention funds, with assistance from state, regional, and local partners and existing evidence-based registries or guides, and through the use of contract-required deliverables.

AHCCCS values the implementation of evidence-based practices and also affords prevention providers with the flexibility to implement evidence-based programs, research-based programs, promising practices/programs, and innovative programs, within certain contract limitations. The Culture as Prevention model is considered by AHCCCS to be evidence-based for tribal/indigenous communities.

For example, contracts for directly-contracted providers requires the implementation of evidence based, research based, and/or promising practices according to peer reviewed journals as defined by current SAMHSA guidance in Selecting Best-fit Programs and Practices. AHCCCS is aware that every community is unique and there may be situations when there is not an appropriate evidence-based program to meet the needs of the community. AHCCCS has developed parameters regarding the use of innovative interventions. If a contractor wishes to implement an innovative program, they are required to submit an AHCCCS Innovative Prevention Program Intervention Protocol for any prevention program/intervention intended to be implemented under SUBG that is not designated as evidence-based. Innovative prevention interventions are to be administered at a ratio of one innovative intervention per every one evidence-based, research-based, or promising practice. The Protocol, developed by AHCCCS staff, requires the prevention providers to formally submit documentation related to the intervention they are proposing to use, prior to the use of the intervention, for review and approval by AHCCCS. This protocol includes pertinent intervention information, including but not limited to:?

Program outcomes,??

Program setting,??

Intervention length,??

Description of the “conceptual” and “practical” fit of the proposed intervention,?

Explanation of how the proposed intervention is the best choice over other Evidence and/or Research Based and Promising interventions available for use in the community,?

Current Intervention Evaluation Methodology, and;?

Protocol to mitigate/remove risks of innovative program/practice implementation on the priority population, including a process for referral to appropriate services as needed.?

Evidence-based programs or practices are interventions that fall into one or more of the following categories:

1. The intervention is included in a federal registry of evidence based interventions, or

2. The intervention produced positive effects on the primary targeted outcome, and these findings are reported in a peer reviewed journal, or

3. The intervention has documented evidence of effectiveness, based on guidelines developed by the Center for Substance Abuse Prevention and/or the state, tribe, or jurisdiction in which the intervention took place. Documented evidence should be implemented under four recommended guidelines, all of which shall be followed. These guidelines require interventions to be:

a. Based on a theory of change that is documented in a clear logic or conceptual mode,

b. Similar in content and structure to interventions that appear in federal registries of evidence-based interventions and/or peer-reviewed journals,

c. Supported by documentation showing it has been effectively implemented in the past, multiple times, and in a manner attentive to scientific standards of evidence. The intervention results should show a consistent pattern of credible and positive effects, and

d. Reviewed and deemed appropriate by a panel of informed prevention experts that includes qualified prevention researchers experienced in evaluating prevention interventions similar to those under review; local prevention professionals; and key community leaders, as appropriate (for example, law enforcement officials, educators, or elders within indigenous cultures).

Depending on the contract-specific language, Contractors are required to utilize 4 out of the 6 Center for Substance Abuse Prevention (CSAP) strategies, and serve each Institute of Medicine (IOM) Category per community need. This promotes comprehensive programming that is more likely to be evidence-based and effective than implementing only a few CSAP strategies.

The AZ National Prevention Network (NPN) representative also participates in many collaborative efforts with the Pacific Southwest Prevention Technology Transfer Center (PTTC), which is a great partner and resources for inquiries related to evidence-based practices. AHCCCS also participates in and collaborates with other state, federal, and community entities through the Arizona Substance Abuse Partnership (ASAP), which is the single statewide council on substance abuse prevention, treatment and recovery efforts.

Narratve Question

SUPTRS BG statute requires states to spend a minimum of 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment which programs (A) educate and counsel the individuals on substance use and substance use disorders; and (B) provide for activities to reduce the risk of substance use and substance use disorders by the individual. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SUPTRS BG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must serve both the general population and sub-groups that are at high risk for substance use. The program must include, but is not limited to, the following strategies:

1. ***Information dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, misuse and substance use disorders on individuals families and communities.
2. ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. ***Alternative programs*** that provide for the participation of priority populations in activities that exclude alcohol, tobacco, and other drug use.
4. ***Problem identification and Referral*** that aims at identification of those who have engaged in illegal/age-inappropriate use of tobacco or alcohol, and those individuals who have engaged in initial use of illicit drugs, in order to assess if the behavior can be addressed by education or other interventions to prevent further use.
5. ***Community-based processes*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. ***Environmental strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the use of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that serve populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Implementation

1. States distribute SUPTRS BG primary prevention funds in a variety of different ways. Please check all that apply to your state:

- **a)** ☐ SSA staff directly implements primary prevention programs and strategies.
- **b)** ☑ The SSA has statewide contracts (e.g. statewide needs assessment contract, statewide workforce training contract, statewide media campaign contract).
- **c)** ☑ The SSA funds regional entities that are autonomous in that they issue and manage their own sub-contracts.
- **d)** ☑ The SSA funds regional entities that provide training and technical assistance.
- **e)** ☑ The SSA funds regional entities to provide prevention services.
- **f)** ☑ The SSA funds county, city, or tribal governments to provide prevention services.
- **g)** ☑ The SSA funds community coalitions to provide prevention services.
- **h)** ☑ The SSA funds individual programs that are not part of a larger community effort.
- **i)** ☑ The SSA directly funds other state agency prevention programs.
- **j)** ☐ Other (please describe)

2. Please list the specific primary prevention programs, practices, and strategies that are funded with SUPTRS BG primary prevention dollars in at least one of the six prevention strategies. Please see the introduction above for definitions of the six strategies:

a) Information Dissemination:

Social media campaigns
· Printed material dissemination
· Radio advertising
· Billboards
· Newsletters
· Resource fairs

· Speaking engagements

b) Education:

Evidence-based and promising practice curriculum administered in schools and summer camps
Community prevention education workshops for youth and adults
Examples include: Too Good for Drugs, Lion's Quest, Rx360, Alcohol360, Botvin's Life Skills, PAX Good Behavior Game, PAX Tools, Thrive, Gathering of Native Americans, Parenting in Two Worlds, Living in Two Worlds, Culture Is Prevention model/education, and many more.

c) Alternatives:

Substance free community events for youth and families.
· Red ribbon week activities
· Youth summer camps
· Cultural programs
· Youth and adult leadership activities
. On campus Sober nights (IHEs)

d) Problem Identification and Referral:

Collaborative partnerships with direct service agencies.
multiple coalitions collaborated to identify youth and families in need of substance use prevention and provided targeted referrals and educational interventions.
LPKNC partnered with juvenile probation to deliver alcohol and marijuana education to referred students.
MATFORCE supported schools and juvenile probation by distributing parent folders and sanction packets, and delivering educational sessions in juvenile detention centers, accommodation schools, and adult diversion programs
AZYP engaged with an alternative school to present marijuana and vaping education to diversion students.
PAACE implemented the evidence-based "Catch My Breath" curriculum as a diversion strategy for students caught vaping on campus, aiming to reduce suspension time and increase classroom reintegration. The program was successfully launched in two schools, with five students completing it and plans for continued education and focus groups.
Child & Family Resources identified five individuals with substance use or mental health needs and referred them to appropriate community services. Casa Grande Alliance facilitated planning meetings with local schools to implement the Catch My Breath program and explore additional interventions to address vaping-related suspensions.
Community Bridges responded promptly to its first referral from the Boys & Girls Club, enrolling a youth in services within 24 hours, demonstrating effective coordination and responsiveness.
The Hopi Foundation exemplified trauma-informed care by immediately enrolling a walk-in community member into prevention and peer recovery services, showcasing culturally responsive and person-first practices.

e) Community-Based Processes:

Monthly coalition meetings
Youth leadership committees
Community and volunteer training
Systematic planning

f) Environmental:

Collaboration with schools and community stakeholders.
· Community drug take back events
· Council meetings
· Review board participation
· Distribution of medication lock boxes
· Promoting/reviewing alcohol, tobacco, and drug use policies in schools

3. Does your state have a process in place to ensure that SUPTRS BG dollars are used only to fund primary prevention services not funded through other means? (●) Yes ( ) No

a) Yes (if so, please describe)

AHCCCS is committed to administering the SUBG primary prevention funds in a manner that is data-driven, cost effective, and enhances service provision across the state in communities in need, aiming to fill gaps and reduce duplication. AHCCCS does this in a number of ways.

One of the first steps to developing a scope of work and an agreement with a potential prevention partner is the submission of a budget. All contracted primary prevention providers submit budgets to AHCCCS for review and approval before work begins. This allows AHCCCS to review planned activities and planned expenditures to ensure that they meet the requirements of the SUBG primary prevention set aside. During this review, AHCCCS program and finance staff look for duplication with other SUBG budgets, other funding sources that AHCCCS may manage such as the SOR funds, and other prevention efforts that AHCCCS is aware of generally. AHCCCS staff actively looks for duplication, and provides feedback to the contractor/partner if there are concerns such as supplanting of funds or the need for cost allocation of funds.

AHCCCS participates in a number of collaborative efforts with other state, regional, tribal, and local entities that allows for system communication regarding which primary prevention services are being funded and implemented throughout the

state. Examples include AHCCCS' work with Substance Abuse Coalition Leaders of Arizona (SACLAz), the Arizona Substance Abuse Partnership (ASAP), Governor's Office of Youth Faith and Family (GOYFF), PTTC, Wellington, and AHCCCS staff overseeing other prevention initiatives. These collaborations allow AHCCCS to ensure there is no service duplication, and for AHCCCS to gather information regarding any gaps and additional needs in services throughout the state, and coordinate additional support to communities in need of prevention services. AHCCCS also maintains a crosswalk of prevention providers that we become aware off across different funding streams (e.g. SUBG, SOR, SPF-PFS, GOYFF Parent's Commission, etc.) so that we may be aware of who is receiving funding. When we are aware that our SUBG subrecipient is a subrecipient of other prevention grant funds, we collaborate with those who oversee those grant funds to ensure there is not duplication of effort.

Further, AHCCCS implements additional contracting and policy mechanisms as well as oversight and monitoring efforts with all contracted prevention partners to review planned and actual activities and provide feedback on service gaps and duplication. Contract deliverable requirements ensure contractors submit information to AHCCCS that allows AHCCCS to assess the use of SUBG dollars and may seek to review this information against other funds. These deliverables include planning deliverables such as provider budgets, logic models, strategic plans, action plans, and evaluation plans as well as Contractor Expenditure Reports (CERs) showing actual expenditures under SUBG prevention. AHCCCS staff reviews CERs from a programmatic and fiscal lens to ensure appropriateness and allowability under the grant.

AHCCCS prevention staff who provide this oversight and monitoring are trained in prevention basics at minimum such as the Substance Abuse Prevention Skills Training (SAPST) or similar, as well as prevention ethics. AHCCCS staff also are provided ongoing training to ensure that they are knowledgeable and competent to support prevention contractors in their primary prevention work. Examples of additional training provided to AHCCCS prevention staff includes the PTTC Prevention Academy, CADCA Annual Leadership Forum, CADCA Mid-Year Forum, NPN Conference, and the AZ Drug Summit, among others.
Since GOYFF administers a large portion of the SUBG prevention funds, AHCCCS works closely with GOYFF to ensure which providers are funded and what programs/activities are funded under the SUBG. The two agencies seek to work together to reduce duplication and cover gaps in the prevention field in AZ.

Narratve Question

SUPTRS BG statute requires states to spend a minimum of 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment which programs (A) educate and counsel the individuals on substance use and substance use disorders; and (B) provide for activities to reduce the risk of substance use and substance use disorders by the individual. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SUPTRS BG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must serve both the general population and sub-groups that are at high risk for substance use. The program must include, but is not limited to, the following strategies:

1. ***Information dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, misuse and substance use disorders on individuals families and communities.
2. ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. ***Alternative programs*** that provide for the participation of priority populations in activities that exclude alcohol, tobacco, and other drug use.
4. ***Problem identification and Referral*** that aims at identification of those who have engaged in illegal/age-inappropriate use of tobacco or alcohol, and those individuals who have engaged in initial use of illicit drugs, in order to assess if the behavior can be addressed by education or other interventions to prevent further use.
5. ***Community-based processes*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. ***Environmental strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the use of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that serve populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Evaluation

1. Does your state have an evaluation plan for substance use primary prevention that was developed within the last five years? (●) Yes ( ) No

If yes, please attach the plan in WebBGAS

Will be attached

2. Does your state's prevention evaluation plan include the following components? (check all that apply):

- **a)** ☑ Establishes methods for monitoring progress towards outcomes, such as prioritized benchmarks
- **b)** ☑ Includes evaluation information from sub-recipients
- **c)** ☑ Includes National Outcome Measurement (NOMs) requirements
- **d)** ☑ Establishes a process for providing timely evaluation information to stakeholders
- **e)** ☑ Formalizes processes for incorporating evaluation findings into resource allocation and decision-making
- **f)** ☐ Other (please describe):
- **g)** ☐ Not applicable/no prevention evaluation plan

3. Please check those process measures listed below that your state collects on its SUPTRS BG funded prevention services:

- **a)** ☑ Numbers served
- **b)** ☑ Implementation fidelity
- **c)** ☐ Participant satisfaction
- **d)** ☑ Number of evidence based programs/practices/policies implemented
- **e)** ☑ Attendance
- **f)** ☑ Demographic information
- **g)** ☑ Other (please describe):

Narrative reports are optional, requesting subrecipients to provide a brief narrative to report on items that are not otherwise captured.

4. Please check those outcome measures listed below that your state collects on its SUPTRS BG funded prevention services:

- **a)** ☑ 30-day use of alcohol, tobacco, prescription drugs, etc
- **b)** ☑ Heavy alcohol use
- **c)** ☑ Binge alcohol use
- **d)** ☑ Perception of harm
- **e)** ☑ Disapproval of use
- **f)** ☑ Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)
- **g)** ☑ Other (please describe):

AHCCCS worked with a contracted evaluation consultant to develop pre- and post-survey tools for SUBG subrecipients to administer as part of prevention direct service education programming. The tool is based off of National Outcome Measures (NOMs) and also includes additional optional measures for prevention programs to choose from. The pre- and post-surveys are to be customized to the program being implemented to measure the most appropriate outcomes being targeted by the programming.

Footnotes:

Environmental Factors and Plan

6. Statutory Criterion for MHBG - Required for MHBG

Narrative Question

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness, including those with co-occurring mental and substance use disorders. Describes available services and resources within a comprehensive system of care, provided with federal, state, and other public and private resources, in order to enable such individual to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

Please respond to the following items

Criterion 1

1. Describe available services and resources in order to enable individuals with mental illness, including those with co-occurring mental and substance use disorders to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

RESPONSE - AHCCCS is the agency responsible for matters related to behavioral health and substance use and provides oversight, coordination, planning, administration, regulation, and monitoring of all facets of the public behavioral health system in Arizona. AHCCCS contracts with Arizona Complete Care Regional Behavioral Health Agreements (ACC-RBHAs), Tribal Behavioral Health Authorities (TRBHAs) and Managed Care Organizations (MCOs) to oversee the provision of comprehensive physical and behavioral health services to eligible persons with an Early Serious Mental Illness (ESMI) including First Episode Psychosis (FEP), a Serious Mental Illness (SMI) designation or Serious Emotional Disturbance (SED) designation.

AHCCCS has intergovernmental agreements (IGAs) with the Tribal Regional Health Authorities (TRBHAs) for the coordination of behavioral health services for American Indian members enrolled with the TRBHA. AHCCCS operates the American Indian Health Program (AIHP), a fee for service program that is responsible for care for American Indian members who select AIHP.

There is an array of outpatient covered health services for individuals experiencing symptoms related to SMI, SED, ESMI/FEP or general mental health (GMH) disorders, substance use disorders (SUDs) and/or co-occurring mental health and substance use disorders. A vast majority of the outpatient services are delivered through Integrated Health Homes/Integrated Clinics, Outpatient Treatment Clinics, Outpatient Substance Use Clinics, Medication Assisted Treatment (MAT) Clinics and Federally Qualified Health Clinics (FQHCs). The goal is to serve the whole person and through integrated behavioral and physical health services. Many facilities have Primary Care Physicians (PCP) on site to address physical health needs including Pharmacy and Laboratory services. If a clinic/facility site does not have Primary Care Services on site, it is the expectation that the Health Home integrates the members' care needs by providing coordination of care between behavioral, medical and physical health providers to ensure the needs of the whole person are addressed. This integrated system reduces fragmentation and improves health outcomes for members.

AHCCCS has participated in the Targeted Investment Program which has driven the implementation of integrated care across the state of Arizona. Individuals who are determined to demonstrate symptoms of a qualifying diagnosis and functional impairments as the result of their symptomatology as SMI or SED, ESMI/FEP are offered an array of covered health and community based services, including, but not limited to:

For adult members:
? Case Management
? Assertive Community Treatment (ACT) as determined by need
? Supportive Level of Care as determined by need
? Connective Level of Care as determined by need
? Evaluations and assessments related to psychiatric services and assignment to a Behavioral Health Medical Provider
? Medication/Medication Management
? Nursing Services
? Rehabilitation Services
? Vocational Services
? Employment Services
? Educational Services
? Housing Services and Community Living Support
? Applications for housing, rental assistance
? Primary Care Services and coordination of care between behavioral health and medical health Providers
? Substance Use services, referrals and coordination of care
? MAT as indicated

? Substance Use Counseling (both individual and group as indicated) provided by Substance Use Specialists/Counselors
? Coordination of crisis services as determined by need
? As an example; a Crisis Mobile Team visits if a person is experiencing symptoms of their illness. Crisis Mobile Team visits can occur during the day, evenings, week-ends and can be coordinated 24/7 to ensure a person has the supports to assist them through a challenging time
? Counseling services
? Individual
? Group
? Family
? Couples
? Non-emergent transportation and/or coordination of transportation services
? Peer Support Services
? Family Support Services
? Assistance with applying for benefits
? AHCCCS/Medicaid benefits
? Social Security
? Food Stamps
? Public Assistance
? Coordination of care/referrals for evidence based practices, as determined clinically appropriate including:
? Assertive Community Treatment (ACT)
? Cognitive Behavioral Therapy (CBT)
? Dialectical Behavior Therapy (DBT)
? Applied Behavior Analysis (ABA)
? Trauma Informed Care
? American Association of Addiction Medicine/ASAM CONTINUUM assessment for persons with substance use challenges to determine levels of care
? Motivational Interviewing
? Other EBP's as indicated by assessments and treatment planning
? Coordination of care and referrals to community based services and natural supports
? Overall development of an Individual Services Plan (ISP) to address the unique needs of the whole person

For Children/Adolescents, including the SED population, AHCCCS has implemented the Child and Family Team (CFT) practice model. The CFT practice is utilized with all Medicaid eligible, uninsured or underinsured children, adolescents and young adults under the age of 21, who are receiving services through the children's T/RBHA system.

The behavioral health service provider is responsible for oversight of the CFT model in practice; a facilitator for the child and family with complex needs has the specialized training and skill set to perform this function. The team identifies and determines a consensus in the development of the child/adolescents' service plan goals and interventions. The child/adolescent, their family members (biological, foster parents, other individuals of support, as determined appropriate for each child), Department of Child Safety (DCS) case manager/s, behavioral health case manager/s, the Division of Developmental Disabilities, education, juvenile justice, other child serving organizations, and advocates can also learn to lead CFTs.

In the Arizona CFT practice model, it is the child's and family's complexity of needs that drive the development, integration, and individualization of service delivery. The level of complexity is determined individually with each child and family. One variable that is considered when determining complexity of needs for children is the involvement of other child-serving agencies, such as Juvenile Justice (Probation or Parole), Division of Developmental Disabilities (DDD), Department of Child Safety (DCS), and Education (Early Intervention or Special Education). The number of system partners involved and invited to participate in CFT practice by the child and family will contribute to the level of integrated service coordination required, as well as consideration by team members of the individual mandates for each agency involved.

A child's and family's overall health status also contributes to their complexity of needs and subsequent level of service intensity. For children with a SED and/or chronic physical condition, symptoms associated with their physical or behavioral health condition can impact their level of functioning in multiple life domains and may result in the use of medications that are monitored through a Behavioral Health Medical Practitioner (BHMP) and/or Primary Care Physician (PCP). Thus, the intensity of service integration through the CFT model is dependent on the level of coordination necessary to support the child and family in making progress toward identified goals in their Individual Service Plan (ISP). Several stressors/risk factors are considered by the CFT when reviewing the child's and family's level of complexity, including environmental stressors such as changes in primary caregiver, inadequate social support, housing problems, mental health or substance use concerns. The team also considers out-of-home setting (group home, therapeutic foster care, etc.) and use of crisis or inpatient services.

One method for determining complexity of needs and intensity of service delivery is through the application of the CALOCUS for children ages 6 to 18. This instrument consists of six dimensions for assessment of service intensity: risk of harm, functional status, co-occurrence of conditions, recovery environment, resiliency, and/or response to services and involvement in services.

For individuals with co-occurring mental health and substance use disorders, outpatient providers provide MAT services,

prevention, treatment, on-going SUD counseling, coordination of care and referrals to community based services; this also includes natural supports and resources such as Alcoholics Anonymous, Narcotics Anonymous, Al-Anon, etc.

MAT is the use of medications in combination with counseling and behavioral therapies for the treatment of substance use disorders. For those with an opioid disorder (OUD), medication addresses the physical challenges that one experiences when they stop taking opioids. MAT can help to re-establish normal brain function, reduce substance cravings and prevent relapse. The longer a person engages in the treatment, the more the individual will be able to manage their dependency and move forward toward recovery.

An important piece of the MAT approach is that the medications are "assisting" other components of treatment. To increase the benefit that individuals receive from psychosocial intervention, services should be best practice. Some examples of best practice for persons who have substance use disorders include, Cognitive Behavioral Therapy (CBT), Motivational Interviewing, Moral Reconation Therapy, Peer and Recovery Support Services, Twelve Step Facilitation, and Contingency Management. Arizona has 24/7 Access Point Locations providing opioid treatment services 24 hours a day, 7 days a week to serve individuals seeking treatment.
MAT services are offered in various settings including Opioid Treatment Programs (OTPs) and Office-Based Opioid Treatment (OBOTs). An OTP is any treatment program certified by the Substance Abuse and Mental Health Services Administration (SAMHSA) to provide medication-assisted treatment for persons diagnosed with OUD. These programs are authorized to administer and distribute all forms of MAT; methadone, buprenorphine (Suboxone/Subutex) and naltrexone. Additional support services within the OTP may include case management, peer support, individual counseling, group counseling and other types of support services identified by the individual being served.

An OBOT program allows for a qualified primary care physician (PCP) to provide opioid treatment services in their office based settings. Federal guidelines allow qualified physicians in the OBOT to prescribe medications for OUD in their office setting although it is required that the physician has the ability to connect their patients to the appropriate level of counseling and other appropriate services, as indicated by the needs of the individual and their treatment plan.

AHCCCS also supports evidence-based Permanent Supportive Housing (PSH) models, including Housing First, for serving persons who are experiencing unsheltered homelessness, persons with behavioral health needs including mental illness or substance use disorders (SUD) and is premised on: 1) access to and availability of both affordable housing subsidies and capacity, and 2) individualized wrap around housing focused supportive services to support housing placement, stability and coordination with member's other service goals and resources. Housing First is an approach to quickly and successfully connect individuals and families experiencing homelessness to permanent housing without preconditions and barriers to entry, such as sobriety, treatment or service participation requirements. Supportive services are offered to maximize housing stability and prevent returns to homelessness as opposed to addressing predetermined treatment goals prior to permanent housing entry.

AHCCCS addresses transitions from the Arizona State Hospital through the screening of members to be discharged and, if they are not already connected with a behavioral health home including case management services in their geographic service area, they are matched with an appropriate team to coordinate support services including, but not limited to, vocational services, psychiatric medication management, counseling, housing, and Peer Recovery Support.

AHCCCS has partnerships and an Interagency Service Agreements(ISA) with the Rehabilitation Services Administration (RSA) Vocational Rehabilitation (VR) to connect members to employment, educational support and opportunities, or other vocational services determined to promote individual success. The VR program provides a variety of services to persons with disabilities and, with the ultimate goal to prepare for, enter into and/or retain employment. The VR program is a public program funded through a Federal/State partnership and administered by the RSA, which in Arizona falls under the Arizona Department of Economic Security (ADES).

Additionally and not related to the ISA, RSA/VR has assigned one of their offices to work with individuals transitioning to the community from the Arizona State Hospital and also has a VR Counselor assigned to the Human Services Campus in Phoenix. The VR Counselor at the Human Services Campus assists people who are experiencing unsheltered homelessness and/or housing insecurity who are wanting to re-enter the workforce. The Human Services Campus is Maricopa's largest homeless service provider.

2. Does your state coordinate the following services under comprehensive community-based mental health service systems?

a)	Physical Health	(●) Yes ( ) No
b)	Mental Health	(●) Yes ( ) No
c)	Rehabilitation services	(●) Yes ( ) No
d)	Employment services	(●) Yes ( ) No
e)	Housing services	(●) Yes ( ) No

f)	Educational services	● Yes	○ No
g)	Substance use prevention and SUD treatment services	● Yes	○ No
h)	Medical and dental services	● Yes	○ No
i)	Recovery Support services	○ Yes	○ No
j)	Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA)	● Yes	○ No
k)	Services for persons with co-occuring M/SUDs	● Yes	○ No

Please describe or clarify the services coordinated, as needed (for example, best practices, service needs, concerns, etc.)

3. Describe your state's case management services

RESPONSE - AHCCCS covers provider case management as a supportive service intended to improve treatment outcomes and meet individuals' Service or Treatment Plan goals. Examples of case management activities include but are not limited to:
1. Assistance in maintaining, monitoring, and modifying behavioral health services.
2. Assistance in finding necessary resources other than behavioral health services.
3. Coordination of care with the individual/Health Care Decision Maker (HCDM), designated representative (DR), healthcare providers, family, community resources, and other involved supports including educational, social, judicial, community, and other State agencies.
4. Coordination of care activities related to continuity of care between levels of care (e.g. inpatient to outpatient care) and across multiple services (e.g. personal care services, nursing services, and family counseling) and providers.
5. Assisting individuals in applying for Social Security benefits when using the SSI/SSDI Outreach, Access, and Recovery (SOAR) approach.
6. Outreach and follow-up of crisis contacts and missed appointments.
Provider case managers are responsible for monitoring the individual's current needs, services, and progress through regular and ongoing contact with the individual. The frequency and type of contact is determined during the treatment planning process, and is adjusted as needed, considering clinical need and individual preference, though generally falls within one of the following categories
1. Assertive Community Treatment (ACT) Case Management (Adult): One component of a comprehensive model of treatment based upon fidelity criteria developed by the Substance Abuse and Mental Health Services Administration. ACT case management focuses upon individuals with severe and persistent mental illness that seriously impairs their functioning in community living, in conjunction with a multidisciplinary team approach to coordinating care across multiple systems (e.g. social services, housing services, health care).
2. High Needs Case Management (Children/Adolescents): Focuses upon providing case management and other support and rehabilitation services to children with complex needs and multiple systems involvements for whom less intensive case management would likely impair their functioning. Children with high service intensity needs who require the assignment of a high needs case manager are identified as:
a. Children 0 through five years of age with two or more of the following:
i. Other agency involvement; specifically: Arizona Early Intervention Program (AzEIP), DCS, and/or DDD, and/or
ii. Out of home placement for behavioral health treatment (within past six months), and/or
iii. Psychotropic medication utilization (two or more medications), and/or
iv. Evidence of severe psycho-social stressors (e.g. family member serious illness, disability, death, job loss, eviction), and
b. Children six through 17 years of age: CALOCUS level of 4, 5, or 6.
3. Medium Level of Intensity Case Management (Adult): Focuses upon individuals for whom less intensive case management would likely impair their functioning. Supportive case management provides assistance, support, guidance and monitoring in order to achieve maximum benefit from services. Caseloads may include individuals with an SMI designation as well as individuals with a general mental health condition or substance use disorder as clinically indicated.
4. Low Level of Intensity Case Management (Adult): Focuses on individuals who have largely achieved recovery and who are maintaining their level of functioning. Case management involves careful monitoring of the individual's care and linkage to service. Caseloads may include both individuals with an SMI designation as well as individuals with a general mental health condition or substance use disorder as clinically indicated.

In addition to the levels of Case Management as listed above, Forensic Assertive Community Tr eatment Teams (FACT) function in Maricopa County to address the unique needs of people determined SMI and have had involvement with the criminal justice system. The goal of the FACT teams is to reduce recidivism and assist members with high needs through an array of integrated, community based services, resources, and supports.
The FACT team utilizes evidence-based practices to:
? Identify and engage members with complex, high needs.
? Remove barriers to services and supports.

? Address the whole person and provide a full range of community-based services and supports wherever and whenever they are needed.
? Reduce hospitalizations and contact with the criminal-justice system, improve health outcomes and help establish and strengthen natural community supports.
FACT team staff have experience in psychiatry, nursing, social work, rehabilitation services, substance-abuse interventions, employment support, independent-living skills and housing. A key member of the team is a peer support person who has lived experience with behavioral health challenges and prior interaction with the criminal justice system likened to the members served. The team assists members with adhering to treatment plans, activities of daily living, employment-related services, finding and maintaining affordable housing, budgeting, obtaining benefits, and engaging in community activities through delivering services in accordance with SAMHSA evidence-based practices (EBP/s).
AHCCCS/Maricopa County also offers Medical Assertive Community Treatment Teams (MACT). The difference between a regular ACT team and the MACT team is that the individuals not only have a SMI qualifying diagnosis but also have significant medical comorbid conditions. MACT employees have experience in Psychiatry (Behavioral Health Medical Provider), nursing, social work, rehabilitation services, and licensed substance use specialists who provide individual and group counseling, interventions/supports, employment support, independent living skills and housing supports. The MACT team additionally employs a Primary Care Medical Provider and closely monitors the medical and physical condition of the member along with their behavioral health condition providing integrated care for the unique challenges the combination of these conditions can present.

MCOs are required to submit an annual Provider Case Management Plan that addresses how the Contractor will implement and monitor provider case management standards and caseload ratios for adults and children. The Provider Case Management Plan includes performance outcomes, lessons learned, and strategies targeted for improvement. MCOs must also ensure that provider sites where provider case management services are delivered have regular and ongoing member and/or family participation in decision making, quality improvement, and enhancement of customer service.

4. Describe activities intended to reduce hospitalizations and hospital stays.

RESPONSE - AHCCCS's System of Care includes an integrated and comprehensive continuum of coordinated community and facility based services/supports for adults and children with, or at risk for, behavioral health challenges. Case managers are responsible for monitoring the individual's current needs, services, and progress through regular and ongoing contact with the individual. The frequency and type of contact is determined during the collaborative CFT and ART treatment planning process and is adjusted as needed, considering clinical need and individual preferences. The goal is to serve individuals in the least restrictive environment by providing individualized outpatient services and engaging community and natural support to divert crisis situations and inpatient admissions.

Arizona is often referenced as an example among Medicaid programs for its innovative approach to behavioral health crisis services. Its comprehensive array of services are available to any resident of the state, regardless of insurance coverage. Crisis services are required to be recovery-oriented, person focused, and work to stabilize the individual as quickly as possible to assist them in returning to their baseline of functioning. All interventions are required to be offered in a clinically and culturally appropriate manner that respects the preferences of the individual in crisis, while recognizing the need to maintain safety.
Arizona's crisis services encompass the full timeline of care and intervention as outlined below:
1. Crisis Prevention and Early Intervention
a. Wellness Recovery Action Plan (WRAP) Crisis Planning
b. Psychiatric Advance Directives
c. Family Engagement
d. Safety Planning
e. Peer-Operated Warm Lines
f. Peer-Run Crisis Respite Programs
g. Suicide Prevention
2. Crisis Interventions/Stabilization
a. Assessment/Triage (Living Room Model)
b. Open Dialogue
c. Crisis Residential/Respite
d. Crisis Intervention Team/Law Enforcement
e. Mobile Crisis Outreach
f. Collaboration with Hospital Emergency Departments and Urgent Care Systems
3. Post Crisis Intervention/Supports
a. Peer Support
b. Follow-up Outreach and Support
c. Family-to-Family Engagement
d. Connection to care coordination and follow-up clinical care for individuals in crisis
e. Follow-up crisis engagement with families and involved community members
f. Recovery community coaches/peer recovery coaches
g. Recovery community organization
AHCCCS utilizes the ACC-Regional Behavioral Health Agreements (ACC-RBHAs) as the Managed Care Organizations (MCOs) responsible for the full continuum of crisis services to all individuals within their assigned Geographical Service Area (GSA) to prevent a potentially dangerous condition, episode, or behavior. Crisis services include crisis telephone response, mobile crisis

teams, and facility-based stabilization (including observation and detox), and all other associated covered services delivered by crisis service providers within the first 24 hours of a crisis episode for Title XIX/XXI individuals.
RBHAs ensure the provision of regular Crisis Intervention Team (CIT) training and Mental Health First Aid for Law Enforcement (LE) and other community partners, including federal and tribal entities. RBHAs encourage two-way connections with LE and behavioral health providers in their communities to enhance relationships and better support individuals experiencing behavioral health crises who become involved with law enforcement. Additionally, RBHAs deliver police culture training to crisis providers to enhance system collaboration.
Case management services, home visits (in person or virtual depending on the situation), appointments with the Behavioral Health Medical Provider, Counseling and other supports are available. These services are intended to address the treatment needs of a person to assist them in the community and have an impact on reduced hospitalizations and crisis situations. Regular and on-going contact with the person, their family or other persons of support is essential to assisting them during their recovery journey.

Beginning in 2016 and renewed in 2021, AHCCCS's Targeted Investment (TI) Program supports participating providers (including hospitals) in delivering integrated and coordinated care at the provider-level. The program reduces fragmentation between physical and behavioral health providers, increase efficiencies in integrated service delivery, and improve health outcomes for adults and children with behavioral health needs who are at high risk for complex care including those experiencing ESMI/FEP, SED, SMI, Substance Use Disorders (SUD), and co-occurring MH/SUD disorders, including justice involved individuals. The TI program incentivizes requirements aimed at building the necessary infrastructure to enable an integrated and high-performing health care delivery system that enhances care coordination, improves health and financial outcomes, and supports a comprehensive approach to integrated care in any setting in which a member may receive either physical or behavioral health services. Improvements in physical and behavioral health integration as the result of AHCCCS's Targeted Investment (TI) Program that support the provision of person-centered, integrated care such as:
? Integrated care plans for members with behavioral health needs
? Primary Care screening for behavioral health using standardized tools for depression, substance use disorders, anxiety and suicide risk
? Primary Care screening, intervention and treatment for children with developmental delays, including early childhood cognitive and emotional problems
? Protocols for behavioral health providers to identify physical health concerns and to effectively connect the member to appropriate physical health care
? High risk registries, health risk assessment tools, predictive analytic systems and other data mining structures to identify individuals at high risk of a declines in acute and/or behavioral health status
? Trauma-Informed Care protocols including screening for Adverse Childhood Events (ACEs), referral processes for children that screen positive, and use of Evidence Based Practices (EBPs) and trauma-informed services.
Protocols to send and receive core Electronic Health Record (EHR) data with the state's Health Information Exchange (Health Current) and receipt of Admission, Discharge, and Transfer (ADT) alerts to notify providers when their patients are hospitalized.
Based on the success of the initial five-year initiative, AHCCCS renewed the TI Program in 2021 to expand provider participation, sustain the integrated point of care infrastructure and protocols, and enable more members to receive greater levels of point of care coordination and integration, especially as the public health emergency intensified the need.

In the event of a hospitalization, MCOs, ACC-RBHAs, and Providers are required to track inpatient admissions, lengths of stay, and discharge dates. MCOs and ACC-RBHAs have Care Managers that track and monitor the status of individuals in hospitals/inpatient facilities to ensure coordination of care and discharge planning occurs to assist members to reintegrate back to the community. Inpatient protocols are in place for Case Managers/Providers to have ongoing contact with the inpatient Social Workers and Behavioral Health Medical Providers while the person is inpatient to ensure coordination of care and appropriate discharge planning occurs.

5. Please indicate areas of technical assistance needs related to this section.

No technical assistance needs at this time

Criterion 2: Mental Health System Data Epidemiology

Contains an estimate of the incidence and prevalence in the state of SMI among adults and SED among children; and have quantitative targets to be achieved in the implementation of the system of care described under Criterion 1.

Criterion 2

1. In order to complete column B of the table, please use the most recent federal prevalence estimate from the National Survey on Drug Use and Health or other federal/state data that describes the populations of focus.

Column C requires that the state indicate the expected incidence rate of individuals with SMI/SED who may require services in the state's M/SUD system.

MHBG Estimate of statewide prevalence and incidence rates of individuals with SMI/SED

Target Population (A)	Statewide prevalence (B)	Statewide incidence (C)
1.Adults with SMI	314875	.15%
2.Children with SED	215748	.25%

2. Describe the process by which your state calculates prevalence and incidence rates and provide an explanation as to how this information is used for planning purposes. If your state does not calculate these rates, but obtains them from another source, please describe. If your state does not use prevalence and incidence rates for planning purposes, indicate how system planning occurs in their absence.

Arizona utilizes an SMI Determination process as outlined in AMPM Policy 320-P Serious Mental Illness Eligibility Determination https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/300/320P.pdf. In order to ensure that individuals who may qualify for SMI designation are promptly identified and enrolled for services, AHCCCS has developed a statewide standardized process for the referral, evaluation, and determination of SMI eligibility. This process requires a BHP working with an individual with an SMI qualifying diagnosis to evaluate and submit an eligibility determination to a third party vendor. The vendor psychiatrists analyze current and past treatment information including assessment, treatment or other medical records and documentation to determine whether or not an individual meets the diagnostic and functional criteria established for the purpose of determining an individual's eligibility for SMI services. With respect to children, they are classified, rather than determined, as having a serious emotional disturbance (SED). Effective March 28, 2025, eligibility for SED identification requires that a child or adolescent under the age of 18 present both a qualifying diagnosis and a functional impairment attributable to that diagnosis. To satisfy the SED functional impairment criteria, the individual must possess a qualifying SED diagnosis and achieve a Child and Adolescent Level of Care Utilization System (CALOCUS) level of care score of 2, 3, 4, 5, or 6. The CALOCUS assessment tool has not been validated for use with children aged five and younger.
When an individual is determined SMI or identified as SED, they are assigned to a RBHA further to a behavioral health home in their geographic service area for follow-up behavioral health services. The process used to calculate prevalence and incidence rates is used to determine the number of members served who meet the designation requirements of SMI or SED identification and then compare those numbers to the overall population of the state within that demographic. Members served are determined through standardized reporting based on expenditure and demographic data. The prevalence and incidence rates are used for allocation of resources throughout the state, in structuring service provision through the RBHAs and TRBHAs, and targeting specific areas of need.

3. Please indicate areas of technical assistance needs related to this section.

No technical assistance needs at this time.

Criterion 3: Children's Services

Provides for a system of integrated services for children to receive care for their multiple needs.

Criterion 3

1. Does your state integrate the following services into a comprehensive system of care?[1]

a)	Social Services	● Yes	○ No
b)	Educational services, including services provided under IDEA	● Yes	○ No
c)	Juvenile justice services	● Yes	○ No
d)	Substance use prevention and SUD treatment services	● Yes	○ No
e)	Health and mental health services	● Yes	○ No
f)	Establishes defined geographic area for the provision of services of such systems	● Yes	○ No

2. Please indicate areas of technical assistance needs related to this section.

No technical assistance needed

[1] *A system of care is a spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families, that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help them to function better at home, in school, in the community, and throughout life.*

Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adults
Provides outreach to and services for individuals who experience homelessness; community-based services to individuals in rural areas; and community-based services to older adults.

Criterion 4

a. Describe your state's tailored services to rural population with SMI/SED. See the federal **Rural Behavioral Health** page for program resources.

RESPONSE -
AHCCCS contracts with ACC-Regional Behavioral Health Agreements (ACC-RBHAs) to cover over 1 million Arizonans throughout the state including rural and tribal areas. For the purposes of ACC-RBHA coverage, Arizona is divided into three Geographic Services Areas (GSAs) to serve the unique needs of each region of the state. While all three GSAs include rural areas, the Northern and Southern GSAs include most of the rural counties and regions characterized by low general population and population densities. A significant portion of Arizona's geography consists of reservation and tribal lands and similar to the ACC-RBHA structure, there are four Tribal Regional Behavioral Health Authorities (TRBHAs) that fulfill similar roles for their designated tribal groups. Each of these groups is responsible under contract with AHCCCS to establish a services network that meets the contractual requirements for all RBHA's while allowing the RBHA or TRHBA to address the specific needs of their GSA including delivery of services in a rural context. Within this service network, AHCCCS has Non-Title XIX/XXI state general funds to provide housing subsidies for persons experiencing homelessness who have been determined to be Seriously Mentally Ill (SMI). As with other AHCCCS programs and services, these housing subsidies and supports are also allocated to each GSA and provide housing to both urban and rural populations.

According to the October, 2022 Arizona Department of Health Services Biennial Report, 82 of Arizona's 126 Primary Care Areas (PCAs) are designated as medically underserved areas. The Health Resources and Services Administration designates the geographic majority of Arizona, particularly (but not exclusively) the rural areas, as Health Professional Shortage Areas (HSPA) in behavioral health. Approximately forty percent of Arizonans live in a Mental Health Professional Shortage Area while, during and since the pandemic, there is an increased need for mental health and substance use treatment for both adults and children. To address these challenges, the Arizona Department of Health Services collaborated with multiple public health, community partners, subject matter experts, and dedicated stakeholders at the state and local levels, including the then AHCCCS Director, Jami Snyder, to create the Arizona Health Improvement Plan (AzHIP) for 2021-2025. The plan outlines action steps and tactics to increase access to mental health management resources, with a particular focus on remote options (telehealth therapy/psychiatry/addition support appointments, virtual support groups, mental health first aid, etc.); increase awareness and utilization of population-based mental health and wellness resources/outreach where they exist and develop strategies to close gaps, and increase the number of public facing/front line staff who receive an approved evidence based suicide prevention training by identifying organizations to receive the training and expand the statewide training capacity in a manner that ensure cultural humility in health equity are a priority. They prioritized addressing health professional shortage by building a diverse healthcare workforce employing multiple tactics including: developing strategies to reduce financial and other barriers for underserved students in health professional education programs, build/grow health care workforce which is representative of the communities served, quantifying healthcare professional shortages in rural and urban underserved areas, developing a curriculum to address local community priorities/concerns, and implementing curriculum with consideration of tribal communities' needs and cultural understanding. AHCCCS is actively involved in these initiatives to overcome these challenges to ensure all Arizonans receive integrated care.

Homeless coordination is one way in which the ACC-RBHA/TRBHA structure meets the needs of rural communities and how collaboration and coordination with other systems have directly improved care and services for members in rural areas. AHCCCS Contractor Operations Manual Policy 448 (Housing) policies require all RBHA and TRBHA contractors and their networks of clinics, services and housing programs to participate in the local HUD Continuum of Care (CoC) for their jurisdiction. This includes participation, when possible, in local case conferencing, homeless coordinated entry systems, care coordination and regional homeless planning efforts. For RBHAs and TRBHAs serving rural or tribal Arizona areas, participation is in the Balance of State CoC (BoSCoC covers the 13 rural counties of Arizona outside of Maricopa County/Phoenix and Pima County/Tucson) and HMIS system. In addition to the aforementioned participation in regional planning and other coordination efforts, RBHA and their providers have established innovative partnerships to increase services to SMI and other persons with behavioral health needs in rural areas. For example, many rural Arizona counties lack homeless service sites, shelters or facilities to serve as HUD CoC Coordinated entry sites for purposes of connecting homeless persons, including those with mental health needs, to HUD homeless programs and housing. To address this, Arizona Complete Health (AZCH) requires all of their health homes and housing providers to serve as CoC Coordinated Entry sites for persons with behavioral health needs. This includes conducting CoC required housing assessments, HMIS data entry and enrollment on the local by name list of persons seeking CoC housing. The site can also enroll the individual, if eligible, in AHCCCS housing programs in addition to other Medicaid covered services. Similarly, rural communities and counties in Arizona access the Project for Assistance to Transition from Homelessness (PATH) grants. PATH teams serving the BoSCoC also coordinate with the regional CoCs and serve as coordinated entry points to enroll members in CoC services and housing lists especially in rural areas where homeless shelters, service sites or access points may be limited.

PATH utilizes federal and state funding dollars to contractors who serve as a point of contact for food, clothing, water, blankets, shelter, and other basic living skills individuals require to reduce homelessness for individuals determined to have a Serious Mental Illness (SMI). PATH funding is critical in creating linkages with the behavioral health crisis system, aiding enrollment into the behavioral health system, obtaining medical records, picture ID and social security cards. PATH funding also allows for affordable housing options and conducting outreach and in-reach to adults 18 and over who are chronically homeless and have a Serious Mental Illness determination..

PATH services are provided in Coconino, Mohave, & Yavapai counties through Catholic Charities; in Maricopa County through Community Bridges Inc; Cochise County through Good Neighbor Alliance; and in Pima County through La Frontera. Of those counties where services are provided, the majority of the population served is rural. The targeted services provided by PATH providers are Outreach services (i.e. case management, peer support, housing services, individual living skills, etc.); Screening and diagnostic treatment (i.e. SMI determinations); Habilitation and rehabilitation; community mental health (i.e. create linkages with behavioral health system); Substance use treatment; Referrals for primary healthcare, job training, educational services, and housing services, and SOAR.

b. Describe your state's tailored services to people with SMI/SED experiencing homelessness. See the federal **Homeless Programs and Resources** for program resources[1]

Arizona's Tailored Services for Individuals with SMI/SED Experiencing Homelessness
Arizona Health Care Cost Containment System (AHCCCS) administers a range of tailored services for individuals with Serious Mental Illness (SMI) or Serious Emotional Disturbance (SED) who are experiencing or at risk of homelessness. These services are aligned with federal guidance and best practices outlined by the Substance Abuse and Mental Health Services Administration (SAMHSA), including the Housing First model and trauma-informed care.
Project for Assistance in Transition from Homelessness (PATH)
AHCCCS receives PATH funding from SAMHSA to support outreach and engagement services for individuals who are homeless or at risk of homelessness and have an SMI, including co-occurring substance use disorders. In May 2020, Arizona finalized a competitive Request for Proposal (RFP) for PATH contractors, resulting in contracts for three years with two optional one-year extensions (up to five years total).
PATH services are provided in six counties: Maricopa, Pima, Cochise, Coconino, Yavapai, and Mohave. Services include:
• Community health screenings
• Case management
• Outreach to locations where individuals experiencing homelessness gather (e.g., food banks, parks, vacant buildings)
• Field assessments and evaluations
• Emergency hotel vouchers
• Assistance with basic needs (e.g., food stamps, Medicaid, SSI/SSDI applications)
PATH contractors use evidence-based and promising practices to prioritize outreach and case management for the most vulnerable individuals. Once enrolled, individuals receive support in accessing mainstream services and behavioral health care. Case plans are updated at least every three months.
PATH teams are integrated into Continuum of Care (CoC) Homeless Management Information System (HMIS) coordination activities, including coordinated entry, case conferencing, and use of the By-Name List to prioritize housing. An annual Point-in-Time (PIT) count is conducted to assess the number of individuals experiencing homelessness, including those with SMI or co-occurring disorders.
2024 PIT Count by County:
• Maricopa (Phoenix): 9,435
• Pima (Tucson): 2,102
• Balance of State: 1,642

Positive Changes
• Pima County saw a 5.6% reduction in total homelessness, decreasing by 125 individuals.
• Balance of State counties experienced a significant 28.6% reduction, with 658 fewer individuals counted as homeless compared to 2022.

AHCCCS Housing Program (AHP)
The AHCCCS Housing Program provides permanent supportive housing and supportive services, primarily for individuals with an SMI designation. Limited housing is also available for individuals with General Mental Health/Substance Use (GMHSU) needs, with priority given to those with high service utilization or complex conditions.
Housing options include:
• Scattered Site Program (rental subsidies in community units)
• Community Living Program (dedicated site-based units)
• Project-Based Vouchers (units set aside for AHP members)
All units must meet federal Housing Quality Standards (HQS), and members contribute up to 30% of their income toward rent. AHP also covers housing-related supports such as deposits, move-in assistance, and eviction prevention. Licensed clinical residential settings are not eligible for AHP participation.
Supportive services are funded by Medicaid and delivered through managed care health plans. The program follows a Housing First model, consistent with SAMHSA best practices. Approximately 2,700 members are supported statewide through AHP, with funding from Arizona's General Fund.

Housing and Health Opportunities (H2O) Demonstration
AHCCCS has submitted an amendment to its 1115 Research and Demonstration Waiver to implement the Housing and Health Opportunities (H2O) demonstration. The initiative aims to expand housing services and improve health outcomes for individuals experiencing or at risk of homelessness.
Target populations include:
• Individuals with SMI or behavioral health/substance use needs
• High-risk/high-cost individuals based on service utilization
• Individuals with frequent emergency/crisis service use
• Pregnant individuals
• Individuals with chronic or co-morbid health conditions
• Individuals exiting institutional settings (e.g., IMDs, correctional facilities)
• Young adults (18–24) aging out of foster care
• ALTCS members transitioning from institutional care
Goals of the H2O demonstration:
• Improve health and well-being outcomes
• Reduce crisis and emergency service utilization
• Increase housing stability and reduce homelessness

Coordination and Oversight
AHCCCS' Mental Health Block Grant (MHBG) team collaborates with PATH to ensure a full continuum of care. The MHBG Grant Administrator also oversees the PATH grant. PATH subrecipients are required to maintain Memorandums of Understanding (MOUs) with local ACC-RBHAs and TRBHAs to facilitate referrals and information sharing.
Subrecipients are held to outreach and service delivery standards through contractual and policy requirements. AHCCCS monitors compliance via annual Operational Reviews (ORs) and implements Corrective Action Plans and technical assistance as needed.

c. Describe your state's tailored services to the older adult population with SMI. See the federal **Resources for Older Adults** webpage for resources[2]

RESPONSE - The 2022-2023 AHCCCS Delivery System Integration information outlines that all members have equitable coverage for physical, behavioral, children's rehabilitative or long term care services.
https://www.azahcccs.gov/shared/Downloads/2022_Delivery_SystemIntegration_10012022.pdf

AHCCCS' Arizona Long Term Care System (ALTCS) program has specific health plan Contractors that manage care for members who are Elderly and/or have a Physical Disability (E/PD) . The health plans provide services to AHCCCS members who are elderly (65 and over), blind, or disabled and at risk of institutionalization. ALTCS E/PD members receive all their medical care under the long term care program, including doctor's office visits, hospitalizations, prescriptions, lab work, long term services and supports, and behavioral health services. The ALTCS E/PD program is recognized as a national model for its success in supporting a high percentage of individuals who receive services in their own home or in the community rather than in institutional settings. In an effort to ensure that members have the opportunity to receive services in their own home, the ALTCS health plans, consistent with other health plans, are required to have a Housing Administrator to identify homeless members and/or members with affordable housing needs and leverage community partnerships or other resources to meet those needs.

AHCCCS aligns systems for members who are dually-eligible for Medicare and Medicaid. Being its own distinct and complex system of care with little to no interface with state Medicaid programs, the over 180,000 Arizonans with dual-eligibility can be overwhelmed by navigating these two separate systems and are more likely to fall through the cracks, receive inefficient care, and not achieve optimal health outcomes. As part of integrated care efforts, AHCCCS contracts with Medicare Advantage Dual Special Needs Plans (D-SNPs) that are each affiliated with its partner AHCCCS Complete Care Medicaid Health Plan. Requiring each ACC Medicaid health plan to offer a partner Medicare D-SNP promotes the enrollment or alignment of dual eligible members in the same health plan for both Medicare and Medicaid services to the greatest possible extent and allows dual eligible members to receive all of their health care services, including prescription drug benefits, from a single, integrated health plan.
https://www.azahcccs.gov/AHCCCS/Downloads/Initiatives/CY23_DSNP_ReferenceTables.pdf

MHBG subrecipients are held to contractual and policy language regarding the outreach of older adult populations to ensure services are being provided to Arizona's most vulnerable populations. AHCCCS monitors the adherence and compliance to these parameters through various reporting mechanisms, including annual Operational Reviews (ORs). The OR includes the submission of all documentation from the subrecipient to show the progress made, as well as any administration policies, to outreach and engage this population. If subrecipients do not meet the requirements through the OR process, AHCCCS develops a Corrective Action plan for the subrecipients and offers technical assistance as needed to the subrecipients.

d. Please indicate areas of technical assistance needs related to this section.

No technical assistance needs at this time

[1] **https://www.samhsa.gov/homelessness-programs-resources**

[2] https://www.samhsa.gov/resources-serving-older-adults

Criterion 5: Management Systems

States describe their financial resources, staffing, and training for mental health services providers necessary for the plan; provides for training of providers of emergency health services regarding SMI and SED; and how the state intends to expend this grant for the fiscal years involved.

Criterion 5

1. Describe your state's management systems.

RESPONSE - AHCCCS leverages several financial resources and funding streams to provide for a well-supported network of behavioral health providers to deliver covered services under the various contracted health plans. Although the Division of Grants and Innovation oversees administration of grants and other Non-Title XIX/XXI funding, AHCCCS staff work collaboratively across divisions to leverage county, state, and federal dollars (Title XIX/XXI and Non-Title XIX/XXI) effectively and appropriately for services included in the state plan. Title XIX/XXI funds provide care for members' physical and behavioral health care needs, including behavioral health prevention/promotion, treatment, recovery, and other support services under one Managed Care or Fee For Service health plan. Non-Title XIX/XXI funds provide coverage for additional mental health services not covered by Title XIX/XXI and also for certain members who are not eligible for Title XIX/XXI but meet other eligibility criteria including both uninsured and underinsured members. These other funding sources may include the Children's Behavioral Health Fund for children's services including SED, the Mental Health Block Grant (MHBG) for SED, SMI, and ESMI/FEP, Maricopa County, Pima and Coconino County funds for certain children's or SMI services and/or Court Ordered Evaluation/Pre-Petition Screening, SMI General Fund, SMI Housing General Fund, Supported Housing General Fund, SMI Housing Trust Fund, Emergency COVID-19 grant for members with co-occurring illness, COVID-19 Emergency Response for Suicide Prevention, and state crisis service dollars. Each funding source may have its own staffing or training requirements, while larger system training requirements are described below.

In accordance with ACOM Policy 407, AHCCCS requires that Contractors establish and maintain a Workforce Development Operation (WFDO) and employ a Workforce Development Administrator. The WFDO works with the MCO's Network and Quality Management functions to ensure the provider network has sufficient workforce capacity, and is staffed by a workforce that is interpersonally, clinically, culturally, and technically competent in the skills needed to provide services. The WFDO is the organizational structure MCOs utilize to monitor and assess current workforce capacity and capability, forecast and plan future workforce capacities and capabilities, and when indicated, deliver technical assistance to provider organizations to strengthen their Workforce Development (WFD) programs. AHCCCS further requires all MCOs to participate in a Single Learning Management System (LMS), and to collaborate with all other AHCCCS MCOs in using the LMS to administer the delivery, documentation, tracking and reporting of all required education and training programs.

AHCCCS requires that Contractors provide, at a minimum, annual training/s to support and develop law enforcement agencies' understanding of behavioral health emergencies and crises. Contractors are also contractually required to have regular and ongoing training for providers to assist members with how to access both Medicaid compensable services as well as Non-Medicaid funded services.

AHCCCS is committed to workforce development and support of the medical residency in the State of Arizona and expects MCOs to support these efforts. AHCCCS also requires that MCOs attempt to contract with graduating residents and providers that are opening new practices in/or relocating to Arizona, especially in rural or underserved areas. AHCCCS encourages MCOs to contract with or otherwise support the many Graduate Medical Education (GME) Residency Training Programs currently operating in the State and to investigate opportunities for resident participation in medical management and other committee activities.

In 2018, AHCCCS required all ACC Health Plans and the three RBHA Health Plans to jointly fund a contract between the AZ Association of Health Plans (AzAHP) and a learning management system (LMS) provider. The provider is responsible for operating a single, statewide LMS for the physical and behavioral health workforces. RELIAS was selected as the LMS provider and remains under contract to provide LMS support to the MCOs, RBHAs and Providers. The system is used by the workforces of provider organizations delivering physical and behavioral health services.

AHCCCS requires the use of an LMS in order to accomplish three goals:

1. To disseminate computer assisted policy and best practice education and training content to provider organizations across Arizona.
2. To collect and store training program transcripts and skill competency evaluations for provider staff and to ensure the transcripts and evaluations are available to staff and their employers upon request.
3. To report training or competency requirements compliance for all AHCCCS policies or mandated practices requiring specific staff training or competency demonstrations.

The RELIAS LMS automatically collects and stores individual staff training and evaluation records for computer disseminated training content. In addition, the LMS has the capability of supporting traditional in-person training and evaluation events and generating required compliance reporting. Included in the Relias LMS platform are training opportunities for the staff employed at the MCOs, RBHAs and providers to learn about the Mental Health Block Grant and services for members with SED, SMI, and/or ESMI/FEP.

AHCCCS continually assesses and updates training requirements based on identified areas of needs and to maintain current best program and practice expectations for all providers. Most recently, AHCCCS is contracting with Arizona's Peer and Support Training Academy to create and implement a mandated clinical supervisor training for all programs employing Peer Support Specialists within their programs to ensure this unique and necessary group of providers receive the clinical supervision required to successfully fulfill their job expectations.

AHCCCS divisions are sensitive and responsive to staffing and training needs for behavioral health services providers. For example, the AHCCCS Division for Fee for Service Management (DFSM) employs staff responsible for provider trainings, inclusive of behavioral health trainings. Some behavioral health trainings are posted online for ease of access for providers. If a provider has questions regarding billing and coding, they are routed to the AHCCCS coding team. Additionally, the AHCCCS Division of Community Advocacy and Intergovernmental Relations (DCAIR) conducts educational sessions for individuals in the system, ACC-RBHA staff/provider staff and other stakeholders on various topics. AHCCCS DCAIR and the Office of Individual and Family Affairs (OIFA), have also established training requirements and credentialing standards for Peer and Recovery Support Service (PRSS) providing Peer Support within the AHCCCS programs, including qualifications, supervision, continuing education, and training. These are a few examples of additional mechanisms by which AHCCCS may ensure training for mental health providers.

Additional training is available at the health plan level through their Workforce Development Administrators, and other staff or departments. Some Contractors utilize Project ECHO for optimizing performance and spreading new medical knowledge throughout the provider network in a manner allowing community providers to learn from specialists, from each other, and for specialists to learn from community providers as well.

CALOCUS/LOCUS/ECSII

AHCCCS implemented the Child and Adolescent Level of Care Utilization System (CALOCUS) as the standardized mechanism for determining the level of intensity in case management supports necessary for children age 6-18. Service intensity assessment and planning is a critical independent element of overall person and family-centered service planning and is a collaborative process between the person or family served and their service providers. Cultural considerations and social determinants of health impact all these dimensions, and the CALOCUS systematically matches individuals and families' dimensional ratings to specific defined levels of case management support to ensure that their needs are met.

The CALOCUS is considered best practice for assessment of service intensity across multiple dimensions, as follows:
1. Risk of Harm
2. Functional Status
3. Medical, Addictive and Psychiatric Co-Morbidity as well as Developmental Disabilities
4. Recovery Environment:
? A-Stressors
? B-Supports
5. Treatment and Recovery History
6. Engagement and Recovery Status

ASAM

AHCCCS has implemented the ASAM CONTINUUM® assessment tool across the state of Arizona to improve treatment outcomes with greater assessment fidelity and proper level of care placement. This assessment tool provides the entire treatment team with a computerized clinical standard decision support system for assessing members with substance use disorders and co-occurring conditions. This is an evidenced based practice (EBP) established by the American Society of Addiction Medicine (ASAM) to assist clinicians in determining levels of care for persons who have substance use disorders.

AHCCCS has collaborated with the with the Managed Care Organizations (MCO) Workforce Development Administrators, ASAM, FEI Systems and the Arizona Association of Health Plans (AzAHP) to have the ASAM CONTINUUM® assessment training videos hosted on the Relias Learning Management System (LMS) platform. This will assist with "ease of access/use" for clinicians and providers and allow for standardized training reports. Providers are expected to ensure that all staff completing the ASAM are trained prior to conducting the assessment.

Mental Health First Aid

AHCCCS has also implemented Mental Health First Aid Training in Arizona. Mental Health First Aid is an eight (8) hour training that is available to anyone age 16 and older interested in learning about mental health. Each session can accommodate 25-33 participants. Participants learn a valuable five (5) step process to assess a situation, select and implement appropriate interventions and help a person experiencing a crisis or who may be exhibiting the signs and symptoms of mental illness. AHCCCS offers the training for employees at AHCCCS and there are also several trainings available in communities throughout the state.

Telehealth is a mode of service delivery that has been used in clinical settings for over 60 years and empirically studied for just over 20 years. Telehealth is not an intervention itself, but rather a mode of delivering services. This mode of service delivery increases access to

screening, assessment, treatment, recovery supports, crisis support, and medication management across diverse behavioral health and primary care settings. Practitioners can offer telehealth through synchronous and asynchronous methods. A priority topic is increasing access to treatment for SMI and SUD using telehealth modalities. Telehealth is the use of telecommunication technologies and electronic information to provide care and facilitate client-provider interactions. Practitioners can use telehealth with a hybrid approach for increased flexibility. For instance, a client can receive both in-person and telehealth visits throughout their treatment process depending on their needs and preferences. Telehealth methods can be implemented during public health emergencies (e.g., pandemics, infectious disease outbreaks, wildfires, flooding, tornadoes, hurricanes) to extend networks of providers (e.g., tapping into out-of-state providers to increase capacity). They can also expand capacity to provide direct client care when in-person, face-to-face interactions are not possible due to geographic barriers or a lack of providers or treatments in a given area. However, implementation of telehealth methods should not be reserved for emergencies or to serve as a bridge between providers and rural areas. Telehealth can be integrated into an organization's standard practices, providing low-barrier pathways for clients and providers to connect to and assess treatment needs, create treatment plans, initiate treatment, and provide long-term continuity of care. States are encouraged to access the federal resource guide **Telehealth for the Treatment of Serious Mental Illness and Substance Use Disorders.**

2. Describe your state's current telehealth capabilities, how your state uses telehealth modalities to treat individuals with SMI/SED, and any plans/initiatives to expand its use.

RESPONSE - According to the Arizona Telemedicine Program at the University of Arizona, Arizona currently has over 100 companies offering a statewide spectrum of behavioral health and integrated health care services in telehealth format. Telehealth services are provided not only from individuals' immediate location, but also a variety of other settings including correctional facilities, rural hospitals, urban hospitals, educational institutions, Urgent Care Centers, and emergency departments. If an individual determined SMI, SED, ESMI/FEP or a SUD does not have access to the necessary technology, transportation to a location in which the technology is available is a covered service under both MHBG and SUPTRS. AHCCCS is currently assessing the need and capability to establish additional locations with telehealth capability in remote communities in rural Arizona further reducing the need and/or distance for transport. The Arizona Telemedicine Program at the University of Arizona and the Southwest Telehealth Resource Center was recently recognized as a "trendsetter in distance learning" by the United States Distance Learning Association and provides a service provider directory, telemedicine training, webinars, and updates regarding telehealth services throughout the state. Anyone can connect with these resources via Facebook, Instagram, LinkedIn, YouTube or at their website: https://telemedicine.arizona.edu/

In 2021, the Telehealth Advisory Committee was created and tasked with identifying best practice for telehealth in Arizona. In June 2022, the committee unanimously voted to adopt the Telehealth Advisory Committee Teleheath Best Practice Guidelines for Health Care Providers and provided the guide to the Arizona Governor, Arizona State Senate President, and Arizona House of Representatives Speaker of the House as required. The Telehealth Advisory Committee will continue to evaluate the need for revisions to this best practice guidelines list at a minimum of annually, including the ongoing review of national and other standards for telehealth best practices and relevant peer-reviewed literature. This report is found here: https://www.azahcccs.gov/AHCCCS/Downloads/TelehealthAdvisoryCommittee/Presentations/TAC_BestPracticesRecommendations2022.pdf.

AHCCCS Medical Policy 320-I Telehealth https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/300/320-I.pdf outlines the expectations in regard to telehealth services. In Arizona, there are no geographic restrictions for Telehealth; services delivered via Telehealth are covered by the Contractor and FFS programs in rural and urban regions. The Contractor and FFS programs may not limit or deny the coverage of services provided through Telehealth and may apply only the same limits or exclusions on a service provided through Telehealth that are applicable to an in-person encounter for the same service, except for services for which the weight of evidence, based on practice guidelines, peer-reviewed clinical publications or research or recommendations by the Telehealth advisory committee on Telehealth best practices established by A.R.S. § 36-3607, determines not to be appropriate to be provided through Telehealth.

3. Please indicate areas of technical assistance needs related to this section.

No technical assistance at this time.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Environmental Factors and Plan

7. Substance Use Disorder Treatment – Required for SUPTRS BG

Narrative Question

Criterion 1: Prevention and Treatment Services - Improving Access and Maintaining a Continuum of Services to Meet State Needs

Criterion 1

Improving access to treatment services

1. Does your state provide:

a) A full continuum of services (with medications for addiction treatment included in v-x):

i)	Screening	◉ Yes	○ No
ii)	Education	◉ Yes	○ No
iii)	Brief intervention	◉ Yes	○ No
iv)	Assessment	◉ Yes	○ No
v)	Withdrawal Management (inpatient/residential)	◉ Yes	○ No
vi)	Outpatient	◉ Yes	○ No
vii)	Intensive outpatient	◉ Yes	○ No
viii)	Inpatient/residential	◉ Yes	○ No
ix)	Aftercare/Continuing Care	◉ Yes	○ No
x)	Recovery support	◉ Yes	○ No

b) Services for special populations:

i)	Prioritized services for veterans?	◉ Yes	○ No
ii)	Adolescents?	◉ Yes	○ No
iii)	Older Adults?	◉ Yes	○ No

Criterion 2

Criterion 3

1. Does your state meet the performance requirement to establish and or maintain new programs or expand programs to ensure treatment availability? (●) Yes ( ) No

2. Does your state make prenatal care available to PWWDC receiving services, either directly or through an arrangement with public or private nonprofit entities? (●) Yes ( ) No

3. Does your state have an agreement to ensure pregnant women are given preference in admission to treatment facilities or make available interim services within 48 hours, including prenatal care? (●) Yes ( ) No

4. Does your state have an arrangement for ensuring the provision of required supportive services? (●) Yes ( ) No

5 Has your state identified a need for any of the following:

a) Open assessment and intake scheduling? (●) Yes ( ) No

b) Establishment of an electronic system to identify available treatment slots? (●) Yes ( ) No

c) Expanded community network for supportive services and healthcare? (●) Yes ( ) No

d) Inclusion of recovery support services? (●) Yes ( ) No

e) Health navigators to assist clients with community linkages? (●) Yes ( ) No

f) Expanded capability for family services, relationship restoration, and custody issues? (●) Yes ( ) No

g) Providing employment assistance? (●) Yes ( ) No

h) Providing transportation to and from services? (●) Yes ( ) No

i) Educational assistance? (●) Yes ( ) No

6. States are required to monitor program compliance related to activities and services for PWWDC. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

RESPONSE -

AHCCCS contracts with ACC-RBHAs to administer behavioral health services. ACC-RBHAs contract with a network of service providers similar to health plans to deliver a comprehensive array of services as outlined in the Non-Title XIX/XXI contract between AHCCCS and the ACC-RBHAs as well as the AHCCCS Medical Policy Manual (AMPM).

Programmatic oversight of the grant by AHCCCS provides an opportunity to receive information about PPW services and provide feedback on any concerns AHCCCS may have. Contracts between AHCCCS and the ACC-RBHAs include language for preferential access to care and provision of interim services, as needed which highlights the requirements for serving PPW.

ACC-RBHAs hold quarterly meetings with their providers about SUD. AHCCCS staff attends the meetings to monitor program compliance for the priority populations, and additional block grant requirements. These meetings serve as collaborative opportunities to disseminate information, address provider concerns, ensure that priorities of the block grant are met, and address any potential compliance issues promptly. AHCCCS sets expectations for prenatal providers to connect women who are pregnant to community resources, as outlined in AMPM 410, which is the AHCCCS policy for maternity care. The AHCCCS PPW SME as well as other subject matter experts (SMEs) including clinical and grant staff review policies annually and continuously improve the policies to ensure expectations are up to date, evidence-based, and clear for the ACCs, ACC-RBHAs, TRBHAs, and provider staff.

Deliverable related to PPW, SUBG, and Non-Title XIX/XXI requirements include the SUBG Performance Progress Report, the Priority Population Waitlist Report, the SUBG/MHBG annual plan, and SUBG/MHBG annual report to AHCCCS.
AHCCCS fiscal and program staff also review planned and actual expenditures to ensure that the system is meeting requirements related to SUBG women's services.

The AHCCCS Division of Behavioral Health and Housing (DBHH) also employs a Compliance Manager that assists the SUBG team in ensuring ACC-RBHAs and TRBHAs are in compliance with contract, agreement, and policy requirements. Additionally, the SUBG team meets regularly, typically monthly, with ACC-RBHAs as well as TRBHAs for oversight and monitoring as well as technical

assistance and support. The Compliance Manager also assists the SUBG team to deliver Corrective Action Plans as needed. In the case of a compliance concern with a TRBHA, the SUBG team works with the AHCCCS Division for Fee For Service Management (DFSM), the division that is responsible for overseeing the Intergovernmental Agreements (IGAs) with TRBHAs.

Operational Reviews

The AHCCCS Division for Managed Care (DMC) (formerly Division for Health Care Services) conducts annual Operational Reviews (ORs) with the ACC and ACC-RBHAs, which DBHH participates in as it pertains to block grant compliance. The most recent SUBG OR tool includes the following compliance measures as it relates to PPW:

1. The Contractor has established guidelines for allocations, required services for programs receiving block grant funds for pregnant women with their dependent children, related to the Substance Abuse Block Grant. [45 CFR 96.124]

? The Contractor treats the family as a unit and, therefore admits both women and their children into treatment services if appropriate.

? The Contractor provides or arranges for primary medical care for women who are receiving substance abuse services, including prenatal care. The Contractor provides or arranges for primary pediatric care for the women's children, including immunization.

? The Contractor provides or arranges for gender-specific substance abuse treatment and other therapeutic interventions for women that may address issues of relationships, sexual abuse, physical abuse, parenting and childcare while the women are receiving these services.

? The Contractor arranges for childcare while the women are receiving services.

? The Contractor provides or arranges for sufficient case management and transportation services to ensure that the women and their children have access to services.

2. The Contractor has established guidelines for treatment services for pregnant women, related to the Substance Abuse Block Grant. [45 CFR 96.131]

? The program gives preference in admission to pregnant women who seek or are referred for and would benefit from SUBG-funded treatment services.

? The program is required to refer pregnant women to the state when the program has insufficient capacity to provide services to any such pregnant women who seek the services of the program. However, AHCCCS SUBG grants team has not received any referrals for pregnant women as programs are able to prioritize them into their programs and/or refer to another appropriate provider.

? The program makes available interim services within 48 hours to pregnant women who cannot be admitted because of lack of capacity.

? The program provides or arranges for gender-specific substance abuse treatment and other therapeutic interventions for women that may address issues of relationships, sexual abuse, physical abuse, parenting and child care while the women are receiving these services.

? The program publicizes to women of services the fact that pregnant women receive preference in admission.

Independent Case Review

In accordance with the 45 CFR § 96.136 ICR Independent Peer Review, AHCCCS contracted with Mercer Government Human Services Consulting (Mercer) to develop and implement the Independent Case Review (ICR) process. Mercer conducted a review of member case files pertaining to members who received SUBG-funded services in State Fiscal Year 2024 (SFY24: July 1 2023-June 30 2024) to assess the quality, appropriateness, and efficacy of treatment services as documented in client records, including but not limited to activities and services for PWWDC. For the SFY24 report, Mercer updated their qualitative data collection component and continued the use of focus groups. These focus groups were conducted with AHCCCS providers and members who received services. To inform and facilitate the focus groups, Mercer used findings from the ICR to frame and guide discussion, allowing participants to comfortably participate in a collaborative learning environment, further enhancing program application and practice. This addition to the ICR provided valuable insight and context to the review findings from the case file reviews. The ICR final report is posted annually to the AHCCCS SUBG webpage upon completion https://www.azahcccs.gov/Resources/Grants/SABG/.

The ICR process serves as an opportunity to continuously improve treatment and recovery services provided to members with SUD in accordance with best practices, grant requirements, and program requirements, which can also relate to program compliance. Although this process typically is to assess the larger system and identify improvements for the system overall (not specific to provider compliance efforts),

AHCCCS PPW SME

The AHCCCS subject matter expert (SME) on the priority population of pregnant and postpartum women with dependent children (PPWDD) who are engaged in substance use disorder treatment participates in a variety of state-wide, cross-sector leadership groups that serve as a mechanism to share updates, best practices, identify and discuss referral pathways and challenges in connecting pregnant and postpartum women to the services and supports that they need to be successful. They maintain a distribution list of nearly 200 members, which is used to distribute policy updates, best practice information and updates, press releases, research findings, professional development and training opportunities, and other communications intended to improve treatment practice. When challenges are raised by providers, health plans, providers, collaborative partners, or when they are observed, that indicate system level concerns that are negatively affecting pregnant or parenting women the SME is well-positioned to elevate those concerns to the AHCCCS Assistant Director of the Division of Behavioral Health and Housing, or to the AHCCCS Chief Medical Officer, as needed.

The PPWDC SME is consulted during the development of scopes of work, task orders, deliverable submissions and other contract-level document development to ensure that the needs of this population are well-articulated, and that the programmatic

treatment deliverables are family–focused and place the mother-infant dyad as the focus of care. The PPWDC SME holds kick-off meetings with each project team, as well as regular standing meetings to discuss successes and challenges, problem solve proactively, and provide guidance and support in a collaborative way to both understand how the project is being implemented and how things are going. The PPWDC SME reviews high-level financial reimbursements, quantitative, and narrative data as part of the overall project monitoring process for each project.

Criterion 4,5&6

Persons Who Inject Drugs (PWID)

1. Does your state fulfill the:

a)	90 percent capacity reporting requirement?	(●) Yes	( ) No
b)	14-120 day performance requirement with provision of interim services?	(●) Yes	( ) No
c)	Outreach activities?	(●) Yes	( ) No
d)	Monitoring requirements as outlined in the authorizing **statute** and implementing **regulation**?	(●) Yes	( ) No

2. Has your state identified a need for any of the following:

a)	Electronic system with alert when 90 percent capacity is reached?	(●) Yes	( ) No
b)	Automatic reminder system associated with 14-120 day performance requirement?	( ) Yes	(●) No
c)	Use of peer recovery supports to maintain contact and support?	(●) Yes	( ) No
d)	Service expansion to specific populations (e.g., military families, veterans, adolescents, older adults)?	(●) Yes	( ) No

3. States are required to monitor program compliance related to activites and services for PWID. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

AHCCCS Oversight of ACC-RBHAs
AHCCCS contracts with ACC-RBHAs to administer behavioral health services. ACC-RBHAs contract with a network of service providers similar to health plans to deliver a comprehensive array of services as outlined in the Non-Title XIX/XXI contract between AHCCCS and the ACC-RBHAs as well as the AHCCCS Medical Policy Manual (AMPM).
Programmatic oversight of the grant by AHCCCS provides assurances that programs that serve PWID are following best practices for strategies and services such as outreach, syringe service programs, HIV prevention/early intervention programs, person-centered and customized treatment services, and recovery supports. Contracts between AHCCCS and the ACC-RBHAs include language for preferential access to care and provision of interim services, as needed which highlights the requirements for serving PWID. AHCCCS monitors for compliance with preferential access standards, including review of data submitted by health plans to the Medicaid claims and encounters system, ACC-RBHA, TRBHA, and other contractor deliverables, and implementing corrective action plans as appropriate. Language continues to be expanded to specifically match the block grant requirements through contracts between AHCCCS and the RBHAs and referenced in the AHCCCS Contractors Operations Manual (ACOM), and AMPM.
ACC-RBHAs hold standing meetings with their providers about SUD. AHCCCS staff attends the meetings to monitor program compliance for the priority populations, and additional block grant requirements. These meetings serve as collaborative opportunities to disseminate information, address provider concerns, ensure that priorities of the block grant are met, and address any potential compliance issues promptly.
AHCCCS Oversight of Sonoran Prevention Works (SPW)

SPW harm reduction program serves PWID through the following activities:
1. Naloxone distribution, education, and training for prescribers, pharmacists, AHCCCS members, and the general public.
2. Provide onsite access or immediate referral/linkages to healthcare, treatment, and wrap-around supports through a SSP in strict accordance with state and local law and SAMHSA guidance, or other evidence-based programming supporting the overall purpose of the harm reduction program.
3. Fentanyl testing strip distribution, education, and training for AHCCCS members and the general public.
4. Relationship and capacity building with key community stakeholders to promote the program and services offered to Arizonans in need of harm reduction strategies utilizing peer support and individuals with lived experience to assist Arizonans in their recovery journey.
5. Tailor harm reduction programming to meet the unique needs of women, including pregnant and parenting women

SPW prioritizes PWID via direct distribution of naloxone education and training. SPW has developed dozens of original trainings related to overdose, opioids, stimulants, supporting pregnant women who use drugs, and other harm reduction topics. SPW has provided education on fentanyl exposure, fentanyl testing strips, and overdose prevention upon fentanyl detection in a substance since 2017. This education has historically been targeted to PWID, encompassing regular and casual users as well as SABGSUBG priority populations. In 2018, SPW founded the Kingman Harm Reduction Program (KHRP) in response to the CDC

designating Mohave County as one of 220 U.S. counties vulnerable to HIV and HCV outbreaks due to injection drug use. Through KHRP, certified peer support staff provide harm reduction counseling, supplies such as syringes and outreach kits (wound care, hygiene, safer use, etc.), made referrals to ancillary services, and received overdose reversal reports. KHRP is a wraparound program in line with CDC recommendations - including sterile syringe disposal, rapid HIV/HCV screening, referrals and navigation to substance use and mental health treatment, naloxone and other overdose prevention supplies, connection to community services that impact the social determinants of health, and peer support.

SPW is required to conduct advisory board meetings, team meetings, and submit expenditure reports and deliverables to AHCCCS quarterly. Monthly expenditure reports present a way for AHCCCS to assure fiscal responsibility as SPW provides an accurate and detailed report along with back up documentation for allowable reimbursement of SABGSUBG grant fund expenditures. Deliverables serve as another way to monitor programmatic compliance as SPW is required to report with the following: include the number and type of training conducted includes county and city/town, the number of Naloxone doses and/or kits, fentanyl test strips, and harm reduction material distributed into the community. This includes the number of doses and/or kits distributed, the number of people reached with trainings, kits, and harm reduction material distribution, the number of reported opioid overdose reversals using Naloxone, fentanyl test strips, and other harm reduction material; and the number of individuals outreached/engaged, referred, and connected to treatment. In tandem, deliverables and monthly expenditure reports allow AHCCCS to ensure accountability and monitor compliance over SPWs activities during the funding period.

In addition, SPW has also incorporated an evaluation design into their method of approach to measure project performance, identify best practices, and facilitate continuous program improvement. Using the RE-AIM framework, SPW gathers data from program staff and participants through monthly programmatic reports and electronic health records. The data will track all measurable objectives, required reports, and reports for use by the advisory committee and executive team to ensure compliance with subcontractors.
Reimbursement Process
In addition to these programmatic efforts to conduct oversight efforts, programs funded by the COVID-19 Supplemental funds (otherwise known at AHCCCS as the Coronavirus Response and Relief Supplemental Appropriations Act (CRRSAA)) and SABGSUBG American Rescue Plan Act (ARPA) have an additional layer of oversight because they are paid to the subrecipients on a reimbursement basis. This means that AHCCCS program and finance staff have the opportunity to review and approve (or not approve) the expenditures requested for reimbursement by the Contractor before they are paid out. This provides an opportunity to flag questions of programmatic and fiscal concern that may relate to services provided to PWID and therefore address concerns with the Contractor.

Operational Review: An annual requirement to ensure Contractors satisfactorily meet AHCCCS requirements as specified in contract.

AHCCCS Medical Policy Manual (AMPM): Manual for covered services for NT-XIX/XXI populations, referenced by AHCCCS and Providers to ensure appropriate use of services. Updated annually.

Contracts & Deliverables: AHCCCS employs multiple contracts and service agreements to ensure appropriate use of SABGSUBG funds. Providers are required to regularly submit deliverables related to program progress, financial standing, and/or ad-hoc information as requested by AHCCCS.

Deliverables allow AHCCCS to monitor programmatic and fiscal compliance. With regularly submitted deliverables and expenditure reports, AHCCCS works to hold Contractors accountable to spend down allocated funds timely and ensures appropriate programmatic progress. Deliverables also provide a mutually beneficial relationship between AHCCCS and Contractors as it becomes a way of communication to better understand programming, community and organizational needs, clear expectations, and offers a channel of additional support throughout the project term.

Independent Peer Review:
The Annual Independent Peer Review assesses the quality, appropriateness, and efficacy of treatment services provided in the State. Although not specific to PWID, there is crossover between Opioid Use Disorder (OUD) and PWID in the following measures within the ICR: opioid specific treatment services: such as if the member's file documents a diagnosis of OUD, was provided Medications for Opioid Use Disorder (MOUD) education and referral, overdose education. Through this process, AHCCCS staff is able to extract data and information pertaining to PWID and use the results to identify barriers, opportunities, and work with ACC -RHBAs for process improvement and grant compliance.

For the SFY24 report, Mercer used a qualitative data collection component through the use of focus groups. These focus groups were conducted with providers, and members who received services. To inform and facilitate the focus groups, Mercer used findings from the ICR to frame and guide discussion. This addition to the ICR provided valuable insight and context to the review findings from the case file reviews. Although the ICR process typically is to assess the larger system and identify improvements for the system overall (not specific to provider compliance efforts), AHCCCS received feedback that the results of the ICR would be most useful if the results could be stratified at the provider level.

Tuberculosis (TB)

1. Does your state currently maintain an agreement, either directly or through arrangements with other public and nonprofit private entities to make available tuberculosis services to individuals receiving SUD treatment and to monitor the service delivery? (●) Yes ( ) No

2. Has your state identified a need for any of the following:

   a) Business agreement/MOU with primary healthcare providers? ( ) Yes (●) No

   b) Cooperative agreement/MOU with public health entity for testing and treatment? ( ) Yes (●) No

   c) Established co-located SUD professionals within FQHCs? ( ) Yes (●) No

3. States are required to monitor program compliance related to tuberculosis services made available to individuals receiving SUD treatment. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

   RESPONSE -

   AHCCCS supports Tuberculosis (TB) services making them available to individuals receiving SUD treatment through partnerships with the ACC-RBHAs, TRBHAs, and Arizona Department of Health Services (ADHS). Respectively, TB services are outlined in the Non-Title XIX/XXI contract, AMPM 320-T1, and in the Interagency Service Agreement (ISA) with ADHS. AHCCCS monitors program compliance through a deliverable required for the ACC-RBHAs, called a SABGSUBG TB Services Treatment Procedure and Protocol, through the ICR, Operational Reviews, and regular and ad hoc meetings with subrecipients of the grant.
   Pursuant to the 45 CFR Part 96 Sect. 127, AHCCCS is required to routinely make available TB services as defined in §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. AHCCCS passes this requirement down into contracting language to ensure all parties involved are aware and in compliance with TB requirements. The ACC-RBHAs are required to conduct site visits to SUBG providers as a part of their oversight and monitoring, and this is one way that the SUBG providers may be assessed for compliance.
   The Independent Case Review (ICR) also measures what percentage of case files reviewed include a documented screening for TB. AHCCCS uses this data source to communicate with the ACC-RBHAs about system improvement needs. ACC-RBHAs are then required to report back to AHCCCS on strategies used to correct issues identified by the ICR, which includes TB compliance.
   In an effort to enhance TB oversight, AHCCCS has made improvements in the SUBG team's relationship with the ADHS TB Officer and collaborates on how to best oversee the SUBG TB requirements. We made strides in this collaborative effort in 2024-2025, and we will continue to consult and collaborate with ADHS as the overseer of infectious diseases. AHCCCS and ADHS meet quarterly to oversee the TB, HIV, and Synar work.

Early Intervention Services for HIV (for "Designated States" Only)

1. Does your state currently have an agreement to provide treatment for persons with substance use disorders with an emphasis on making available within existing programs early intervention services for HIV in areas that have the greatest need for such services and monitoring such service delivery? (●) Yes ( ) No

2. Has your state identified a need for any of the following:

   a) Establishment of EIS-HIV service hubs in rural areas? ( ) Yes (●) No

   b) Establishment or expansion of tele-health and social media support services? ( ) Yes (●) No

   c) Business agreement/MOU with established community agencies/organizations serving persons with HIV/AIDS? ( ) Yes (●) No

Hypodermic Needle Prohibition

1. Does your state have in place an agreement to ensure that SUPTRS BG funds are NOT expended to provide individuals with hypodermic needles or syringes for the purpose of injecting illicit substances **(42 U.S.C.§ 300x-31(a)(1)(F))**? (●) Yes ( ) No

Criterion 8,9&10

Service System Needs

1. Does your state have in place an agreement to ensure that the state has conducted a statewide assessment of need, which defines prevention, and treatment authorized services available, identified gaps in service, and outlines the state's approach for improvement? (●) Yes ( ) No

2. Has your state identified a need for any of the following:

a) Workforce development efforts to expand service access? (●) Yes ( ) No

b) Establishment of a statewide council to address gaps and formulate a strategic plan to coordinate services? ( ) Yes (●) No

c) Establish a peer recovery support network to assist in filling the gaps? (●) Yes ( ) No

d) Incorporate input from special populations (military families, service members, veterans, tribal entities, older adults, persons experiencing homelessness)? (●) Yes ( ) No

e) Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, such as primary healthcare, public health, VA, and community organizations? (●) Yes ( ) No

Service Coordination

1. Does your state have a current system of coordination and collaboration related to the provision of person -centered care? (●) Yes ( ) No

2. Has your state identified a need for any of the following:

a) Identify MOUs/Business Agreements related to coordinate care for persons receiving SUD treatment and/or recovery services (●) Yes ( ) No

b) Establish a program to provide trauma-informed care (●) Yes ( ) No

c) Identify current and perspective partners to be included in building a system of care, such as FQHCs, primary healthcare, recovery community organizations, juvenile justice system, adult criminal justice system, and education. (●) Yes ( ) No

Charitable Choice

1. Does your state have in place an agreement to ensure the system can comply with the services provided by nongovernment organizations (**42 U.S.C.§ 300x-65**, 42 CF Part 54 (**§54.8(b) and §54.8(c)(4)**) and **68 FR 56430-56449**)? (●) Yes ( ) No

2. Does your state provide any of the following:

a) Notice to Program Beneficiaries? (●) Yes ( ) No

b) An organized referral system to identify alternative providers? (●) Yes ( ) No

c) A system to maintain a list of referrals made by religious organizations? (●) Yes ( ) No

Referrals

1. Does your state have an agreement to improve the process for referring individuals to the treatment modality that is most appropriate for their needs? (●) Yes ( ) No

2. Has your state identified a need for any of the following:

a) Review and update of screening and assessment instruments? (●) Yes ( ) No

b) Review of current levels of care to determine changes or additions? (●) Yes ( ) No

c) Identify workforce needs to expand service capabilities? (●) Yes ( ) No

Patient Records

1. Does your state have an agreement to ensure the protection of client records? (●) Yes ( ) No

2. Has your state identified a need for any of the following:

a) Training staff and community partners on confidentiality requirements? (●) Yes ( ) No

b) Training on responding to requests asking for acknowledgement of the presence of clients? (●) Yes ( ) No

c) Updating written procedures which regulate and control access to records? (●) Yes ( ) No

d) Review and update of the procedure by which clients are notified of the confidentiality of their records including the exceptions for disclosure? (●) Yes ( ) No

Independent Peer Review

1. Does your state have an agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers? (●) Yes ( ) No

2. Section 1943(a) of Title XIX, Part B, Subpart III of the Public Health Service Act (**42 U.S.C.§300x-52(a)**) and **45 §CFR 96.136** require states to conduct independent peer review of not fewer than 5 percent of the Block Grant sub-recipients providing services under the program involved.

a) Please provide an estimate of the number of Block Grant sub-recipients identified to undergo such a review during the fiscal year(s) involved.

36

3. Has your state identified a need for any of the following:

a) Development of a quality improvement plan? (●) Yes ( ) No

b) Establishment of policies and procedures related to independent peer review? (●) Yes ( ) No

c) Development of long-term planning for service revision and expansion to meet the needs of specific populations? (●) Yes ( ) No

4. Does your state require a Block Grant sub-recipient to apply for and receive accreditation from an independent accreditation organization, such as the Commission on the Accreditation of Rehabilitation Facilities (CARF), The Joint Commission, or similar organization as an eligibility criterion for Block Grant funds? ( ) Yes (●) No

If Yes, please identify the accreditation organization(s)

i) ☐ Commission on the Accreditation of Rehabilitation Facilities

ii) ☐ The Joint Commission

iii) ☐ Other (please specify)

Criterion 7&11

Group Homes

1. Does your state have an agreement to provide for and encourage the development of group homes for persons in recovery through a revolving loan program? (●) Yes ( ) No

2. Has your state identified a need for any of the following:

a) Implementing or expanding the revolving loan fund to support recovery home development as part of the expansion of recovery support service? (●) Yes ( ) No

b) Implementing MOUs to facilitate communication between block grant service providers and group homes to assist in placing clients in need of housing? (●) Yes ( ) No

Professional Development

1. Does your state have an agreement to ensure that prevention, treatment and recovery personnel operating in the state's substance use disorder prevention, treatment and recovery systems have an opportunity to receive training on an ongoing basis, concerning:

a) Recent trends in substance use disorders in the state? (●) Yes ( ) No

b) Improved methods and evidence-based practices for providing substance use disorder prevention and treatment services? (●) Yes ( ) No

c) Performance-based accountability? ( ) Yes (●) No

d) Data collection and reporting requirements? ( ) Yes (●) No

If the answer is No to any of the above, please explain the reason.

Prevention subrecipients are supported by a statewide evaluator that provides training on data collection and reporting requirements.

2. Has your state identified a need for any of the following:

a) A comprehensive review of the current training schedule and identification of additional training needs? (●) Yes ( ) No

b) Addition of training sessions designed to increase employee understanding of recovery support services? (●) Yes ( ) No

c) Collaborative training sessions for employees and community agencies' staff to coordinate and increase integrated services? ( ) Yes (●) No

d) State office staff training across departments and divisions to increase staff knowledge of programs and initiatives, which contribute to increased collaboration and decreased duplication of effort? ( ) Yes (●) No

3. Has your state utilized the Regional Prevention, Treatment and/or Mental Health Training and Technical Assistance Centers[1] (TTCs)?

a) Prevention TTC? (●) Yes ( ) No

b) SMI Adviser (●) Yes ( ) No

c) Addiction TTC? (●) Yes ( ) No

d) State Opioid Response Network? ( ) Yes (●) No

e) Strategic Prevention Technical Assistance Center (SPTAC) (●) Yes ( ) No

Waivers

*Upon the request of a state, the Secretary may waive the requirements of all or part of the sections **42 U.S.C.§ 300x-22(b)**,**300x-23**,**300x-24**, and **300x-28** (**42 U.S.C.§ 300x-32(e)**).*

1. Is your state considering requesting a waiver of any requirements related to:

a) Allocations regarding women (300x-22(b)) ( ) Yes (●) No

2. Is your state considering requesting a waiver of any requirements related to:

a) Intravenous substance use (300x-23) ○ Yes ◉ No

3. Is Your State Considering Requesting a Waiver of any Requirements Related to Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus (300x-24)

a) Tuberculosis ○ Yes ◉ No

b) Early Intervention Services Regarding HIV ○ Yes ◉ No

4. Is Your State Considering Requesting a Waiver of any Requirements Related to Additional Agreements (**42 U.S.C. § 300x-28**)

a) Improvement of Process for Appropriate Referrals for Treatment ○ Yes ◉ No

b) Professional Development ○ Yes ◉ No

c) Coordination of Various Activities and Services ○ Yes ◉ No

Please provide a link to the state administrative regulations that govern the Mental Health and Substance Use Disorder Programs.

Arizona Administrative Code Title 9. Health Services.

Chapter 21. Department of Health Services Behavioral Health Services for Persons with Serious Mental Illness https://apps.azsos.gov/public_services/Title_09/9-21.pdf

Chapter 10. Department of Health Services - Health Care Institutions: Licensing https://apps.azsos.gov/public_services/Title_09/9-10.pdf

Arizona Revised Statute Title 36 https://www.azleg.gov/arsDetail/?title=36

Chapter 1 State and Local Boards and Departments of Health

Chapter 2 State Health Institutions and Agencies

Chapter 5 Mental Health Services

Chapter 18 Alcohol and Drug Abuse

Chapter 28 Controlled Substances Prescription Monitoring Program

Chapter 34 Behavioral Health Services

---

[1] **https://www.samhsa.gov/technology-transfer-centers-ttc-program**

Footnotes:

Environmental Factors and Plan

8. Uniform Reporting System and Mental Health Client-Level Data (MH-CLD)/Mental Health Treatment Episode Data Set (MH-TEDS) – Required for MHBG

Narrative Question

Health surveillance is critical to the federal government's ability to develop new models of care to address substance use and mental illness. Health surveillance data provides decision makers, researchers, and the public with enhanced information about the extent of substance use and mental illness, how systems of care are organized and financed, when and how to seek help, and effective models of care, including the outcomes of treatment engagement and recovery. Title XIX, Part B, Subpart III of the Public Health Services Act **(42 U.S.C. §300x-52(a))**, mandates the Secretary of the Department of Health and Human Services to assess the extent to which states and jurisdictions have implemented the state plan for the preceding fiscal year. The annual report aims to provide information aiding the Secretary in this determination.

42 U.S.C. §300x-53(a) requires states and jurisdictions to provide any data required by the Secretary and cooperate with the Secretary in the development of uniform criteria for data collection. Data collected annually from the 59 MHBG grantees is done through the Uniform Reporting System (URS), Mental Health Client-Level Data (MH-CLD), and Mental Health Treatment Episode Data Set (MH-TEDS) as part of the MHBG Implementation Report. The URS is an initiative to utilize data in decision support and planning in public mental health systems, fostering program accountability. It encompasses 23 data tables collected from states and territories, comprising sociodemographic client characteristics, outcomes of care, utilization of evidence-based practices, client assessment of care, Medicaid funding status, living situation, employment status, crisis response services, readmission to psychiatric hospitals, as well as expenditures data. Currently, data are collected through a standardized Excel data reporting template. The MHBG program uses the URS, which includes the National Outcome Measures (NOMS), offering data on service utilization and outcomes. These data are aggregated by individual states and jurisdictions.

In addition to the aggregate URS data, Mental Health Client-Level Data (MH-CLD) are currently collected. SMHAs are state entities with the primary responsibility for reporting data in accordance with the reporting terms and conditions of the Behavioral Health Services Information System (BHSIS) Agreements funded by the federal government. The BHSIS Agreement stipulates that SMHAs submit data in compliance with the Community Mental Health Services Block Grant (MHBG) reporting requirements. The MH-CLD is a compilation of demographic, clinical attributes, and outcomes that are routinely collected by the SMHAs in monitoring individuals receiving mental health services at the client-level from programs funded or provided by the SMHA.

MH-TEDS is focused on treatment events, such as admissions and discharges from service centers. Admission and discharge records can be linked to track treatment episodes and the treatment services received by individuals. Thus, with MH-TEDS, both the individual client and the treatment episode can serve as a unit of analysis. In contrast, with MH-CLD, the client is the sole unit of analysis. The same set of mental health disorders for National Outcome Measures (NOMs) enumerated under MH-CLD is also supported by MH-TEDS. Thus, while both MH-TEDS and MH-CLD collect similar client-level data, the collection method differs.

Please note: *Efforts are underway to standardize the client level data collection by requiring states to submit client-level data through the MH-CLD system. Currently, over three-quarters of states participate in MH-CLD reporting. Starting in Fiscal Year 2028, MH-CLD reporting will be mandatory for all states. States that currently submit data through MH-TEDS are encouraged to begin transitioning their systems now and may request technical assistance to support this transition process*

This effort reflects the federal commitment to improving data quality and accessibility within the mental health field, facilitating more comprehensive and accurate analyses of mental health service provision, outcomes, and trends. This unified reporting system would promote efficiency in data collection and reporting, enhancing the reliability and usefulness of mental health data for policymakers, researchers, and service providers.

Please respond to the following items:

1. Briefly describe the SMHA 's data collection and reporting system and what level of data are reported currently (e.g., at the client, program, provider, and/or other levels).

As the State Mental Health Agency (SMHA), AHCCCS utilizes a comprehensive data system that includes multiple subsystems for tracking client eligibility and service encounters. This system feeds into a centralized data warehouse, which supports robust reporting capabilities. AHCCCS is able to collect and report data at various levels, including the client, provider, and program levels, with minimal restrictions. These capabilities enable the agency to monitor service delivery, evaluate outcomes, and support planning and oversight across the behavioral health system.

2. Is the SMHA 's current data collection and reporting system specific to mental health services or it is part of a larger data system? If

the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.).

AHCCCS, serving as Arizona's State Mental Health Agency (SMHA), operates a data collection and reporting system that is part of a larger, integrated Medicaid data system. This system captures a wide range of data beyond mental health services, including physical health, long-term care, and pharmacy services. Data are collected for various populations, including individuals enrolled in Medicaid, members of the Arizona Long Term Care System (ALTCS), and tribal populations served by Tribal Regional Behavioral Health Authorities (TRBHAs). In addition to system-wide data, AHCCCS also receives program-specific data directly from mental health service providers to support targeted reporting and oversight.

3. What is the current capacity of the SMHA in linking data with other state agencies/entities (e.g., Medicaid, criminal/juvenile justice, public health, hospitals, employment, school boards, education, etc.)?

AHCCCS, as Arizona's State Mental Health Agency (SMHA), has established data sharing agreements with several state agencies, enabling the linkage of member data across systems. This capacity allows AHCCCS to match and integrate data from entities such as Medicaid, the Department of Child Safety, the Department of Corrections, and public health agencies. These linkages support coordinated care, cross-system reporting, and improved service planning for individuals with complex needs, including those involved in the criminal justice system, child welfare, and other public programs.

4. Briefly describe the SMHA 's ability to report evidence-based practices (EBPs) including Early Serious Mental Illness (ESMI and Behavioral Health Crisis Services (BHCS) outcome data at the client-level.

AHCCCS does not consistently receive data that is explicitly flagged as Evidence-Based Practices (EBPs), Early Serious Mental Illness (ESMI), or Behavioral Health Crisis Services (BHCS). As a result, the agency must define and identify these services using available data sources, primarily through claims data and supplemental information submitted directly by providers. While this approach allows AHCCCS to track service utilization related to EBPs, ESMI, and BHCS, the ability to report client-level outcome data is limited and varies depending on the specificity and completeness of the data received.

5. Briefly describe the limitations of the SMHA 's existing data system.

One of the primary limitations of AHCCCS's current data system is the inability to consistently link individual services to specific funding sources—such as Medicaid, federal block grants, discretionary grants, or state and local funds—particularly for clients who are not Medicaid-eligible. This makes it challenging to track expenditures and outcomes by funding stream at the client level. Additionally, some data elements not captured in the claims and encounter systems must be obtained directly from health plans or providers, which can limit the completeness and timeliness of reporting.

6. What strategies are being employed by the SMHA to enhance data quality?

AHCCCS employs a comprehensive set of strategies to enhance data quality, including over 500 automated data edits and audits across its data systems. These checks help ensure accuracy, completeness, and consistency in reported data. In addition, AHCCCS has documented testing procedures and convenes dedicated workgroups that routinely review and validate data. These efforts support continuous improvement and help maintain the integrity of data used for reporting, planning, and oversight.

7. Please describe any barriers (staffing, IT infrastructure, legislative, or regulatory policies, funding, etc.) that would limit your state from collecting and reporting data to the federal government.

AHCCCS faces several barriers that impact its ability to collect and report data to the federal government. One of the most significant challenges is linking service provision to specific funding streams at the client level, particularly for individuals not covered by Medicaid. This limitation stems from the complexity of the service delivery system and the variety of funding sources involved. Additionally, there are challenges related to IT infrastructure and data availability, as some necessary data elements are not captured in claims or encounter systems and must be obtained directly from providers or health plans. AHCCCS has initiated workgroups to evaluate and improve its reporting capacity, including efforts to enhance the accuracy and completeness of Uniform Reporting System (URS) tables.

8. Please indicate areas of technical assistance needs related to this section.

AHCCCS is seeking technical assistance specifically focused on optimizing the use of our existing data systems to meet the Uniform Reporting System (URS) reporting requirements. While we have robust infrastructure in place, we would benefit from targeted guidance on how to align our current data elements and reporting processes with federal expectations, particularly in areas where data is not explicitly flagged or categorized. Support in interpreting URS specifications and integrating them into our workflows would significantly improve our reporting accuracy and efficiency.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Environmental Factors and Plan

9. Crisis Services – Required for MHBG, Requested for SUPTRS BG

Narrative Question

There is a mandatory 5 percent set-aside within MHBG allocation for each state to support evidence-based crisis systems. The statutory language outlines the following for the 5 percent set-aside:

> *…….to support evidence-based programs that address the crisis care needs of individuals with serious mental illnesses and children with serious emotional disturbances, which may include individuals (including children and adolescents) experiencing mental health crises demonstrating serious mental illness or serious emotional disturbance, as applicable.*
>
> *CORE ELEMENTS: At the discretion of the single State agency responsible for the administration of the program, the funds may be used to fund some or all of the core crisis care service components, as applicable and appropriate, including the following:*
>
> - *Crisis call centers*
> - *24/7 mobile crisis services*
> - *Crisis stabilization programs offering acute care or subacute care in a hospital or appropriately licensed facility, as determined by such State, with referrals to inpatient or outpatient care.*
>
> *STATE FLEXIBILITY: In lieu of expending 5 percent of the amount the State receives pursuant to this section for a fiscal year to support evidence-based programs as required a State may elect to expend not less than 10 percent of such amount to support such programs by the end of two consecutive fiscal years.*

A crisis response system has the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family.The expectation is that states will build on the emerging and growing body of evidence, including guidance developed by the federal government, for effective community-based crisis-intervention and response systems. Given the multi-system involvement of many individuals with M/SUD issues, the crisis system approach provides the infrastructure to improve care coordination, stabilization services to support reducing distress, and the promotion of skill development and outcomes, all towards managing costs and better investment of resources.

Several resources exist to help states. These include **Crisis Services: Meeting Needs, Saving Lives**, which consists of the **National Guidelines for Behavioral Health Coordinated System of Crisis Care** as well as an **Advisory: Peer Support Services in Crisis Care** There is also the **National Guidelines for Child and Youth Behavioral Health Crisis Care** which offers best practices, implementation strategies, and practical guidance for the design and development of services that meet the needs of children, youth, and their families experiencing a behavioral health crisis. Please note that this set aside funding is dedicated for the core set of crisis services as directed by Congress. Nothing precludes states from utilizing more than 5 percent of its MHBG funds for crisis services for individuals with serious mental illness or children with serious emotional disturbances. If states have other investments for crisis services, they are encouraged to coordinate those programs with programs supported by the 5 percent set aside. This coordination will help ensure services for individuals are swiftly identified and are engaged in the core crisis care elements.

When individuals experience a crisis related to mental health, substance use, and/or homelessness (due to mental illness or a co-occurring disorder), a no-wrong door comprehensive crisis system should be put in place. Based on the National Guidelines, there are three major components to a comprehensive crisis system, and each must be in place in order for the system to be optimally effective. These three-core structural or programmatic elements are: Crisis Call Center, Mobile Crisis Response Team, and Crisis Receiving and Stabilization Facilities.

Crisis Contact Center. In times of mental health or substance use crisis, 911 is typically called, which results in police or emergency medical services (EMS) dispatch. A crisis call center (which may provide text and chat services as well) provides an alternative. Crisis call centers should be made available statewide, provide real-time access to a live crisis counselor on a 24/7 basis, meet National Suicide Prevention Lifeline operational guidelines, and serve as "Air Traffic Control" to assess, coordinate, and determine the appropriate response to a crisis. In doing so, these centers should integrate and collaborate with existing 911 and 211 centers, as well as other applicable call centers, to ensure access to the appropriate level of crisis response. 211 centers serve as an entry point to crisis services in many states and provide information and referral to callers on where to obtain assistance from local and national social

services, government agencies, and non-profit organizations.

The public has become accustomed to calling 911 for any emergency because it is an easy number to remember, and they receive a quick response. Many of the crisis systems in the United States continue to use 911 for several reasons such as they are still building their crisis systems or because they have no mechanism to fund a call center separate from 911. However, they recognize that the sure way to minimize the involvement of law enforcement in a behavioral health crisis response is to divert calls from 911. There are basically three diversion models in operation at this time: (1) the 911-based system with dispatchers who forward calls to either law enforcement's responder team (law enforcement officer with a behavioral health professional) or to their Crisis Intervention Team (CIT) with law enforcement officers who have received Crisis Intervention Training, including awareness of mental health and substance use disorders, and related symptoms, de-escalation methods, and how to engage and connect people to supportive services; (2) the 911-based system with well-trained 911 dispatchers who triage calls to state or local crisis call centers for individuals who are not a threat to themselves or others; the call centers may then refer appropriate calls to local mobile response teams (MRTs), also called mobile crisis teams (MCTs); and (3) State or local Crisis Contact Centers with well-trained counselors who receive calls directly (without utilizing 911 at all) on their own toll-free numbers.

Mobile Crisis Response Team. Once a behavioral health crisis has been identified and a crisis line has been called, a mobile response may be required if the crisis cannot be resolved by phone alone. Historically, law enforcement has been dispatched to the location of the individual in crisis. But in an effective crisis system, mobile crisis teams, including a licensed clinician, should be dispatched to the location of the individual in crisis, accompanied by Emergency Medical Services (EMS) or police only as warranted. Ideally, peer support professionals would be integrated into this response. Assessment should take place on site, and the individual should be connected to the appropriate level of care, if needed, as deemed by the clinician and response team.

Crisis Receiving and Stabilization Facilities. In a typical response system, EMS or police would transport the individual in crisis either to an ED or to a jail. Crisis Receiving and Stabilization Facilities provide a cost-effective alternative. These facilities should be available to accept individuals by walk-in or drop-off 24/7 and should have a "no wrong door" policy that supports all individuals, including those who need involuntary services. When anyone arrives, including law enforcement or EMS who are dropping off an individual, the hand-off should be "warm" (welcoming), timely and efficient. These facilities provide assessment for, and treatment of mental health and substance use crisis issues, including initiating medications for opioid use disorder (MOUD), and also provide wrap-around services. The multi-disciplinary team, including peers, at the facility can work with the individual to coordinate next steps in care, to help prevent future mental health crises and repeat contacts with the system, including follow-up care.

Currently, the 988 Suicide and Crisis Lifeline (Lifeline) connects with local call centers throughout the United States. Call center staff is comprised of individuals who are trained to utilize best practices in handling behavioral health calls. Local call centers automatically engage in a safety assessment for every call; if an imminent risk exists and cannot be deescalated, they forward the call to either 911 or to a local mobile crisis team for a response. If there is no imminent risk, the call center will work with the individual (or the person calling on their behalf) for as long as needed or, if necessary, dispatch a local MRT.

988 – 3-Digit behavioral health crisis number. The National Suicide Hotline Designation Act (**P.L. 116-172**) provides an opportunity to support the infrastructure, service and long-term funding for community and state 988 response, a national 3-digit behavioral health crisis number that was approved by the Federal Communications Commission in July 2020. In July 2022, the National Suicide Prevention Lifeline transitioned to 988 Suicide & Crisis Lifeline, but the 1-800-273-TALK is still operational and directs calls to the Lifeline network. The 988 transition has supported and expanded the Lifeline network and will continue utilizing the life-saving behavioral health crisis services that the Lifeline and Veterans Crisis Line centers currently provide.

Building Crisis Services Systems. Most communities across the United States have limited, but growing, crisis services, although some have an organized system of services that provide on-demand behavioral health assessment and stabilization services, coordinate and collaborate to divert from jails, minimize the use of EDs, reduce hospital visits, and reduce the involvement of law enforcement. Those that have such systems did not create them overnight, but it involved dedicated individuals, collaboration, considerable planning, and creative methods of blending sources of funding.

1. Briefly describe your state's crisis system. For all regions/areas of your state, include a description of access to crisis contact centers, availability of mobile crisis and behavioral health first responder services, utilization of crisis receiving and stabilization centers.

RESPONSE -
Arizona's Medicaid programs have garnered acclaim for their innovative approach to behavioral health crisis services. The crisis care continuum overseen by AHCCCS (Arizona Health Care Cost Containment System) encompasses a comprehensive array of services designed to promptly stabilize individuals, facilitating their return to baseline functioning. This continuum includes crisis telephone response, crisis mobile team intervention, facility-based stabilization (including observation and detox), and all other covered services, available universally to Arizona residents regardless of insurance coverage.

AHCCCS manages the crisis care continuum through Regional Behavioral Health Agreements (RBHAs) acting as Managed Care Organizations (MCOs). These RBHAs are tasked with delivering crisis services such as crisis hotlines, text & chat, crisis mobile teams, and crisis receiving & stabilization centers across designated Geographical Service Areas (GSAs) on a 24/7/365 basis (366 days in leap years). Central to this operation is an adequately staffed crisis call center, pivotal in providing assessment, de-escalation support, and connections to further resources like crisis mobile teams or stabilization facilities.
Crisis Mobile Teams (CMTs) are pivotal in this framework, leveraging GPS technology for rapid deployment statewide. These teams, including a mandated 25% peer credentialing, ensure timely responses with specific benchmarks: 30 minutes for law enforcement calls, 60 minutes in urban Through these strategic initiatives, Arizona's crisis system aims to deliver effective and timely services tailored to meet the diverse needs of its residents, promoting recovery and overall well-being within the community. settings, and 90 minutes in rural areas. CMTs collaborate closely with crisis stabilization facilities, facilitating seamless transitions for individuals navigating the crisis continuum.
RBHAs establish and sustain crisis stabilization settings offering comprehensive 24-hour substance use disorder (SUD)/psychiatric crisis services, 23-hour crisis stabilization/observation, access to all FDA-approved Medication Assisted Treatment (MAT) options covered by AHCCCS, and short-term crisis stabilization services. Emphasizing a "no wrong door" policy, these facilities accept all referrals and streamline transfers from law enforcement and public safety agencies to ensure continuity of care.

2. In accordance with the guidelines below, identify the stages where the existing/proposed system will fit in.

*a) The **Exploration** stage: is the stage when states identify their communities' needs, assess organizational capacity, identify how crisis services meet community needs, and understand program requirements and adaptation.*
*b) The **Installation** stage: occurs once the state comes up with a plan and the state begins making the changes necessary to implement the crisis services based on the published guidance. This includes coordination, training and community outreach and education activities.*
*c) **Initial Implementation** stage: occurs when the state has the three-core crisis services implemented and agencies begin to put into practice the published guidelines.*
*d) **Full Implementation** stage: occurs once staffing is complete, services are provided, and funding streams are in place.*
*e) **Program Sustainability** stage: occurs when full implementation has been achieved, and quality assurance mechanisms are in place to assess the effectiveness and quality of the crisis services.*

Check one box for each row indicating state's stage of implementation

	Exploration Planning	Installation	Early Implementation Less than 25% of counties	Partial Implementation About 50% of counties	Majority Implementation At least 75% of counties	Program Sustainment
Someone to contact	☐	☐	☐	☐	☐	☑
Someone to respond	☐	☐	☐	☐	☐	☑
Safe place to be	☐	☐	☐	☐	☐	☑

3. Briefly explain your stages of implementation selections here.

All components of the Arizona crisis system continue to reside in the program sustainment phase of implementation.
The utilization of crisis services in Arizona has shown a consistent upward trajectory, notably increasing following the launch and promotion of the national lifeline, 988. The growing recognition of the benefits provided by crisis services, alongside reduced stigma, indicates continued escalation in demand for these critical services. In response, AHCCCS is committed to enhancing our system by rigorously monitoring network adequacy, service excellence, and individual outcomes. Furthermore, we are dedicated to strategically allocating resources to promote innovation and expand access to care.

4. Based on the National Guidelines for Behavioral Health Crisis Care and the **National Guidelines for Child and Youth Behavioral Health Crisis Care**, explain how the state will develop the crisis system.

According to SAMHSA's National Guidelines for Behavioral Health Crisis Care, the Arizona crisis system continues to be in the program sustainment stage. While in this phase, Arizona's efforts will concentrate on sustaining and continually enhancing the system's effectiveness and outcomes.
To align with the National Guidelines for Child and Youth Behavioral Health Crisis Care, Arizona continues to expand access to 24/7 crisis services tailored to youth, including mobile response teams and youth-friendly stabilization centers. The state is enhancing coordination across systems like schools, child welfare, and juvenile justice, while ensuring culturally competent care that reaches underserved and rural communities.
Workforce development remains a key area of Arizona focus, as we increase the training of professionals in trauma-informed, youth-centered care and integrating peer and family support roles. Finally, Arizona has a robust data system to monitor outcomes and continuously improve service quality in line with SAMHSA's standards

5. Other program implementation data that characterizes crisis services system development.

Someone to contact: Crisis Contact Capacity

a. Number of locally based crisis call Centers in state

i. In the 988 Suicide and Crisis lifeline network: 1

ii. Not in the suicide lifeline network: 0

b. Number of Crisis Call Centers with follow up protocols in place

i. In the 988 Suicide and Crisis lifeline network: 1

ii. Not in the suicide lifeline network: 0

c. Estimated percent of 911 calls that are coded out as BH related: 0

Someone to respond: Number of communities that have mobile behavioral health crisis mobile capacity (in comparison to the toal number of communities)

a. Independent of public safety first responder structures (police, paramedic, fire): 104

b. Integrated with public safety first responder structures (police, paramedic, fire): 0

c. Number that utilizes peer recovery services as a core component of the model: 0

Safe place to be

a. Number of Emergency Departments: 0

b. Number of Emergency Departments that operate a specialized behavioral health component: 0

c. Number of Crisis Receiving and Stabilization Centers (short term, 23-hour units that can diagnose and stabilize individuals in crisis): 16

6. Briefly describe the proposed/planned activities utilizing the 5% set aside. If applicable, please describe how the state is leveraging the CCBHC model as a part of crisis response systems, including any role in mobile crisis response and crisis follow-up. As a part of this response, please also describe any state-led coordination between the 988 system and CCBHCs.

Proposed activities utilizing the 5% MHBG Crisis set-aside include:

1. Crisis Hotlines and Helplines: Enhancing or maintaining access to state-operated crisis hotlines and helplines providing 24/7 support via call, text, or chat options, ensuring immediate access to trained professionals for individuals in crisis.

2. Mobile Crisis Response Teams: Strengthening mobile crisis response teams to swiftly intervene in community crisis situations, delivering on-site support and de-escalation services.

3. Crisis Stabilization Centers: Establishing or enhancing crisis stabilization centers as alternatives to emergency room admissions, offering short-term, intensive care for individuals experiencing crises.

4. Crisis Intervention Training: Providing crisis intervention training to first responders, law enforcement, and healthcare professionals to improve their capacity to identify and assist individuals in mental health crises.

5. Peer Support Programs: Investing in peer support programs where individuals with personal experience in mental health crises provide empathetic guidance to those currently in crisis.

6. Outreach and Prevention Efforts: Launching community outreach and prevention initiatives aimed at early identification of individuals at risk of crisis, providing timely support to prevent escalation.

Crisis System Integration: Facilitating improved integration and coordination among crisis services, mental health facilities, law enforcement, and social support programs to enhance the overall effectiveness of crisis response efforts.

7. Please indicate areas of technical assistance needs related to this section.

Currently, there are no identified areas requiring technical assistance.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Environmental Factors and Plan

10. Recovery – Required for MHBG & SUPTRS BG

Narrative Question

Recovery supports and services are essential for providing and maintaining comprehensive, quality behavioral health care. The expansion in access to; and coverage for, health care drives the promotion of the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals. Recovery encompasses the spectrum of individual needs related to those with mental health and substance use disorders.

Recovery is supported through the key components of health (access to quality physical health and M/SUD treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of a recovery- guided approach to person-centered care is inclusive of shared decision-making, culturally welcoming and sensitive to social needs of the individual, their family, and communities. Because mental and substance use disorders can be chronic relapsing conditions, long term systems and services are necessary to facilitate the initiation, stabilization, and management of recovery and personal success over the lifespan.

The following working definition of recovery from mental and/or substance use disorders has stood the test of time:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

In addition, there are 10 identified guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see **Working Definition of Recovery.**

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Technical assistance and training on a variety of such services are available through the several federally supported national technical assistance and training centers. States are strongly encouraged to take proactive steps to implement and expand recovery support services and collaborate with existing RCOs and RCCs. Block Grant guidance is also available at the **Recovery Support Services Table**.

Because recovery is based on the involvement of peers/people in recovery, their family members and caregivers, SMHAs and SSAs should engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing organizations and direct resources for enhancing peer, family, and youth networks such as RCOs and RCCs and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing, and monitoring the state behavioral health treatment system.

1. Does the state support recovery through any of the following:

a) Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care? (●) Yes ( ) No

b) Required peer accreditation or certification? (●) Yes ( ) No

c) Use Block Grant funds for recovery support services? (●) Yes ( ) No

d) Involvement of people with lived experience /peers/family members in planning, implementation, or evaluation of the impact of the state's behavioral health system? (●) Yes ( ) No

2. Does the state measure the impact of your consumer and recovery community outreach activity? (●) Yes ( ) No

3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.

RESPONSE - SAMHSA, defines recovery as "the process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential."

In Arizona, we have Peer-Run Organizations, Family-Run Organizations, and Specialty Providers that provide services to these populations based on the principles of recovery and resiliency. Recovery support services are for all AHCCCS members including adults with a serious mental illness designation. AHCCCS requires all members with a designation of SMI or SED be offered recovery support services during the initial planning process. These services are provided to many specialty populations including members involved in the justice system, dual diagnosis, in tribal communities, and faith- based organizations. These services include peer support and credentialed family support. All individuals providing peer support and/or credentialed family support are credentialed as Peer Recovery Support Specialists (PRSS) through an AHCCCS approved training program.

Credentialed family support training is established in AHCCCS policy including elements for children with SED. Credentialed family support (CFSS) is provided by family members of children with SED who have completed training and credentialing with state approved curricula. This applies the peer principle to family support which traditionally can be provided by individuals without "lived experience." CFSS ensures that those providing the service can relate to those they are serving as peers with shared lived experience of raising children with SED.

AHCCCS Policy AMPM Exhibit 300-3 establishes the 9 Guiding Principles of Adult System of Care and Arizona Vision and 12 Principles for Children's System of Care as outlined below. These principles came directly from members and family members to guide us as the State Medicaid Authority in the fundamental values of recovery in the adult system and resiliency in the children's system.

The ASOC developed the following Nine Guiding Principles to promote recovery in the adult behavioral health system and for engaging with adults who have a serious mental illness:

1. RESPECT: Respect is the cornerstone. Meet the person where they are without judgment, with great patience and compassion.

2. PERSONS IN RECOVERY CHOOSE SERVICES AND ARE INCLUDED IN PROGRAM DECISIONS AND PROGRAM DEVELOPMENT EFFORTS: A person in recovery has choice and a voice. Their self-determination in driving services, program decisions, and program development is made possible, in part, by the ongoing dynamics of education, discussion, and evaluation, thus creating the "informed consumer" and the broadest possible palette from which choice is made. Persons in recovery should be involved at every level of the system, from administration to service delivery.

3. FOCUS ON INDIVIDUAL AS A WHOLE PERSON, WHILE INCLUDING AND/OR DEVELOPING NATURAL SUPPORTS: A person in recovery is held as nothing less than a whole being: capable, competent, and respected for their opinions and choices. As such, focus is given to empowering the greatest possible autonomy and the most natural and well-rounded lifestyle. This includes access to and involvement in the natural supports and social systems customary to an individual's social community.

4. EMPOWER INDIVIDUALS TAKING STEPS TOWARDS INDEPENDENCE AND ALLOWING RISK TAKING WITHOUT FEAR OF FAILURE: A person in recovery finds independence through exploration, experimentation, evaluation, contemplation, and action. An atmosphere is maintained whereby steps toward independence are encouraged and reinforced in a setting where both security and risk are valued as ingredients promoting growth.

5. INTEGRATION, COLLABORATION, AND PARTICIPATION WITH THE COMMUNITY OF ONE'S CHOICE:
A person in recovery is a valued, contributing member of society and, as such, is deserving of and beneficial to the community. Such integration and participation underscores one's role as a vital part of the community, the community dynamic being inextricable from the human experience. Community service and volunteerism is valued.

6. PARTNERSHIP BETWEEN INDIVIDUALS, STAFF, AND FAMILY MEMBERS/NATURAL SUPPORTS FOR SHARED DECISION MAKING WITH A FOUNDATION OF TRUST: A person in recovery, as with any member of a society, finds strength and support through partnerships. Compassion-based alliances with a focus on recovery optimization bolster self-confidence, expand understanding in all participants, and lead to the creation of optimum protocols and outcomes.

7. PERSONS IN RECOVERY DEFINE THEIR OWN SUCCESS: A person in recovery – by their own declaration – discovers success, in part, by quality of life outcomes, which may include an improved sense of well-being, advanced integration into the community,

and greater self-determination. Persons in recovery are the experts on themselves, defining their own goals and desired outcomes.

8. STRENGTHS-BASED, FLEXIBLE, RESPONSIVE SERVICES REFLECTIVE OF AN INDIVIDUAL'S CULTURAL PREFERENCES: A person in recovery can expect and deserves flexible, timely, and responsive services that are accessible, available, reliable, accountable, and sensitive to cultural values and mores. A person in recovery is the source of his/her own strength and resiliency. Those who serve as supports and facilitators identify, explore, and serve to optimize demonstrated strengths in the individual as tools for generating greater autonomy and effectiveness in life.

9. HOPE IS THE FOUNDATION FOR THE JOURNEY TOWARDS RECOVERY: A person in recovery has the capacity for hope and thrives best in associations that foster hope. Through hope, a future of possibility enriches the life experience and creates the environment for uncommon and unexpected positive outcomes to be made real. A person in recovery is held as boundless in potential and possibility.
In addition, Arizona/AHCCCS collaborated with the child, family, and others to provide services that are tailored to meet the needs of children with serious emotional disturbances and their caregivers. The goal is to ensure that services are provided to the child and family in the most appropriate setting, in a timely manner, in accordance with the best practices and respecting the child, family and their cultural heritage.

Arizona/AHCCCS developed The Twelve (12) Principles for Children's in the Behavioral Health Service Delivery System:

1. COLLABORATION WITH THE CHILD AND FAMILY: Respect for and active collaboration with the child and parents is the cornerstone to achieving positive behavioral health outcomes. Parents and children are treated as partners in the assessment process, and the planning, delivery, and evaluation of behavioral health services, and their preferences are taken seriously.

2. FUNCTIONAL OUTCOMES: Behavioral health services are designed and implemented to aid children to achieve success in school, live with their families, avoid delinquency, and become stable and productive adults. Implementation of the behavioral health services plan stabilizes the child's condition and minimizes safety risks.

3. COLLABORATION WITH OTHERS: When children have multi-agency, multi-system involvement, a joint assessment is developed and a jointly established behavioral health services plan is collaboratively implemented. Client centered teams plan and deliver services. Each child's team includes the child and parents and any foster parents, any individual important in the child's life who is invited to participate by the child or parents. The team also includes all other persons needed to develop an effective plan, including, as appropriate, the child's teacher, DCS and/or DDD caseworker, and the child's probation officer. The team (a) develops a common assessment of the child's and family's strengths and needs, (b) develops an individualized service plan, (c) monitors implementation of the plan, and (d) makes adjustments in the plan if it is not succeeding.

4. ACCESSIBLE SERVICES: Children have access to a comprehensive array of behavioral health services, sufficient to ensure that they receive the treatment they need. Plans identify transportation the parents and child need to access behavioral health services, and how transportation assistance will be provided. Behavioral health services are adapted or created when they are needed but not available.

5. BEST PRACTICES: Competent individuals who are adequately trained and supervised provide behavioral health services. They are delivered in accordance with guidelines adopted by ADHS that incorporate evidence-based "best practice." Behavioral health service plans identify and appropriately address behavioral symptoms that are reactions to death of a family member, abuse or neglect, learning disorders, and other similar traumatic or frightening circumstances, substance abuse problems, the specialized behavioral health needs of children who are developmentally disabled, maladaptive sexual behavior, including abusive conduct and risky behavior, and the need for stability and the need to promote permanency in class member's lives, especially class members in foster care. Behavioral Health Services are continuously evaluated and modified if ineffective in achieving desired outcomes.

6. MOST APPROPRIATE SETTING: Children are provided behavioral health services in their home and community to the extent possible. Behavioral health services are provided in the most integrated setting appropriate to the child's needs. When provided in a residential setting, the setting is the most integrated and most home-like setting that is appropriate to the child's needs.

7. TIMELINESS: Children identified as needing behavioral health services are assessed and served promptly.

8. SERVICES TAILORED TO THE CHILD AND FAMILY: The unique strengths and needs of children and their families dictate the type, mix, and intensity of behavioral health services provided. Parents and children are encouraged and assisted to articulate their own strengths and needs, the goals they are seeking, and what services they think are required to meet these goals.

9. STABILITY: Behavioral health service plans strive to minimize multiple placements. Service plans identify whether a class member is at risk of experiencing a placement disruption and, if so, identify the steps to be taken to minimize or eliminate the risk. Behavioral health service plans anticipate crises that might develop and include specific strategies and services that will be employed if a crisis develops. In responding to crises, the behavioral health system uses all appropriate behavioral health services to help the child remain at home, minimize placement disruptions, and avoid the inappropriate use of the police and criminal

justice system. Behavioral health service plans anticipate and appropriately plan for transitions in children's lives, including transitions to new schools and new placements, and transitions to adult services.

10. RESPECT FOR THE CHILD AND FAMILY'S UNIQUE CULTURAL HERITAGE: Behavioral health services are provided in a manner that respects the cultural tradition and heritage of the child and family. Services are provided in Spanish to children and parents whose primary language is Spanish.

11. INDEPENDENCE: Behavioral health services include support and training for parents in meeting their child's behavioral health needs, and support and training for children in self-management. Behavioral health service plans identify parents' and children's need for training and support to participate as partners in assessment process, and in the planning, delivery, and evaluation of services, and provide that such training and support, including transportation assistance, advance discussions, and help with understanding written materials, will be made available.

12. CONNECTION TO NATURAL SUPPORTS: The behavioral health system identifies and appropriately utilizes natural supports available from the child and parents' own network of associates, including friends and neighbors, and from community organizations, including service and religious organizations.

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state. i.e., RCOs, RCCs, peer-run organizations.

RESPONSE - Peer recovery support services are available to all AHCCCS members, including those with substance use disorders, with specialty training and support specifically to members with opioid use disorders. Peer and Recovery Support Specialists (PRSS) serving members with SUD, have substantial representation within Arizona's recovery support workforce. PRSS who serve members with SUD are employed in many settings including within Medication for Opioid Use Disorder (MOUD) programs.

Recovery support services are offered to members in all stages of treatment and all levels of care. Outpatient clinics, residential facilities, inpatient facilities, and MOUD facilities all have necessary recovery support services to help ensure the best chance at recovery. These services are provided both in office and in the community. Recovery support services can help provide support and assistance in gaining and growing a community support system as well as teach important independent living skills.

The AHCCCS Medical Policy Manual (AMPM 310-B) outlines coverage for PRSS Medicaid members including children and adults while the AMPM 300-2B outlines covered services for Non-Medicaid funding such as SUBG, which includes Peer Services. AMPM 963 Peer and Recovery Support Service Provision Requirements such as qualifications for the PRSS, continuing education, supervision of PRSS by a BHT or BHP, training standards, and the approval process, among others.

In addition to the coverage of recovery and peer support through both Title XIX/XXI and Non-Title XIX/XXI funding streams, the SUBG funds additional recovery efforts through the ACC-RBHAs, TRBHAs and the Sonoran Prevention Works harm reduction program. Examples include:
? Oxford House - a democratic, self-run, peer-run sober living environment that provides a housing option with an environment conducive to recovery for members in recovery from SUD
? The Barbell Saves Project - a gym for and by people in recovery from SUD that implements recovery programming around physical fitness and holistic health, highlighting the impacts that the support of peers and health and fitness focus can have on maintaining sobriety
? Supporting to expansion of PRSS through hiring and training additional PRSS across the BH provider network and system, including placement of PRSS in the crisis system
? Community Medical Service's pilot implementation of the Recovery Path application
? Valle Del Sol's implementation of recovery coaches re-engaging member when they no-show to the clinic
? Connie Hillman house implementing programs for supporting parenting individuals in recovery
? Engagement specialists provision of recovery toolbox groups

5. Does the state have any activities that it would like to highlight?

All policies overseeing Recovery services are informed and guided directly by stakeholders including behavioral health service providers, RBHAs/TRBHAs, and members who receive said services and their professional and personal support systems.

6. Please indicate areas of technical assistance needs related to this section.

No technical assistance requested at this time

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Environmental Factors and Plan

11. Children and Adolescents M/SUD Services – Required for MHBG, Requested for SUPTRS BG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SUPTRS BG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health disorder and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community.[1] Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24.[2] For youth between the ages of 10 and 14 and young adults between the ages of 25 and 34, suicide is the second leading cause of death and for youth and young adults between 15 and 24, the third leading cause of death.[3]

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started using substances the age of 18. Of people who started using substances before the age of 18, one in four will develop a substance use disorder compared to one in 25 who started using substances after age 21.[4]

Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance use, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, states are encouraged to designate a point person for children to assist schools in assuring identified children relate to available prevention services and interventions, mental health and/or substance use screening, treatment, and recovery support services.

Since 1993, the federally funded Children's Mental Health Initiative (CMHI) has been used as an approach to build the system of care model in states and communities around the country. This has been an ongoing program with 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then, states have also received planning and implementation grants for adolescent and transition age youth SUD and MH treatment and infrastructure development. This work has included a focus on formal partnership development across child serving systems and policy change related to financing, workforce development, and implementing evidence-based treatments.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the functioning of children, youth and young adults in home, school, and community settings. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult, and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs.[5]

According to data from the 2017 Report to Congress on systems of care, services reach many children and youth typically underserved by the mental health system.

1. improve emotional and behavioral outcomes for children and youth.
2. enhance family outcomes, such as decreased caregiver stress.
3. decrease suicidal ideation and gestures.
4. expand the availability of effective supports and services; and
5. save money by reducing costs in high-cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

The expectation is that states will build on the well-documented, effective system of care approach. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes:

1. non-residential services (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);
2. supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education

and employment); and

3. residential services (e.g., therapeutic foster care, crisis stabilization services, and inpatient medical withdrawal management).

---

[1]Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children - United States, 2005-2011. MMWR 62(2).

[2]Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593-602.

[3]Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from www.cdc.gov/injury/wisqars/index.html.

[4]The National Center on Addiction and Substance use disorder at Columbia University. (June, 2011). Adolescent Substance use disorder: America's #1 Public Health Problem.

[5]Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from **https://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings-Executive-Summary/PEP12-CMHI0608SUM**

Please respond to the following items:

1. Does the state utilize a system of care approach to support:

a) The recovery of children and youth with SED? (●) Yes ( ) No

b) The resilience of children and youth with SED? (●) Yes ( ) No

c) The recovery of children and youth with SUD? (●) Yes ( ) No

d) The resilience of children and youth with SUD? (●) Yes ( ) No

2. Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address M/SUD needs:

a) Child welfare? (●) Yes ( ) No

b) Health care? (●) Yes ( ) No

c) Juvenile justice? (●) Yes ( ) No

d) Education? (●) Yes ( ) No

3. Does the state monitor its progress and effectiveness, around:

a) Service utilization? (●) Yes ( ) No

b) Costs? (●) Yes ( ) No

c) Outcomes for children and youth services? (●) Yes ( ) No

4. Does the state provide training in evidence-based:

a) Substance use prevention, SUD treatment and recovery services for children/adolescents, and their families? (●) Yes ( ) No

b) Mental health treatment and recovery services for children/adolescents and their families? (●) Yes ( ) No

5. Does the state have plans for transitioning children and youth receiving services:

a) to the adult M/SUD system? (●) Yes ( ) No

b) for youth in foster care? (●) Yes ( ) No

c) Is the child serving system connected with the Early Serious Mental Illness (ESMI) services? (●) Yes ( ) No

d) Is the state providing trauma informed care? (●) Yes ( ) No

6. Describe how the state provides integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

RESPONSE - AHCCCS requires all health plans, regardless of the type, amount, duration, scope, service delivery method, and

population served to ensure that their service delivery systems:
1. Coordinate and provide access to high-quality health care services informed by evidence-based practice guidelines in a cost-effective manner
2. Coordinate and provide access to high-quality health care services that are culturally and linguistically appropriate, maximize personal and family voice and choice, and incorporate a trauma-informed care approach
3. Coordinate and provide access to preventive and health promotion services, including wellness services
4. Coordinate and provide access to comprehensive care coordination and transitional care across settings; follow-up from inpatient to other settings; participation in discharge planning; and facilitating transfer from the children's system to the adult system of health care
5. Coordinate and provide access to chronic disease management support, including self-management support
6. Conduct behavioral health assessment and service planning following a Health Home model
7. Coordinate and provide access to peer and family delivered support services, based on member's needs, voice, and choice
8. Provide covered services to members in accordance with all applicable Federal and State laws, regulations, and policies
9. Coordinate and integrate clinical and non-clinical health-care related needs and services across all systems
10. Implement health information technology to link services, facilitate communication among treating professionals and between the health team and individual and family caregivers
11. Deliver services by providers that are appropriately licensed or certified, operating within their scope of practice, and registered as an AHCCCS provider.

AHCCCS further requires that at all ACC Plans work in partnership to meet, agree upon, and create in writing joint collaborative protocols with each County, District, or Regional Office of:
1. Administrative Office of the Courts
2. Juvenile Probation and Adult Probation
3. Arizona Department of Corrections and Arizona Department for Juvenile Corrections
4. Arizona Department of Child Safety (DCS)
5. Tribal Nations and Providers (Refer to this section above)
6. The Veterans Administration and
7. The County jails.

In order to coordinate the delivery of services to members served by both/all involved entities, ACC plans must ensure that each collaborative protocol addresses, at a minimum, the procedures for each entity.

AHCCCS ACC plans are contractually required to report on performance measures that consider underlying performance, performance gaps, reliability and validity, feasibility, and alignment. These performance measures are also evaluated based on several demographics to reduce, to the extent practical, health disparities based on age, race, ethnicity, sex, primary language, and disability status. These measures are used to evaluate whether ACC Plans are fulfilling key contractual obligations and are an important element of the agency's approach to transparency in health services and Value Based Purchasing (VBP). ACC Plans performance is publicly reported on the AHCCCS website (e.g., report cards and rating systems), as well as other means, such as the sharing of data with state agencies and other community organizations and stakeholders. ACC Plans performance is compared to AHCCCS requirements, with the national NCQA Medicaid Mean (for NCQA HEDIS ® measures) and the CMS Medicaid Median (for CMS Core Set Only measures) for the associated measurement period serving as the performance target for each contractually required performance measure. ACC-RBHAs providing SUPTRS BG and MHBG services are contractually required to submit quarterly, bi-annual and/or annual reports which are reviewed by the prospective teams and discussed at monthly meetings as needed.

MHBG-Specific Examples

For the youth population identified as experiencing First Episode Psychosis (FEP) or Serious Emotional Disturbances (SED), AHCCCS ensures providers are coordinating with an array of community services, including but not limited to: treatment services including outreach, engagement/reengagement, peer support, individual, family and group therapies, educational support, medication management, medical services, Federally Qualified Health Centers (FQHCs), school-based service programs, case management, suicide prevention and ideation services, crisis intervention, skills training and development, and family preservation services.

AHCCCS has recently contracted with The Innovations Institute, a founding member of the National Wraparound Initiative (NWI) and the National Wraparound Implementation Center (NWIC) to develop and procure a Arizona based Center of Excellence in the implementation of Wraparound, FOCUS, and MRSS installation. NWIC provides training, coaching, systems level technical assistance, research/evaluation and enhances distance coaching options to states and organizations implementing Wraparound. Wraparound is an evidence-based model of care coordination that is utilized for children diagnosed with SED and/or CALOCUS score of 4 or higher; FOCUS modernizes traditional case management models and operationalizes values within a system of care framework for youth with lesser complex needs than the intensity of Wraparound but remain at risk of intensified system involvement including custody/involvement with Department of Child Services (DCS) or juvenile justice involvement or whose needs exceed the resources of a single organization or a family's capacity to gain access to needed supports and services. Mobile Response and Stabilization Services (MRSS) is a child, youth, and family specific crisis intervention model that meets a parent/caregiver's sense or urgency with a child/youth demonstrates escalating behavioral health and/or substance use

symptomatology with the goal of in home de escalation and intervention reducing the need for immediate higher level of care.

Within the next year, all First Episode Psychosis programs throughout Arizona will be actively utilizing the Coordinated Specialty Care (CSC) model for treatment to standardize expectations for service delivery and to improve member outcomes statewide. AHCCCS is collaborating with and supporting all ACC-RBHAs as they expand and/or bolster FEP services throughout the state including additional treatment locations in highly populated areas and efforts for mobile FEP service delivery, training, and technical assistance for previously underserved frontier areas of Arizona.

AHCCCS providers also focus on services and programs that address school violence related to mental health through Youth Engagement Specialists that are trained to outreach and assess the needs of these youth populations and ensure refer to services are occurring as needed. The Youth Engagement Specialists are trained in assessment and suicide prevention and work with students referred by schools for behavioral health services. These supportive services are offered to students through tele-health and in-person appointments. AHCCCS providers continue to build relationships with school districts within each Geographic Service Area (GSA), with many partnerships within local schools already in place to ensure coordination of services between youth identified as at risk.

AHCCCS is currently utilizing supplemental MHBG funding to expand services within these vulnerable populations through the building and identification of additional services and providers for children and adolescents. AHCCCS will ensure providers are building partnerships with key stakeholders for these populations to ensure youth services are inclusive of all areas of need. These additional projects include the following items:

Children/Adolescents with SED/FEP
? Implementation of a statewide standardized process for early identification and referral for SED assessment.
? Implementation of an SED assessment and determination process to standardize identification and utilization statewide
? Implementation of co-located models of care and strengthening of evidence-based practice delivery for justice involved youth.
? Implementation of a Child Psychiatry Access Program (CPAP) to expand access to child and adolescent psychiatrists for Primary Care Providers (PCPs)
? Creation of electronic crisis services locator and bed registry
? Expansion of the availability of parent and family support services, Child and Family Team (CFT) coaches, and professional development opportunities to support the behavioral health workforce.
? Development of 23 hour crisis child and adolescent observation units in Central and Northern Arizona
? Development of statewide intensive crisis wraparound teams
? Wraparound, FOCUS, and MCSS Center of Excellence

SUPTRS BG-specific examples

To better serve youth who are most at risk for substance use disorder, AHCCCS is utilizing SUPTRS BG funding to launch several new projects within the continuum of care that target adolescents.

? Service providers are developing opportunities to cultivate youth with lived experience to serve as peer support as adults. AHCCCS is referring to this as pre-peer support. Programming includes mentorship programs, youth-led community projects, and youth development programs collaboratively implemented with American Indian tribes, justice system partners, and youth diversion.
? Detention Centers employ Behavioral Health Technicians and Clinicians to administer assessments for youth without an existing community-based treatment relationship. This improves continuity of care for youth in detention settings.
? Expansion of Juvenile Justice Engagement Team (JJET) Liaisons to include services for juveniles in qualified detention facilities. JJET's primary purpose is to resolve service barriers and other concerns for Probation, families, or other treatment stakeholders while juveniles temporarily reside in detention facilities.
? AHCCCS' plan also includes non-billable outreach and coordination staff for qualified detention centers and billable Covered Services to include substance use disorder treatment and support services. Individual therapy, case management, and Teen AA classes are most offered to juveniles in a detention setting.

Building upon the work of the PPW-PLT learning collaborative, AHCCCS is using SUPTRS BG funding to support programs that integrate SUD treatment with health and family service agencies with a focus on pregnant and postpartum women and their babies and children.

? Service providers are offering maternal mental health programs that support the complex OB and substance use disorder needs of pregnant and postpartum women in recovery. Services include the provision of MAT (Medication Assisted Treatment) modalities through data-waivered, office-based opioid treatment counselors, expanding both perinatal and postpartum depression programs and family support services.
? Detoxification programs for substance-exposed newborns and supportive services to their mothers are being offered together, serving the mother/baby dyad. Parenting courses are a key component of programming.
? Supported independent living programs utilize outpatient services for women in substance use disorder who are living with their children while in recovery. In these programs, treatment is designed to replicate a full-time job. Women are engaged in

services 40 hours per week and childcare is provided. Case management, group processing, individual counseling, life skills (budgeting, scheduling, meal planning etc.), vocational services, and 12 step meetings are offered.

7. Does the state have any activities related to this section that you would like to highlight?

8. Please indicate areas of technical assistance needs related to this section.

No technical assistance needed at this time

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Environmental Factors and Plan

12. Suicide Prevention – Required for MHBG, Requested for SUPTRS BG

Narrative Question

Suicide is a major public health concern, it is a leading cause of death nationally, with over 49,000 people dying by suicide in 2022 in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance use, painful losses, exposure to violence, economic and financial insecurity, and social isolation. Mental illness and substance use are possible factors in 90 percent of deaths by suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, M/SUD agencies are urged to lead in ways that are suitable to this growing area of concern. M/SUD agencies are encouraged to play a leadership role on suicide prevention efforts, including shaping, implementing, monitoring, care, and recovery support services among individuals with SMI/SED.

Please respond to the following items:

1. Have you updated your state's suicide prevention plan since the FY2024-2025 Plan was submitted? (●) Yes ( ) No

2. Describe activities intended to reduce incidents of suicide in your state.

RESPONSE - In Arizona, our state suicide prevention team is housed within our sister agency, the Arizona Department of Health Services (AZDHS). AZDHS partners with multiple stakeholders, including AHCCCS, in creating and implementing recommendations outlined in the Suicide Prevention Action Plan. This plan is updated bi-annually and can be located here: https://www.azdhs.gov/prevention/tobacco-chronic-disease/suicide-prevention/index.php

The primary goals of our state plan to address suicide in Arizona include ensuring suicide prevention resources, crisis support, and treatment services are universally available to clinicians, communities, families, and survivors; utilizing current community trends in order to best address emergent threats and direct future efforts; supporting disproportionately affected persons and populations with focused interventions that are appropriate and delivered with cultural humility and respect; supporting state prevention efforts by serving as a focal point for internal and external coalitions and partnerships; and improving the resilience of individuals and communities.

AHCCCS implements, oversees, and supports multiple programs and projects to carry out the goals outlined in the Suicide Prevention Plan. Initiatives and activities intended to reduce incidents of suicide are imbedded into all elements of our behavioral health delivery system.

An integral part of suicide prevention is accessible, high quality intervention in times of crisis. Arizona's crisis services are often referenced as an example among Medicaid programs. SAMHSA recently described Arizona as a "pace car" state in regard to our innovative approach to behavioral health crisis services. The AHCCCS model approaches crisis care with a "no wrong door" policy and offers a comprehensive array of ancillary crisis services that are available to any Arizona resident, regardless of insurance coverage, and exemplifies SAMHSA's guidelines of "someone to call, someone to respond and a safe place to receive help." Crisis services are required to be recovery-oriented, person focused, and work to stabilize the individual as quickly as possible to assist them in returning to their baseline of functioning. All interventions are required to be offered in a clinically and culturally appropriate manner that respects the preferences of the individual in crisis, while recognizing the need to maintain safety.

Arizona's crisis services utilize a braided funding model including Medicaid, State Appropriated, Block Grant, and other funding that allows our Managed Care Organizations (MCO's) with Regional Behavioral Health Agreements (RBHAs) to support this no wrong door model throughout Arizona's crisis care continuum. This braided funding prioritizes immediate service provision and funding can be assigned after a crisis has been resolved.

AHCCCS utilizes the Regional Behavioral Health Agreements (RBHAs) as the Managed Care Organizations (MCOs) responsible for the full continuum of crisis services to all individuals within their assigned Geographical Service Area (GSA) to prevent a potentially dangerous condition, episode, or behavior. AHCCCS Medical Policy 590 - Behavioral Health Crisis Services and Care Coordination - https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/500/590.pdf specifies how AHCCCS defines a crisis and outlines RBHA's responsibilities in providing the continuum of crisis care. The crisis care continuum includes crisis telephone response, mobile crisis teams, facility-based stabilization (including observation and detox), and all other associated covered services delivered by crisis service providers. AHCCCS and the RBHAs contract with a single provider, Solari, to ensure consistency in the crisis call center process by utilizing a single provider as opposed to coordinating services through several agencies.

Arizona's State Crisis Line and the 988 National Suicide Prevention Lifeline are integrated to provide a live answer response to all callers 24 hours a day, 7 days a week. AHCCCS and the Arizona Department of Health Services partnered to fund a substantial media campaign to increase awareness and encourage use of the 988 Suicide and Crisis Prevention Lifeline. Call center staff are qualified behavioral health professionals (BHP) and/or behavioral health technicians (BHT) under the supervision of a BHP and are trained to assess caller needs, provide deescalation support, and connect callers to additional supports such as crisis mobile teams or crisis stabilization facilities if the caller's crisis cannot be resolved by phone. By operating the call center as a hub, call center staff are able to maintain contact with the callers while establishing a warm hand off to other services providers including directly dispatching crisis mobile teams and arranging transportation for callers who prefer to go to a 24/7 crisis stabilization facility. For individuals who disclose their identity and are already enrolled in an AHCCCS Medicaid program, the call center is required to provide notification to the plan of enrollment within 24 hours to ensure follow up and support during and after the crisis episode. For individuals not actively enrolled in an AHCCCS Medicaid program who may be uninsured or underinsured, the

RBHA is required to ensure the provision of continued support to the individual for up to 72 hours to confirm that the crisis is resolved and ensure the person is connected to community support and services available in their area (e.g. behavioral health services, counseling, support groups, faith based organizations, food banks, housing support and/or other resources dependent upon member's needs). Call centers are required to adhere to SAMHSA's National Guidelines for Behavioral Health Crisis Care, National Suicide Lifeline Policy for Helping Callers at Imminent Risk of Suicide, and partner in Zero Suicide efforts. Call center counselors are also able to connect callers to Warm Lines operated by credentialed peers for ongoing connection and support if requested.

Crisis Mobile Teams (CMT) dispatched by the call center use GPS technology to identify the team closest to the caller. CMT's are available to respond to all areas of the state 24 hours a day, 7 days a week. CMT composition is outlined in contract and policy including a requirement to employ no less than 25% credentialed peers. The RBHAs are required to ensure that CMTs respond to requests for assistance from Law enforcement within 30 minutes of request, community members in urban areas within 60 minutes of request, and to community members in rural areas within 90 minutes of request. Data verifying response times are provided to and monitoring by AHCCCS via monthly deliverables. Crisis Mobile teams that are not able to support a person in resolving the crisis in the community are able to coordinate directly with a crisis stabilization facility and provide transportation to a facility when needed. This direct coordination ensures a warm hand off and minimizes the amount of duplication a person has to endure when moving through the crisis continuum.

RBHAs are required to establish and maintain crisis stabilization settings that provide 24-hour SUD/psychiatric crisis stabilization services and 23-hour crisis stabilization/observation capacity, crisis stabilization services that provide access to all Food and Drug Administration (FDA) approved MAT options covered under the AHCCCS Drug List, short-term crisis stabilization services in an effort to successfully resolve the crisis and return the individual to the community instead of transitioning to a higher level of care, accept all referrals adhering to a "no wrong door" approach, and ensure streamlined practices for swift and easy transfer of individuals from law enforcement and public safety personnel.

The RBHAs are additionally required to provide community information about crisis services and develop and maintain collaborative relationships with community partners including: fire, police, emergency medical services, hospital Emergency Departments (EDs), AHCCCS Health Plans, Tribal partners and other providers of public health and safety services. RBHAs provide regular Crisis Intervention Team (CIT) training and Mental Health First Aid to law enforcement (LE) and other community partners, including federal and tribal entities. RBHAs encourage two-way connections between LE and behavioral health providers in their communities to enhance relationships and better support individuals experiencing behavioral health crises who engage with law enforcement.

Recognizing that consistent, proactive, and ongoing quality behavioral health care to address factors leading to a behavioral health crisis reduces the risk of suicide, AHCCCS requires that RBHA Contractors ensure individuals receive a Post-Crisis Care Plan and ensure that post-crisis care coordination and service delivery occur to address the individual's ongoing needs and ensure resolution of the crisis. AHCCCS Policy 1040 - Outreach, Engagement, and Re-Engagement for Behavioral Health: https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/1000/1040.pdf outline essential elements of clinical practice and mandate the provision of critical activities regarding service delivery with the AHCCCS System of Care including:

1. Establish expectations for the engagement of members seeking or receiving behavioral health services.
2. Determine procedures to re-engage members who have withdrawn from participation in the behavioral health treatment process.
3. Describe conditions necessary to end re-engagement activities for members who have withdrawn from participation in the treatment process, and
4. Determine procedures to minimize barriers for serving members who are attempting to re-engage with behavioral health services.

The policy also outlines requirements for ensuring providers are eliciting active engagement in treatment planning policies, following up after significant and/or critical events (including member involvement in the behavioral health crisis system within 72 hours and member discharge from inpatient services no later than 7 days following discharge), refusal to adhere to prescribed psychotropic medication schedule, when a member changes location or when there is a change in the individual's level of care.

The ability of an individual to access and obtain transportation to integrated services to address their needs also reduces suicide risk. As such, AHCCCS Contractor Operations Manual Policy 417 - Appointment Availability, Transportation Timelines, Monitoring, and Reporting: https://www.azahcccs.gov/shared/Downloads/ACOM/PolicyFiles/400/417_Appointment_Availability_Monitoring_and_Reporting.pdf establishes appointment accessibility and availability standards and establishes a common process for Contractors to monitor and report appointments accessibility and availability including provision of a comprehensive provider network and standards to validate adequacy of their established network, written policies and procedures about educating its provider network regarding appointment time requirements, and general appointment standards for all contractors. Urgent Need General Behavioral Health appointments need occur "as expeditiously as the member's health condition requires but not later than 24 hours from identification of need" and Routine Care Appointments as follows:

? Initial assessment within seven calendar days of referral or request for service
? The first behavioral health service following the initial assessment as expeditiously as the member's health condition requires but, for members ages 18 years or older, no later than 23 calendar days after the initial assessment, and for members under the age of 18 years old, no later than 21 days after the initial assessment.
? All subsequent behavioral health services, as expeditiously as the member's health condition requires but no later than 45 calendar days from identification of need.

In 2019, the Arizona State legislature passed ARS 15-120: https://www.azleg.gov/ars/15/00120.htm also known as the Mitch Warner Act, mandating that all public school staff who interaction with students grades 6 through 12 be trained in suicide prevention that includes: training in suicide prevention, training to identify the warning signs of suicidal behavior in adolescents

and teens, and appropriate intervention and referral techniques. Jake's Law requires that schools have a policy for behavioral health referrals and a process for obtaining parental consent and post it on their website. The Arizona School Board Association has created a policy with assistance from AHCCCS and ADE to assist school districts with the statutory requirements for Jake's Law. AHCCCS, in coordination with the Arizona Department of Education (ADE) and Arizona Department of Health Service, select multiple school suicide prevention training curricula from which schools can choose to train their staff. These, along with additional resources for schools, are posted annually on the AHCCCS website with direct links to curriculum information and a request form for schools who want to receive training. The ADE prioritizes training to school staff, however, also offers training to community members across the state.

In March 2020, the Arizona Legislature charged ADHS with establishing a Suicide Mortality Review (SMR) to develop a data collection system and evaluate the incidences and causes of death by suicide within the state. AHCCCS leadership serve on the team to examine and evaluate circumstances surrounding a death by suicide in order to:

? Identify specific barriers and service systems issues experienced in suicide deaths.

? Identify significant risk factors and trends in suicides.

? Identify potential protective factors that may decrease suicide risk.

? Improve the delivery of services to individuals, families, and community members.

? Analyze the adequacy of state and local laws, trainings, and services to recommend what changes are needed to decrease the occurrences of preventable suicides and, as appropriate, take steps to implement these changes.

? Inform local and state suicide prevention strategies.

? Educate the public regarding the incidences and causes of suicide as well as the public's role in preventing suicide deaths.

Additionally, the state SMR Team is charged with developing standards and protocols to assist with the formation of local multi-disciplinary suicide mortality review teams to better understand and address county-level needs and make recommendations and take appropriate actions to reduce the number of preventable suicides. AHCCCS utilizes the information to influence policy and protocol revisions in addition to innovative use of all funding sources to eliminate barriers and service system issues identified.

3. Have you incorporated any strategies supportive of the Zero Suicide Initiative? (●) Yes ( ) No

4. Do you have any initiatives focused on improving care transitions for patients with suicidal ideation being discharged from inpatient units or emergency departments? (●) Yes ( ) No

If yes, please describe how barriers are eliminated.

RESPONSE - AHCCCS has partnered with and allocated MHBG ARPA funding to our Regional Behavioral Health Agreement in that GSA, AZ-CH North, to establish short term transitional residential facilities for youth transitioning out of crisis. The project is underway with facilities in Mohave and Coconino counties being renovated to house two dually licensed facilities providing crisis stabilization and short term transitional residential services for youth. The project also provides additional funding for local behavioral health home providers to increase crisis intervention, care coordination, and high needs care management services for this population.

Recognizing that uninsured or underinsured individuals with suicidal ideation being admitted/discharged from inpatient units and/or emergency departments face barriers to fluid and/or timely transition to outpatient services based on a lack of medical coverage, AHCCCS is revising policies, procedures, and NTIX contracts to expand the utilization of MHBG set-aside funding for Early Serious Mental Illness (ESMI). These revisions will provide coverage to individuals with a recently diagnosed SMI for up to 90 days allowing for additional professional assessment, monitoring, medication management and case management during the time it takes to complete/process both a Medicaid application and a SMI Determination (qualifying a person for long-term SMI coverage in Arizona) in addition to concurrent planning for ongoing service provision should the individual not qualify for Medicaid or be determined SMI. Ensuring fluid access to care during this critical time reduces suicide risk not only in the short term due based on accessibility to less restrictive intervention in this high-risk time of need, but also improves long-term outcomes as people learn that when they come to the system for help, the system effectively provides them with what they need to manage symptoms. This confidence in the system's dependability decreases the discouragement, solitude, and hopelessness related to managing symptoms including suicidal ideation.

5. Have you begun any prioritized or statewide initiatives since the FFY 2024 - 2025 plan was submitted? (●) Yes ( ) No

If so, please describe the population of focus?

RESPONSE - AHCCCS has increased utilization of population-based suicide prevention science. AHCCCS partnered with the Arizona Coalition for Military Families (ACMF) on the Be Connected Initiative to further suicide prevention resources to those who are served in the military and their families, including the development of a gun hygiene tool kit called "Secure Your Weapon." This toolkit is used statewide at gun ranges and with Veteran groups to reduce the rate of suicide by firearm.

The Suicide Prevention Team has worked to identify potential health and behavioral health clinics hospitals and other partners that could adopt or have already adopted the Zero Suicide Model and is promoting adoption of the ZSM in Arizona hospitals and behavioral health clinics. ADHS established internal and external workgroups, including AHCCCS, with the intent of soliciting input and creating buy-in across the state. Foundational planning for ZSM is ongoing with possible inclusion into Arizona's medical infrastructure as a priority for the 2023-2025 Suicide Prevention Action Plan.

A statewide initiative to reduce access to lethal means has been implemented through sharing take-back information on the ADHS Suicide Prevention website as well as beginning community level listening sessions to identify recommendations for reducing the number of firearm-related suicides in Arizona.

AHCCCS partnered with ADHS to fund a campaign advertising the availability of 988 crisis services throughout Arizona. The rollout of this statewide marketing campaign is underway in order to increase public awareness of the crisis services.

In partnership with the American Foundation for Suicide Prevention, AHCCCS contributed funding and expanded distribution of Local Outreach to Survivors of Suicides (LOSS) materials to all Arizona's counties to raise community awareness and support survivors of suicide in addition to identifying volunteers in high priority rural counties to help lead LOSS activities including counseling.

6. Please indicate areas of technical assistance needs related to this section.

No technical assistance requested at this time

Footnotes:

Environmental Factors and Plan

13. Support of State Partners – Required for MHBG & SUPTRS BG

Narrative Question

The success of a state's MHBG and SUPTRS BG programs will rely heavily on the strategic partnerships that SMHAs and SSAs have or will develop with other health, social services, community-based organizations, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The State Medicaid Authority agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations.
- The state justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with M/SUD who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment.
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that prioritize risk and protective factors for mental and substance use disorders, and, for those youth with or at-risk of M/SUD, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;
- The state public housing agencies which can be critical for the implementation of Olmstead.
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and
- The state's emergency management agency and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in M/SUD needs and/or impact persons with M/SUD and their families and caregivers, providers of M/SUD services, and the state's ability to provide M/SUD services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in M/SUD.
- The state's agency on aging which provides chronic disease self-management and social services critical for supporting recovery of older adults with M/SUD.
- The state's intellectual and developmental disabilities agency to ensure critical coordination for individuals with ID/DD and co-occurring M/SUD.
- Strong partnerships between SMHAs and SSAs and their counterparts in physical health, public health, and Medicaid, Medicare, state, and area agencies on aging and educational authorities are essential for successful coordinated care initiatives. While the State Medicaid Authority (SMA) is often the lead on a variety of care coordination initiatives, SMHAs and SSAs are essential partners in designing, implementing, monitoring, and evaluating these efforts. SMHAs and SSAs are in the best position to offer state partners information regarding the most effective care coordination models, connect current providers that have effective models, and assist with training or retraining staff to provide care coordination across prevention, treatment, and recovery activities.
- SMHAs and SSAs can also assist the state partner agencies in messaging the importance of the various coordinated care initiatives and the system changes that may be needed for success with their integration efforts. The collaborations will be critical among M/SUD entities and comprehensive primary care provider organizations, such as maternal and child health clinics, community health centers, Ryan White HIV/AIDS CARE Act providers, and rural health organizations. SMHAs and SSAs can assist SMAs with identifying principles, safeguards, and enhancements that will ensure that this integration supports key recovery principles and activities such as person-centered planning and self-direction. Specialty, emergency and rehabilitative care services, and systems addressing chronic health conditions such as diabetes or heart disease, long-term or post-acute care, and hospital emergency department care will see numerous M/SUD issues among the persons served. SMHAs and SSAs should be collaborating to educate, consult, and serve patients, practitioners, and families seen in these systems. The full integration of community prevention activities is equally important. Other public health issues are impacted by M/SUD issues and vice versa. States should assure that the M/SUD system is actively engaged in these public health efforts.
- Enhancing the abilities of SMHAs and SSAs to be full partners in implementing and enforcing MHPAEA and delivery of health system improvement in their states is crucial to optimal outcomes. In many respects, successful implementation is dependent on leadership and

collaboration among multiple stakeholders. The relationships among the SMHAs, SSAs, and the state Medicaid directors, state housing authorities, insurance commissioners, prevention agencies, child-serving agencies, education authorities, justice authorities, public health authorities, and HIT authorities are integral to the effective and efficient delivery of services. These collaborations will be particularly important in the areas of Medicaid, data and information management and technology, professional licensing and credentialing, consumer protection, and workforce development.

Please respond to the following items:

1. Has your state added any new partners or partnerships since the last planning period? (●) Yes ( ) No

2. Has your state identified the need to develop new partnerships that you did not have in place? (●) Yes ( ) No

If yes, with whom?

RESPONSE -
Since the last planning period, AHCCCS has added Yavapai College to our cohort of Institutes of Higher Education (IHEs) subrecipients for substance use primary prevention services.

Although not a new partner, AHCCCS also partnered with the Matforce Coalition and the Substance Awareness Coalition Leaders of Arizona (SACLAz) in a new way. From 2021-2024, AHCCCS contracted directly with 20 community-based prevention coalitions for the provision of community coalition-based primary prevention services. Beginning in 2024, AHCCCS replaced those 20 contracts with 1 contract with Matforce/SACLAz to administer and oversee this cohort of coalition-based primary prevention services. This change has opened up the capacity of AHCCCS grants staff to further streamline state oversight and monitoring, but more importantly, provides coalitions with additional training and support from a model coalition and their entire network of coalitions. Under the oversight of AHCCCS, Matforce/SALCAz conducted a Request for Proposals (RFP) in 2025 and selected a new cohort of coalitions as subrecipients of the grant. Two of the previous subrecipient coalition contracts were not renewed, but 9 coalitions were added anew. This new cohort of SUBG prevention subrecipients will be referred to as the Arizona Community Coalitions Implementing Primary Prevention (ACCIPP).

Vive18 is a new partner who will plan and implement a 3-day Arizona Youth Prevention Conference that will provide youth leaders with an opportunity to enhance their leadership skills and special skills in substance use prevention and mental health promotion to be even more effective change agents in their communities. Vive18 exists to save young lives from addiction (and boredom) with relevant, engaging, high-energy drug prevention programs, with a special focus on youth trainings. Deterra is a new partner who will conduct a household mailer campaign to get drug disposing/deactivating pouches with substance use messaging directly into the homes of Arizonans who either a) have less access to prescription drop off locations such as rural and remote areas, and/or b) have elevated rates of select risk factors for substance misuse and overdose.

The treatment and recovery sector also saw some new partners, as selected under the ACC-RBHAs. This includes but may not be limited to Choice Health (outpatient provider with a sober living component) and Zero Overdose who provided opioid overdose training to clinicians and other stakeholders/partners in Phoenix. Additionally, although ADHS is not a new partner, AHCCCS SUBG staff has been intentional in improving the collaboration across teams, especially with HIV and Tuberculosis staff, for enhanced oversight of these requirements for the SUBG, and to discuss opportunities to partner around funding and initiatives that intersect between SUD and infectious disease.
Regarding the Mental Health Block Grant (MHBG), AHCCCS has identified areas where new partnerships are needed to improve service provision. AHCCCS has collaborated with the Matforce Coalition to increase awareness of first episode psychosis (FEP) throughout Arizona. Ongoing collaboration with various providers through ACC-RBHAs aims to inform schools about available funding sources for student behavioral health services. These efforts include presentations and maintaining a guide to assist schools in developing comprehensive school mental health programs, including making referrals to community behavioral health providers. AHCCCS requires ACC plans and ACC-RBHAs to post contact information on their websites so schools can seek assistance in establishing partnerships with community behavioral health providers. Additionally, AHCCCS holds two quarterly meetings with ACC plans, ACC-RBHAs, ADE, and other system partners to report on initiatives to enhance awareness, build relationships between schools and providers, and support access to care for students. A feedback form has also been developed by AHCCCS to allow schools to report both successes and barriers encountered when referring students to providers.

3. Describe the manner in which your state and local entities will coordinate services to maximize the efficiency, effectiveness, quality and cost-effectiveness of services and programs to produce the best possible outcomes with other agencies to enable consumers to function outside of inpatient or residential institutions, including services to be provided by local school systems under the Individuals with Disabilities Education Act.

RESPONSE - State and local entities coordinate services in a number of ways that impact the efficiency, effectiveness, quality, and cost effectiveness of services as well as outcomes.

One mechanism for ensuring this coordination is through contract requirements. AHCCCS requires that all ACC plans work in partnership with all other ACC plans, ACC-RBHAs and TRBHAs in its Geographical Service Area(s) to meet, agree upon and establish MOUs and/or joint Collaborative Protocols with other state agencies and system partners. Protocols and/or MOUs represent robust and meaningful collaborative processes and relationships to meet members' specific needs (e.g., adult, child, SMI, GMHSU, justice-involved). Each collaborative protocol, at a minimum, is required to address:

1) Procedures for each entity to coordinate the delivery of covered services to members served by both entities.
2) Mechanisms for resolving problems.
3) Information and data sharing.
4) Resources each entity commits for the care and support of members mutually served.
5) Procedures to identify and address joint training needs.
6) Where applicable, procedures to have providers co-located with jails, prisons, and detention facilities or other agency locations as directed by AHCCCS.

Additionally, the Non-Title XIX/XXI contact includes language for coordination of care and services, including but not limited to continuity of care for members in court ordered treatment, coordination of housing subsidies and supportive services, coordination of treatment and early intervention services with other appropriate services (including health, social, correctional, criminal justice, educational, vocational rehabilitation, and employment services), coordination of benefits and third party liability, coordination with the Title XIX/XXI funding/payors, private insurance, tribal payors, and providers.
AHCCCS policies for Covered Behavioral Health Services under Title XIX/XXI (AMPM 310-B) and the Non-Title XIX/XXI funds (AMPM 300-2B) are posted on the AHCCCS website.
The Non-Title XIX/XXI requires a "no wrong door" model to maximize access to the SUD treatment system and the monitoring provider interventions that serve a variety of populations of focus.
AHCCCS also implements requirements and systems around case management and referral processes that contribute. AHCCCS implements requirements for ACC-RBHAs to have established processes in place to receive referrals for, and refer members to, Non-Title XIX/XXI services, and also requires most primary prevention providers to have MOUs with ACC plans, ACC-RBHAs, TRBHAs, and/or providers as applicable to their local jurisdiction, for referrals to appropriate care. Additionally, the Closed Loop Referral System is a new platform that AHCCCS launched in late 2022, known as CommunityCares. The CLRS supports members' health-related social needs, which have a direct impact on their physical and mental health. CommunityCares is an electronic tool that AHCCCS health care providers can use to screen and refer members for health-related social needs. The system contains preloaded screening tools like the Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) which allows providers to quickly screen members for gaps in care and immediately provide referrals to local community based organizations to address their health-related social needs. The tool supports streamlined care coordination between health care providers and community based organizations, where there has historically not been a connection. The tool is free of cost for AHCCCS-registered health care providers and community-based organizations, which is a cost-effective way of addressing critical needs that impact our members' physical and mental health.
Case management services are a covered service for all members, and AHCCCS implements additional requirements for case management for Tuberculosis and HIV/AIDS services SUBG members.
Additionally, services among those at increased risk for behavioral health problems and those disproportionately impacted by substance use, related risk factors, etc. are another way that services are implemented in a way to enhance effectiveness, efficiency, and outcomes. Service provision is often targeted toward members and populations that experience the highest need, thereby addressing the most vulnerable and most impacted populations. When services are implemented among these populations, successful treatment results in better health outcomes that reduce the cost of health care.

An example is behavioral health supports in the criminal justice system. AMPM 320-T1 and AHCCCS' SAMHSA-approved plan for use of block grants the juvenile justice system outlines the requirements and program efforts for this work. As outlined in the policy, services shall be provided:
1) Only to voluntary members,
2) By qualified BHPs/BHTs/BHPPs,
3) Based upon assessed need for SUD services,
4) Utilizing EBPPs,
5) Following an individualized service plan,
6) For a therapeutically indicated amount of duration and frequency, and
7) With a relapse Prevention plan completed prior to discharge/transfer to a community-based provider.
These interventions facilitate the provision of services either before, during, or after engagement in the system. Tools such as telehealth services can be leveraged to efficiently provide certain behavioral health and related services.

Arizona's approach to coordinating mental health services across state and local entities is rooted in a multi-tiered, collaborative framework designed to ensure that individuals with serious mental illness (SMI), serious emotional disturbance (SED), and early serious mental illness (ESMI) receive comprehensive, community-based care. This coordination is essential to reduce reliance on inpatient or residential institutions and promote recovery-oriented outcomes.
1. Strategic Partnerships and Interagency Collaboration
AHCCCS leads the integration of funding streams and service delivery through partnerships with county governments, Medicaid, behavioral health providers, and other state agencies. These partnerships include:
• State Medicaid Authority: AHCCCS collaborates with Medicaid to develop health homes and oversee benefits for populations with chronic conditions. DBHH grants teams collaborate with the teams that oversee the Medicaid covered behavioral health services, and these teams now sit within the same division.
• Justice System Authorities: Coordination with local and tribal judicial systems supports diversion programs, screening, treatment, and transition services for justice-involved individuals with mental health or substance use disorders. DBHH also houses the AHCCCS Justice Administrator and collaborates as needed on issues relating to SUBG and SUD access to care for justice-involved members.

• Education Agencies: The Arizona Department of Education (ADE) works with local school districts to ensure students with disabilities under IDEA receive appropriate mental health supports, reducing out-of-district placements and improving graduation rates. DBHH includes staff who work directly with ADE staff on behavioral health in schools issues and these partnerships are leveraged as part of our SUBG and MHBG oversight and administration.
• Department of Child Safety (DCS) and Department of Economic Security (DES): The AHCCCS State Opioid Treatment Authority (SOTA) who also is the Women's Services Network (WSN) Coordinator, sits in DBHH and is a systems connector especially focusing on connections between these systems. AHCCCS has utilized SOR funds previously, and currently SUBG funds, to support a contract with Prevent Child Abuse Arizona (PCAAZ), who furthers our strategic partnerships and interagency collaborations in these spaces. For example, PCAAZ increases the system partners' workforce capacity by offering Triple P Parenting training of trainers, as well as implementing Hope Horizons Regional Institutes focused on Navigating Recovery for Arizona Families, a training/conference that brings these system partners together to enhance the services provided to families impacted and served by AHCCCS, DCS, and DES.

2. Integrated Care Models and Workforce Development
Arizona promotes integrated care through evidence-based models such as the Collaborative Care Model (CoCM), which embeds behavioral health professionals within primary care settings. This model enhances early identification and treatment of mental health conditions and supports whole-person care.
AHCCCS mandates that Managed Care Organizations (MCOs) maintain a Workforce Development Operation (WFDO) to ensure provider networks are clinically and culturally competent. MCOs also participate in a unified Learning Management System (LMS) to deliver and track training programs, including those for law enforcement on behavioral health emergencies.
3. Care Coordination and Service Intensity
Arizona's system varies the intensity of care coordination based on individual needs. Models include:
• High-Fidelity Wraparound and Systems of Care for children and families.
• Assertive Community Treatment (ACT) for individuals at high risk of institutionalization.
• Recovery Support Services for individuals with substance use disorders.
These models connect individuals to essential supports in education, employment, and housing, facilitating community integration and reducing institutional dependency.
4. Funding and Resource Allocation
AHCCCS leverages Title XIX/XXI and Non-Title XIX/XXI funds to support a robust network of behavioral health services. Non-Medicaid funds, including the MHBG, support services for uninsured and underinsured populations, including children with SED and adults with SMI.
Funding sources include:
• SMI Housing Trust Fund
• Emergency COVID-19 grants
• County-specific funds for court-ordered evaluations and services

5. Advisory Council and Stakeholder Engagement
Arizona's Behavioral Health planning Council (BHPC) includes representatives from state agencies, provider organizations, peer-run agencies, and individuals with lived experience. The Council ensures diverse perspectives inform planning and implementation, and vacancies are actively managed with clear timelines for resolution.
This coordinated approach reflects Arizona's commitment to delivering high-quality, cost-effective mental health services that empower individuals to thrive in their communities.

4. Please indicate areas of technical assistance needs related to this section.

No technical assistance needed at this time.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Environmental Factors and Plan

14. State Planning/Advisory Council and Input on the Mental Health/Substance Use Block Grant Application – Required for MHBG, Requested for SUPTRS BG

Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council to carry out the statutory functions as described in **42 U.S.C. §300x-3** for adults with SMI and children with SED. To assist with implementing and improving the Planning Council, states should consult the **State Behavioral Health Planning Councils: An Introductory Manual.**

Planning Councils are required by statute to review state plans and annual reports; and submit any recommended modifications to the state. Planning councils monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state. They also serve as advocates for individuals with M/SUD. States should include any recommendations for modifications to the application or comments to the annual report that were received from the Planning Council as part of their application, regardless of whether the state has accepted the recommendations. States should also submit documentation, preferably a letter signed by the Chair of the Planning Council, stating that the Planning Council reviewed the application and annual report. States should transmit these documents as application attachments.

Please respond to the following items:

1. How was the Council involved in the development and review of the state plan and report? Attach supporting documentation (e.g., meeting minutes, letters of support, letter from the Council Chair etc.)

2. Has the state received any recommendations on the State Plan or comments on the previous year's State Report?

a. State Plan ○ Yes ○ No

b. State Report ○ Yes ○ No

Attach the recommendations /comments that the state received from the Council (without regard to whether the State has made the recommended modifications).

3. What mechanism does the state use to plan and implement community mental health treatment, substance use prevention, SUD treatment, and recovery support services?

4. Has the Council successfully integrated substance use prevention and SUD treatment recovery or co-occurring disorder issues, concerns, and activities into its work? ○ Yes ○ No

5. Is the membership representative of the service area population (e.g., rural, suburban, urban, older adults, families of young children?) ○ Yes ○ No

6. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.

7. Please indicate areas of technical assistance needs related to this section.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Environmental Factors and Plan

Advisory Council Members

For the Mental Health Block Grant, **there are specific agency representation requirements** for the State representatives. States MUST identify the individuals who are representing these state agencies.

State Mental Health Agency
State Education Agency
State Vocational Rehabilitation Agency
State Criminal Justice Agency
State Housing Agency
State Social Services Agency
State Medicaid Agency

Start Year: 2026 End Year: 2027

Name	Type of Membership*	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
No Data Available				

*Council members should be listed only once by type of membership and Agency/organization represented.
OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Environmental Factors and Plan

Advisory Council Composition by Member Type

Start Year: 2026 End Year: 2027

Type of Membership	Number	Percentage of Total Membership
1. Individuals in recovery (including adults with SMI who are receiving or have received mental health services)	0	
2. Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)	0	
3. Parents of children with SED	0	
4. Vacancies (individuals and family members)	0	
5. Total individuals in recovery, family members, and parents of children with SED	**0**	**0.00%**
6. State Employees	0	
7. Providers	0	
8. Vacancies (state employees and providers)	0	
9. Total State Employees & Providers	**0**	**0.00%**
10. Persons in Recovery from or providing treatment for or advocating for SUD services	0	
11. Representatives from Federally Recognized Tribes	0	
12. Youth/adolescent representative (or member from an organization serving young people)	0	
13. Advocates/representatives who are not state employees or providers	0	
14. Other vacancies (who are not individuals in recovery/family members or state employees/providers)	0	
15. Total non-required but encouraged members	**0**	**0.00%**
16. Total membership (all members of the council)	**0**	

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Environmental Factors and Plan

15. Public Comment on the State Plan – Required for MHBG & SUPTRS BG

Narrative Question

Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. §300x-51) requires, as a condition of the funding agreement for the grant, that states will provide an opportunity for the public to comment on the state Block Grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to the federal government.

Please respond to the following items:

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?

a) Public meetings or hearings? Yes No

b) Posting of the plan on the web for public comment? Yes No

If yes, provide URL:

If yes for the previous plan year, was the final version posted for the previous year? Please provide that URL:

c) Other (e.g. public service announcements, print media) Yes No

d) Please indicate areas of technical assistance needs related to this section.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Environmental Factors and Plan

16. Syringe Services Program (SSP) – Required for SUPTRS BG if Planning for Approval of SSP

Planning Period Start Date: 10/1/2025 Planning Period End Date: 9/30/2026

Narrative Question:
Use of SUPTRS BG funds to support syringe service programs (SSP) is authorized through appropriation acts which provide authority for federal programs or agencies to incur obligations and make payment, and therefore are subject to annual review. The following guidance for the application to budget SUPTRS BG funds for SSPs is therefore contingent upon authorizing language during the fiscal year for which the state is applying to the SUPTRS BG.

A state experiencing, or at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, (as determined by CDC), may propose to use SUPTRS BG to fund elements of an SSP other than to purchase sterile needles or syringes for the purpose of illicit drug use. States interested in directing SUPTRS BG funds to SSPs must provide the information requested below and receive approval from the State Project Officer.

States may consider making SUPTRS BG funds available to either one or more entities to establish elements of a SSP or to establish a relationship with an existing SSP. States should keep in mind the related PWID SUPTRS BG authorizing legislation and implementing regulation requirements when developing its Plan, specifically, requirements to provide outreach to persons who inject drugs (PWID), SUD treatment and recovery services for PWID, and to routinely collaborate with other healthcare providers, which may include HIV/STD clinics, public health providers, emergency departments, and mental health centers. Federal funds cannot be supplanted, or in other words, used to fund an existing SSP so that state or other non-federal funds can then be used for another program.

The federal government released three guidance documents regarding SSPs, These documents can be found on the **HIV.gov website.**

Please refer to guidance documents provided by the federal government on SSPs to inform the state's plan for use of SUPTRS BG funds for SSPs, if determined to be eligible. The state must follow the steps below when requesting to direct SUPTRS BG funds to SSPs during the award year for which the state is eligible and applying:

Step 1 - Request a **Determination of Need** from the CDC

Step 2 - Include request in the SUPTRS BG Application Plan to expend the funds for the award year which the state is planning support an existing SSP or establish a new SSP. Items to include in the request:

- Proposed protocols, timeline for implementation, and overall budget
- Submit planned expenditures and agency information on Table 16a listed below

Step 3 - Obtain SUPTRS BG State Project Officer Approval

Use of SUPTRS BG funds for SSPs future years are subject to authorizing language in appropriations bills, and must be re-applied for on an annual basis.

Additional Notes:

1. Section 1931(a(1)(F) of Title XIX, Part B, Subpart II of the Public Health Service (PHS) Act (**42 U.S.C.§ 300x-31(a)(1)(F)**) and **45 CFR § 96.135(a)(6)** explicitly prohibits the use of SUPTRS BG funds to provide PWID with hypodermic needles or syringes so that such persons may inject illegal drugs unless the Surgeon General of the United States determines that a demonstration needle exchange program would be effective in reducing injection drug use and the risk of HIV transmission to others. On February 23, 2011, the Secretary of the U.S. Department of Health and Human Services published a notice in the Federal Register (76 FR 10038) indicating that the Surgeon General of the United States had made a determination that syringe services programs, when part of a comprehensive HIV prevention strategy, play a critical role in preventing HIV among PWID, facilitate entry into SUD treatment and primary care, and do not increase the illicit use of drugs.

2. Section 1924(a) of Title XIX, Part B, Subpart II of the PHS Act (**42 U.S.C. § 300x-24(a)**) and **45 CFR § 96.127** requires entities that receives SUPTRS BG funds to routinely make available, directly or through other public or nonprofit private entities, tuberculosis services as described in section 1924(b)(2) of the PHS Act to each person receiving SUD treatment and recovery services.

3. Section 1924(b) of Title XIX, Part B, Subpart II of the PHS Act (**42 U.S.C. § 300x-24(b)**) and **45 CFR 96.128** requires "designated states" as defined in Section 1924(b)(2) of the PHS Act to set- aside SUPTRS BG funds to carry out 1 or more projects to make available early intervention services for HIV as defined in section 1924(b)(7)(B) at the sites at which persons are receiving SUD treatment and recovery services.

Section 1928(a) of Title XXI, Part B, Subpart II of the PHS Act (**42 U.S.C. 300x-28(c)**) and **45 CFR 96.132(c)** requires states to ensure that substance use prevention and SUD treatment and recovery services providers coordinate such services with the provision of other services including, but not limited to health services.

Syringe Services Program (SSP) Agency Name	Main Address of SSP	Planned Budget of SUPTRS BG for SSP	SUD Treatment Provider (Yes or No)	# of locations (include any mobile location)	Naloxone or other Opioid Overdose Reversal Medication Provider (Yes or No)
Sonoran Prevention Works (Contractor)	2211 S 48th St STE B, Tempe, AZ - 85282	$553,580.00	No	7	Yes
Totals:		$553,580.00		7	

Arizona Health Care Cost Containment System (AHCCCS) and Sonoran Prevention Works (SPW) Syringe Services Plan

Substance Use Prevention Treatment and Recovery Services Block Grant (SUPTRS BG)

FFY26-27 Combined Application – Environmental Factors Table 16.

2. BACKGROUND

In 2021, Sonoran Prevention Works (SPW) responded to a Request for Proposals (RFP) released by AHCCCS to procure statewide substance use harm reduction services. This resulted in a contract between AHCCCS and SPW that was effective for an initial 3-year term of January 1, 2022 – December 31, 2024 with 2 optional 1-year extensions (Calendar year 2025 and calendar year 2026).

Prior to utilizing SUPTRS BG (herein referred to as SUBG) funds to support SPW's syringe services program (SSP), AHCCCS received approval to do so from SAMHSA in the FFY2022-2023 application. AHCCCS work closely with SPW to ensure the use of federal funds are within federal and state law, including Presidential Executive Orders (EOs) (e.g. EO on Ending Crime and Disorder on America's Streets).

This workplan reflects the 2025 updated version of the contractually agreed upon workplan.

3. WORKPLAN

AHCCCS, through the statewide contractor, SPW, has developed and is implementing a comprehensive, evidence-based harm reduction program for the State of Arizona to meet the needs of the most vulnerable to overdose and other drug-related harms. *Figure 1* below displays the conceptual model developed for this project, illustrating the relationship between the interventions, immediate outcomes, and long-term outcomes.

Figure 1. Conceptual Model

Intervention	Immediate Outcomes	Long-term Outcomes
1) Naloxone distribution, education, and training 2) Syringe Services Program 3) Education and training 4) Peer support and wraparound services 5) Fentanyl and xylazine testing strip distribution, education, and training 6) Tailored programming and services for women 7) Culturally appropriate services and resources 8) Expanded network of key community stakeholders	• Increased initiation, continuation, and coordination of evidence-based treatment for individuals who use drugs • Increased harm reduction behaviors such as reduced or safer use through education, supply testing, and overdose prevention kits • Increased proper disposal of used syringes • Increased public awareness and community engagement	• Reduced rates of overdose, drug-related deaths and injuries, and transmission of infectious diseases • Improved health and wellness of people who use drugs • Reduced costs and burden associated with substance use/misuse on public systems

To achieve the listed outcomes, our strategy consists of eight (8) overarching strategies/interventions:

1) **Naloxone distribution, education, and training:** Expand a comprehensive, statewide naloxone distribution, education, and training initiative for people who use drugs (PWUD), prescribers, pharmacists, AHCCCS members and the public. Through the subcontracted provider, we aim to achieve the following objectives:
    - **a.** Distribute naloxone doses via kits to communities across Arizona through targeted street and community outreach.
    - **b.** Conduct in-person and web-based training sessions for prescribers, pharmacists, AHCCCS members, and the public, emphasizing evidence-based responses to opioid overdose and post-overdose support.
    - **c.** *SPW reports that the following objectives have been eliminated since CY2022:*
        i. Provide naloxone training and technical assistance to the correctional system to at least 50 percent of Arizona jails and 75 percent of state prisons distributing naloxone upon release.
            1. *Efforts were made towards this objective during CY2022, but SPW's subcontracted service provider (Community Medical Services) was not making significant progress & a similarly appropriate service provider could not be identified. With AHCCCS' permission, the objective was eliminated as a result.*
        ii. Train 10 percent of Arizona group homes for transition-age youth on overdose prevention, recognition, and response.
            1. *Efforts were made towards this objective during CY2022, but SPW's subcontracted service provider (Community Medical Services) was not making significant progress & a similarly appropriate service provider could not be identified. With AHCCCS' permission, the objective was eliminated as a result.*
2) **A statewide SSP:** Through SPW, AHCCCS aims to implement the following elements for a statewide SSP:
    - **a.** Develop and expand needle and hypodermic syringe disposal education and options for the State of Arizona to reach at least 5,640 individuals who inject drugs. In order to maximize our reach among our target population, we have developed three strategies to deliver supplies to PWUD: 1) fixed sites, 2) mobile units, and 3) mail order programs. Supplies include syringes (NOT funded by federal dollars), safe disposal containers, hygiene and wound care kits, internal and external condoms, rapid home HIV tests, and other associated supplies.
        i. *SPW reports that the following strategy was also employed from CY2022 – CY2024: Supply distribution kiosks. For CY2025 and CY2026, the future of this effort is unknown, as SPW is awaiting input from SPW's subcontracted service provider (Community Medical Services) about its capacity to continue with the kiosk strategy.*
    - **b.** Implement a statewide SSP with sites in Cochise, Coconino, Maricopa, Mohave, Pima, Santa Cruz, & Yuma Counties (in partnership with Southwest Recovery Alliance and Cochise Harm Reduction). The statewide provider will also create

new and expanded mobile and delivery based SSP services to reach PWUD across Arizona. In this project period, we aim to reach at least 5,640 Arizonans who inject drugs.

i. *SPW reports that the following additional counties also had SSP sites prior to CY2025: Graham, Navajo, Pinal, and Yavapai. If the kiosk strategy currently paused ultimately moves forward, it is possible that could reinstate implementation in some or all of these counties.*

c. Coordinate navigation services and treatment referrals for mental illness, substance use disorder, and other co-occurring disorders for SSP participants, as appropriate. SSPs provide an excellent opportunity to engage PWUD in a community setting with peer support from people with lived experience with substance use. Individuals seeking sterile needles or other supplies may also be offered referrals to navigation services, treatment referrals, or additional services as appropriate.

d. Develop and disseminate educational materials to at least 5,640 individuals through the SSP. Educational material may include the following topics: Overdose prevention, peer support services, infectious disease and transmission prevention, education, referrals, and treatment referrals for mental illness, SUD, and co-occurring disorders.

e. Develop and distribute evidence-based standards for distributing and disposing of needles and hypodermic syringes.

i. *SPW reports that a complete "SSP Best Practices Manual" was provided to both AHCCCS & Arizona Department of Health Services (AZDHS) in October 2023. Under a training contract separate from SUBG, SPW has also provided ongoing training entitled, "Building Successful SSPs," at AZDHS' request.*

3) Training for professionals and the broader community; Through SPW, AHCCCS aims to implement the following stigma reduction trainings for professionals and the broader community:

a. Develop and distribute educational material to at least 30,000 people through print and electronic distribution. With AHCCCS guidance, SPW will review and adapt existing educational material targeted at PWUD, the general public, providers, pharmacists, AHCCCS members, and other specific populations as appropriate.

b. Provide at least 20 free training sessions for community members and the broader public. SPW's training sessions are typically geared toward community members, resource organizations, and medical/behavioral health professionals, with specialized curricula for numerous populations and professions. In coordination with AHCCCS and the program officer, SPW will review and update all training curricula and materials for free general training sessions geared toward community members. Current training topics include overdose prevention and naloxone use, opioid use disorder, stimulant use disorder, stigma, injection-related complications, and other relevant issues. These

general trainings are offered in-person or virtually, including virtual video workshops or self-paced online courses.

c. Provide at least 15 training sessions to medical, behavioral health, and social service providers. SPW will develop or enhance trainings on overdose prevention, fentanyl testing strip use, stimulants, and other emerging topics and deliver to drug treatment providers, substance use prevention coalitions, health care providers, AHCCCS members, SUBG priority populations, organizations who serve women who use drugs, and other groups who engage with PWUD.

d. *SPW reports that the following objectives have been eliminated since CY2022:*

i. Conduct at least three trainings each year in each Geographic Service Area (GSA) in Arizona to the Department of Child Safety regional offices on overdose prevention and harm reduction. SPW will adapt existing curriculum to specifically address the unique needs of transition-age youth struggling with substance use/misuse.

1. *Efforts were made towards this objective during CY2022, but SPW's subcontracted service provider (Community Medical Services) was not making significant progress & a similarly appropriate service provider could not be identified. With AHCCCS' permission, the objective was eliminated as a result.*

ii. Provide training to at least 50 percent of Community Corrections offices on overdose prevention. Due to the disproportionate impact of opioid overdoses on criminal-justice involved individuals, we will make a concerted effort to train those that work in the criminal justice system with specialized content for this population.

1. *Efforts were made towards this objective during CY2022, but SPW's subcontracted service provider (Community Medical Services) was not making significant progress & a similarly appropriate service provider could not be identified. With AHCCCS' permission, the objective was eliminated as a result.*

4) Peer support program to facilitate linkages to treatment and wrap-around supports; Through SPW, AHCCCS aims to implement the following peer support program through the following strategies:

a. Develop and implement a network of at least 75 provider organizations to facilitate linkages to evidence-based care navigation services for individuals requiring a higher level of care. Peer support staff at SPW work at SSPs and conduct street outreach in order to identify new clients and facilitate referrals to organizations which provide the additional services they seek.

b. Provide at least 1,500 referrals to treatment through peer support staff for individuals requiring a higher level of care. Referrals may include treatment for: SUD, mental illness, mental health and harm reduction-based counseling, screening and treatment for HIV, viral hepatitis, and STIs, medical treatment and basic wound care. SPW's outreach staff are peer support-certified and specially trained to provide support around drug treatment, medical care,

mental health, housing, criminal justice involvement, identification replacement, and other services.

c. Disseminate risk reduction material through peer support staff to 5,640 individuals. Supply kits may include condoms, hygiene products, naloxone kits, fentanyl test strips, and other necessities.

d. Promote awareness through in-depth training for 2,700 individuals about the relationship between injection drug use and communicable diseases, recommended steps for disease transmission prevention, and options for treatment. Through syringe services and rapid HIV/HCV screening, outreach specialists will provide education on prevention, risk mitigation, and treatment for HIV, HCV, and other communicable diseases including hepatitis A and B, COVID-19, and STIs.

5) Fentanyl testing strip distribution, education, and training; Through SPW, AHCCCS aims to implement the following strategies:

a. Distribute 120,000 rapid fentanyl testing strips (FTS) to communities across the State of Arizona by the end of Year 3 (2024). Distribution will be prioritized to people who use drugs (all drugs, including heroin, stimulants, and pills), their friends and family, and organizations who can effectively distribute testing strips to people at risk for overdose. SPW maintains the lowest available cost-effective pricing agreement with pharmaceutical companies for FTS in Arizona and will continue to do so for this project. Our budget for this proposal includes resources to purchase 120,000 FTS for statewide distribution.

b. Develop and distribute FTS training materials and modules. FTS educational material will include content such as the use of FTS; alleviating fears and stigma; education on harm reduction and how it relates to using the testing strips to test for the presence of fentanyl; and information regarding use and/or disposal of substances that test positive for fentanyl. This content will be made available to PWUD, families, AHCCCS members, community-based organizations, and the general public.

6) Tailored programming and services for women, especially pregnant and parenting women (SUBG Priority Population); Through SPW, AHCCCS aims to implement the following strategies for this SUBG Priority Population:

a. Provide outreach and care coordination services to at least 200 women who use drugs, prioritizing pregnant and parenting women. Tailored programming and services for women who use drugs may include pediatric medical treatment and care, child welfare, Arizona Department of Child Safety (DCS) coordination, legal assistance, early childhood education, family counseling, and other services needed by all PWUD. We aim to serve a minimum of 30 women in each region.

b. Staff the statewide SSP with at least one staff member who specializes in supporting women who use drugs, particularly pregnant and parenting women. The staff member will travel throughout the state to provide services, as well as training and education for project staff and partners.

c. Prioritize the delivery of services and training to SUBG priority populations. In compliance with SAMHSA and AHCCCS regulations for the use of SUBG funds, all services provided through the resources requested for this project will prioritize the following SUBG populations: 1) pregnant women/teenagers who use drugs by injection, 2) pregnant women/teenagers with a SUD, 3) other persons who use drugs by injection, 4) women/teenagers with a SUD, with dependent children and their families, including women who are attempting to regain custody of their children, and 5) all other individuals with a SUD, regardless of gender or route of use. With respect to naloxone distribution, education and training, we aim to increase the utilization of SPW services among SUBG priority populations by at least 10 percent during the three-year project period (2022-2024).

d. Participate in statewide groups to conduct provider education on decreasing stigma and utilization of evidence-based practices for pregnant and parenting women who use drugs. Along with Objective 3E, we will make concerted efforts to train providers who treat women who use drugs, as well as incorporate gender-informed principles in our general training.

7) Culturally appropriate services and resources; Through SPW, AHCCCS aims to implement the following:

a. Provide Spanish translations and culturally sensitive versions of services and resources. SPW has provided Spanish translations of educational and outreach materials, as well as offered peer support services in Spanish since 2019. SPW currently has Spanish-speaking outreach staff in five Arizona counties. All printed educational materials will be available in English and Spanish, and additional materials will be revised for cultural sensitivity when working with tribal nations.

i. *SPW reports that in CY2022, we offered a telephone translation service to our outreach staff, but it was never used, so we eliminated it to reduce program costs.*

ii. *SPW reports that during CY2024, one of our SSP staff enrolled in additional training to become more proficient in the Navajo/Diné language to assist him in working more effectively with tribal participants.*

b. Host at least 20 training sessions in Spanish and distribute materials to at least 1,000 Spanish-speaking clients.

8) Stakeholder relationship and capacity building to ensure long-term program sustainability. Through SPW, AHCCCS aims to implement the following:

a. Convene a Community Advisory Board (CAB) consisting of impacted individuals from across the state of Arizona. Through regular meetings, the CAB provides SPW with critical feedback and insights into program efficacy & accessibility, builds community capacity to prevent overdoses and overdose deaths, & mitigates stigma. SPW utilizes successes & lessons learned from the CAB to build, train, & sustain a statewide network of professional partners, including SSPs, state and local government agencies, Substance Use Disorder and behavioral health treatment

providers, health departments, health clinics and systems, correctional health, first responders, community-based organizations, mutual aid groups, local businesses, schools, colleges and universities, and neighborhood associations.

b. Evaluate and continuously improve the services provided through our program through regular data monitoring, performance reports, and quality improvement methods. A critical part of this project is collecting reliable data to assess performance, evaluate progress, and continuously improve services and internal control systems. Additionally, we will maintain and expand SPW's inventory tracking system to monitor the supply and distribution of naloxone, FTS, and related outreach supplies purchased with SUBG funds.
    i. *In CY2022, SPW subcontracted ASU CHS for evaluation services. Due to high costs associated with this subcontractor and no evaluations completed beyond those which SPW itself is capable of completing via SUBG-supported staff, the subcontract did not continue after CY2022. Instead, SPW continues to collect and report to AHCCCS program implementation data (e.g. reach, referrals, trainings completed, syringes collected, distributed, etc.)*
c. Identify and disseminate best practices and recommendations for sustaining and expanding the program. All project processes, protocols, tools, evaluations, publications, and reports will be documented for dissemination to sustain and expand our collective efforts.

Acquiring Syringes and Needles through Non-Federal Funds: The statewide contractor, SPW, understands they will not utilize federal funds to purchase syringes/needles. AHCCCS will continue to ensure compliance with state and federal regulations. SPW is dedicated to ensuring that participants have access to all the supplies they need to stay as safe and healthy as possible, including syringes and needles. In support of this project, SPW will continue to fund the purchase of syringes and needles through a combination of grassroots fundraising methods as well as grant funding from a diverse range of private and public funders. SPW has a long history of utilizing grassroots fundraising methods, including one-time and monthly sustaining donations and program service revenue to support the work and help to fund the purchase of program supplies. SPW is committed to seeking out a diverse range of funders who share our values, and can support the purchasing of lifesaving supplies, such as syringes and needles, for participants. For years, SPW has worked to build and maintain relationships with funders dedicated to supporting health and harm reduction services to people impacted by substance use, including Broadway Cares, the Gilead Foundation, AIDS United, and more. SPW has also received funding from county health departments, hospital systems, and foundations across Arizona. Additionally, SPW proactively seeks out and applies to new funding opportunities that can further support the purchase of syringes and needles.

Applicable MOUs with SSP Providers who can supply needles: SPW is the acquirer of the syringes and needles needed for the program, and therefore no MOU is needed for supplying needles. In lieu of an MOU, SPW has an executed contract that may be submitted if required.

3. TIMELINE FOR IMPLEMENTATION

Please refer to **Attachment A** at the end of this document for the timeline for implementation.

4. COPY OF EXISTING SSP PROTOCOLS OR GUIDELINES

AHCCCS, in consultation with SPW, will utilize the following protocols/guidelines, and applicable state law such as:

a) Arizona Revised Statutes (ARS) Title 36, Chapter 6, Article 15: *Title 36, chapter 6, Arizona Revised Statutes. ARTICLE 15. OVERDOSE AND DISEASE PREVENTION. 36-798.51. Overdose and disease prevention programs; requirements; standards*
b) Centers for Disease Control and Prevention: *Syringe Service Programs, A Technical Package of Effective Strategies and Approaches for Planning, Design, and Implementation (published 2020)*
c) NASTAD: *Syringe Services Program (SSP) Development and Implementation Guidelines for State and Local Health Departments (published 2012)*
d) National Harm Reduction Coalition: *Guide to Developing and Managing a Syringe Service Program (published 2010, updated 2020)*
e)

5. BUDGET, BUDGET JUSTIFICATION, AND PROPOSED ACTIVITIES, INCLUDING A PLAN FOR DISPOSAL OF INJECTION EQUIPMENT

Category	2025 SUBG annual and ARPA
Personnel	$971,572
Fringe	$257,952
Travel	$42,607
Equipment	$0
Supplies	$429,759
Contractual	$74,300
Other	$42,383
Total Direct Charges	$1,818,573
Indirect Charges or Administration	$381,876
Total Project Costs	**$2,091,359**

**Footnote: This is based on level funding from CY25 budget subject to change based on funding availability and has not yet been approved or obligated to the contractor.*

Proposed Activities:

1) Naloxone distribution, education, and training;
2) A statewide SSP;
3) Trainings for professionals and the broader community;
4) Peer support program to facilitate linkages to treatment and wrap-around supports;
5) Fentanyl testing strip distribution, education, and training;
6) Tailored programming and services for women, especially pregnant and parenting women (SUBG Priority Population);
7) Culturally appropriate services and resources; and

8) Stakeholder relationship and capacity building to ensure long-term program sustainability.

Plan for disposal of injection equipment: SPW provided a "Syringe Services Program Best Practices Manual" to both AHCCCS & Arizona Department of Health Services (AZDHS) in October 2023 and remains on record at AHCCCS. This document contains evidence-based standards for disposing of needles and hypodermic syringes. SPW aims to follow applicable Arizona law regarding the disposal of injection equipment *(SB 1250: Article 15: 36-798.51. Overdose and disease prevention programs; requirements; standards):*

> *"A program established pursuant to this section shall develop standards for distributing and disposing of needles and hypodermic syringes based on scientific evidence and best practices. the number of needles and hypodermic syringes disposed of through a program shall be at least equivalent to the number of needles and hypodermic syringes distributed through the program."*

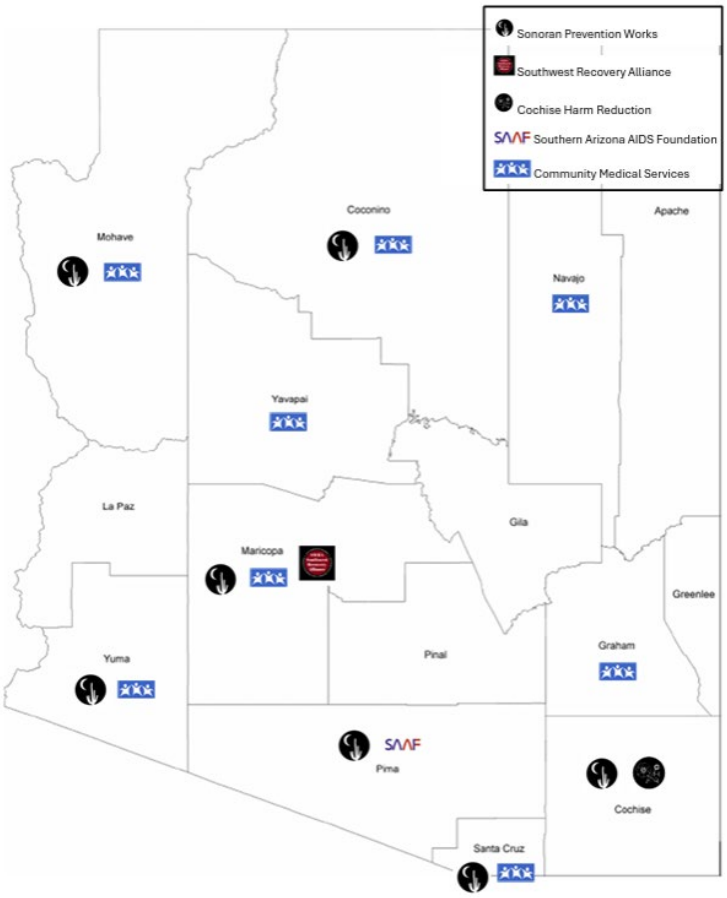
6. DESCRIPTION OF CURRENT TRAINING AND TECHNICAL ASSISTANCE NEEDS

Training/Technical Assistance Item	Description	Resource
None at this time		

7. LOCATION OF SSP RELATED ACTIVITIES TO BE SUPPORTED WITH FEDERAL FUNDS

AHCCCS will implement a statewide SSP to adequately address the needs of PWUD across the Arizona community. *Figure 2* (below) shows the statewide reach of our program, with SPW and its partners having a presence in a combined 10 of Arizona's 15 counties.

Figure 2.



8. SSP METRIC INFORMATION

SUBG sub-recipients (i.e., community-based organizations), implementing new or expanding existing SSPs will need to collect basic SSP metrics information (e.g., number of syringes distributed, estimated number of syringes returned for safe disposal, number of persons tested for HIV or viral hepatitis, and referrals to HIV, viral hepatitis and substance use disorder treatment).

AHCCCS developed an evaluation design into the method of approach to measure project performance, identify best practices, and facilitate continuous program improvement. Using the RE-AIM framework, the contracted provider, SPW, will gather data from program staff and participants through monthly programmatic reports. The data will track all measurable objectives, required reports, and reports for use by the advisory committee and executive team. All data collection methods will take into consideration the language, norms and values of the focus populations.

In compliance with SAMHSA guidance for State Block Grants, AHCCCS will collect the following information related to SSPs:

- Number of syringes distributed,
- Estimated number of syringes returned for safe disposal,
- Number of persons tested for HIV or viral hepatitis,
- Referrals to HIV/Viral Hepatitis testing and treatment, and
- Referrals to substance use disorder treatment.

Footnotes:

The planned budget for SUPTRS BG for SSP is assuming level funding of the SPW contract between calendar year 2025 and 2026. AHCCCS is awaiting the FFY2026 final allocation in order to finalize SPW's budget allocation for the time period of January 1, 2026 – December 31, 2026. There are no 2027 spend projections at this time.

Arizona Health Care Cost Containment System (AHCCCS) and Sonoran Prevention Works (SPW) Syringe Services Plan

Substance Use Prevention Treatment and Recovery Services Block Grant (SUPTRS BG)

FFY26-27 Combined Application – Environmental Factors Table 16.

2. BACKGROUND

In 2021, Sonoran Prevention Works (SPW) responded to a Request for Proposals (RFP) released by AHCCCS to procure statewide substance use harm reduction services. This resulted in a contract between AHCCCS and SPW that was effective for an initial 3-year term of January 1, 2022 – December 31, 2024 with 2 optional 1-year extensions (Calendar year 2025 and calendar year 2026).

Prior to utilizing SUPTRS BG (herein referred to as SUBG) funds to support SPW's syringe services program (SSP), AHCCCS received approval to do so from SAMHSA in the FFY2022-2023 application. AHCCCS work closely with SPW to ensure the use of federal funds are within federal and state law, including Presidential Executive Orders (EOs) (e.g. EO on Ending Crime and Disorder on America's Streets).

This workplan reflects the 2025 updated version of the contractually agreed upon workplan.

3. WORKPLAN

AHCCCS, through the statewide contractor, SPW, has developed and is implementing a comprehensive, evidence-based harm reduction program for the State of Arizona to meet the needs of the most vulnerable to overdose and other drug-related harms. *Figure 1* below displays the conceptual model developed for this project, illustrating the relationship between the interventions, immediate outcomes, and long-term outcomes.

Figure 1. Conceptual Model

Intervention	Immediate Outcomes	Long-term Outcomes
1) Naloxone distribution, education, and training 2) Syringe Services Program 3) Education and training 4) Peer support and wraparound services 5) Fentanyl and xylazine testing strip distribution, education, and training 6) Tailored programming and services for women 7) Culturally appropriate services and resources 8) Expanded network of key community stakeholders	• Increased initiation, continuation, and coordination of evidence-based treatment for individuals who use drugs • Increased harm reduction behaviors such as reduced or safer use through education, supply testing, and overdose prevention kits • Increased proper disposal of used syringes • Increased public awareness and community engagement	• Reduced rates of overdose, drug-related deaths and injuries, and transmission of infectious diseases • Improved health and wellness of people who use drugs • Reduced costs and burden associated with substance use/misuse on public systems

To achieve the listed outcomes, our strategy consists of eight (8) overarching strategies/interventions:

1) **Naloxone distribution, education, and training:** Expand a comprehensive, statewide naloxone distribution, education, and training initiative for people who use drugs (PWUD), prescribers, pharmacists, AHCCCS members and the public. Through the subcontracted provider, we aim to achieve the following objectives:
    - **a.** Distribute naloxone doses via kits to communities across Arizona through targeted street and community outreach.
    - **b.** Conduct in-person and web-based training sessions for prescribers, pharmacists, AHCCCS members, and the public, emphasizing evidence-based responses to opioid overdose and post-overdose support.
    - **c.** *SPW reports that the following objectives have been eliminated since CY2022:*
        i. Provide naloxone training and technical assistance to the correctional system to at least 50 percent of Arizona jails and 75 percent of state prisons distributing naloxone upon release.
            1. *Efforts were made towards this objective during CY2022, but SPW's subcontracted service provider (Community Medical Services) was not making significant progress & a similarly appropriate service provider could not be identified. With AHCCCS' permission, the objective was eliminated as a result.*
        ii. Train 10 percent of Arizona group homes for transition-age youth on overdose prevention, recognition, and response.
            1. *Efforts were made towards this objective during CY2022, but SPW's subcontracted service provider (Community Medical Services) was not making significant progress & a similarly appropriate service provider could not be identified. With AHCCCS' permission, the objective was eliminated as a result.*
2) **A statewide SSP:** Through SPW, AHCCCS aims to implement the following elements for a statewide SSP:
    - **a.** Develop and expand needle and hypodermic syringe disposal education and options for the State of Arizona to reach at least 5,640 individuals who inject drugs. In order to maximize our reach among our target population, we have developed three strategies to deliver supplies to PWUD: 1) fixed sites, 2) mobile units, and 3) mail order programs. Supplies include syringes (NOT funded by federal dollars), safe disposal containers, hygiene and wound care kits, internal and external condoms, rapid home HIV tests, and other associated supplies.
        i. *SPW reports that the following strategy was also employed from CY2022 – CY2024: Supply distribution kiosks. For CY2025 and CY2026, the future of this effort is unknown, as SPW is awaiting input from SPW's subcontracted service provider (Community Medical Services) about its capacity to continue with the kiosk strategy.*
    - **b.** Implement a statewide SSP with sites in Cochise, Coconino, Maricopa, Mohave, Pima, Santa Cruz, & Yuma Counties (in partnership with Southwest Recovery Alliance and Cochise Harm Reduction). The statewide provider will also create

new and expanded mobile and delivery based SSP services to reach PWUD across Arizona. In this project period, we aim to reach at least 5,640 Arizonans who inject drugs.

i. *SPW reports that the following additional counties also had SSP sites prior to CY2025: Graham, Navajo, Pinal, and Yavapai. If the kiosk strategy currently paused ultimately moves forward, it is possible that could reinstate implementation in some or all of these counties.*

c. Coordinate navigation services and treatment referrals for mental illness, substance use disorder, and other co-occurring disorders for SSP participants, as appropriate. SSPs provide an excellent opportunity to engage PWUD in a community setting with peer support from people with lived experience with substance use. Individuals seeking sterile needles or other supplies may also be offered referrals to navigation services, treatment referrals, or additional services as appropriate.

d. Develop and disseminate educational materials to at least 5,640 individuals through the SSP. Educational material may include the following topics: Overdose prevention, peer support services, infectious disease and transmission prevention, education, referrals, and treatment referrals for mental illness, SUD, and co-occurring disorders.

e. Develop and distribute evidence-based standards for distributing and disposing of needles and hypodermic syringes.

i. SPW reports that a complete "SSP Best Practices Manual" was provided to both AHCCCS & Arizona Department of Health Services (AZDHS) in October 2023. Under a training contract separate from SUBG, SPW has also provided ongoing training entitled, "Building Successful SSPs," at AZDHS' request.

3) Training for professionals and the broader community; Through SPW, AHCCCS aims to implement the following stigma reduction trainings for professionals and the broader community:

a. Develop and distribute educational material to at least 30,000 people through print and electronic distribution. With AHCCCS guidance, SPW will review and adapt existing educational material targeted at PWUD, the general public, providers, pharmacists, AHCCCS members, and other specific populations as appropriate.

b. Provide at least 20 free training sessions for community members and the broader public. SPW's training sessions are typically geared toward community members, resource organizations, and medical/behavioral health professionals, with specialized curricula for numerous populations and professions. In coordination with AHCCCS and the program officer, SPW will review and update all training curricula and materials for free general training sessions geared toward community members. Current training topics include overdose prevention and naloxone use, opioid use disorder, stimulant use disorder, stigma, injection-related complications, and other relevant issues. These

general trainings are offered in-person or virtually, including virtual video workshops or self-paced online courses.

c. Provide at least 15 training sessions to medical, behavioral health, and social service providers. SPW will develop or enhance trainings on overdose prevention, fentanyl testing strip use, stimulants, and other emerging topics and deliver to drug treatment providers, substance use prevention coalitions, health care providers, AHCCCS members, SUBG priority populations, organizations who serve women who use drugs, and other groups who engage with PWUD.

d. *SPW reports that the following objectives have been eliminated since CY2022:*

i. Conduct at least three trainings each year in each Geographic Service Area (GSA) in Arizona to the Department of Child Safety regional offices on overdose prevention and harm reduction. SPW will adapt existing curriculum to specifically address the unique needs of transition-age youth struggling with substance use/misuse.

1. *Efforts were made towards this objective during CY2022, but SPW's subcontracted service provider (Community Medical Services) was not making significant progress & a similarly appropriate service provider could not be identified. With AHCCCS' permission, the objective was eliminated as a result.*

ii. Provide training to at least 50 percent of Community Corrections offices on overdose prevention. Due to the disproportionate impact of opioid overdoses on criminal-justice involved individuals, we will make a concerted effort to train those that work in the criminal justice system with specialized content for this population.

1. *Efforts were made towards this objective during CY2022, but SPW's subcontracted service provider (Community Medical Services) was not making significant progress & a similarly appropriate service provider could not be identified. With AHCCCS' permission, the objective was eliminated as a result.*

4) Peer support program to facilitate linkages to treatment and wrap-around supports; Through SPW, AHCCCS aims to implement the following peer support program through the following strategies:

a. Develop and implement a network of at least 75 provider organizations to facilitate linkages to evidence-based care navigation services for individuals requiring a higher level of care. Peer support staff at SPW work at SSPs and conduct street outreach in order to identify new clients and facilitate referrals to organizations which provide the additional services they seek.

b. Provide at least 1,500 referrals to treatment through peer support staff for individuals requiring a higher level of care. Referrals may include treatment for: SUD, mental illness, mental health and harm reduction-based counseling, screening and treatment for HIV, viral hepatitis, and STIs, medical treatment and basic wound care. SPW's outreach staff are peer support-certified and specially trained to provide support around drug treatment, medical care,

mental health, housing, criminal justice involvement, identification replacement, and other services.

c. Disseminate risk reduction material through peer support staff to 5,640 individuals. Supply kits may include condoms, hygiene products, naloxone kits, fentanyl test strips, and other necessities.

d. Promote awareness through in-depth training for 2,700 individuals about the relationship between injection drug use and communicable diseases, recommended steps for disease transmission prevention, and options for treatment. Through syringe services and rapid HIV/HCV screening, outreach specialists will provide education on prevention, risk mitigation, and treatment for HIV, HCV, and other communicable diseases including hepatitis A and B, COVID-19, and STIs.

5) Fentanyl testing strip distribution, education, and training; Through SPW, AHCCCS aims to implement the following strategies:

a. Distribute 120,000 rapid fentanyl testing strips (FTS) to communities across the State of Arizona by the end of Year 3 (2024). Distribution will be prioritized to people who use drugs (all drugs, including heroin, stimulants, and pills), their friends and family, and organizations who can effectively distribute testing strips to people at risk for overdose. SPW maintains the lowest available cost-effective pricing agreement with pharmaceutical companies for FTS in Arizona and will continue to do so for this project. Our budget for this proposal includes resources to purchase 120,000 FTS for statewide distribution.

b. Develop and distribute FTS training materials and modules. FTS educational material will include content such as the use of FTS; alleviating fears and stigma; education on harm reduction and how it relates to using the testing strips to test for the presence of fentanyl; and information regarding use and/or disposal of substances that test positive for fentanyl. This content will be made available to PWUD, families, AHCCCS members, community-based organizations, and the general public.

6) Tailored programming and services for women, especially pregnant and parenting women (SUBG Priority Population); Through SPW, AHCCCS aims to implement the following strategies for this SUBG Priority Population:

a. Provide outreach and care coordination services to at least 200 women who use drugs, prioritizing pregnant and parenting women. Tailored programming and services for women who use drugs may include pediatric medical treatment and care, child welfare, Arizona Department of Child Safety (DCS) coordination, legal assistance, early childhood education, family counseling, and other services needed by all PWUD. We aim to serve a minimum of 30 women in each region.

b. Staff the statewide SSP with at least one staff member who specializes in supporting women who use drugs, particularly pregnant and parenting women. The staff member will travel throughout the state to provide services, as well as training and education for project staff and partners.

c. Prioritize the delivery of services and training to SUBG priority populations. In compliance with SAMHSA and AHCCCS regulations for the use of SUBG funds, all services provided through the resources requested for this project will prioritize the following SUBG populations: 1) pregnant women/teenagers who use drugs by injection, 2) pregnant women/teenagers with a SUD, 3) other persons who use drugs by injection, 4) women/teenagers with a SUD, with dependent children and their families, including women who are attempting to regain custody of their children, and 5) all other individuals with a SUD, regardless of gender or route of use. With respect to naloxone distribution, education and training, we aim to increase the utilization of SPW services among SUBG priority populations by at least 10 percent during the three-year project period (2022-2024).

d. Participate in statewide groups to conduct provider education on decreasing stigma and utilization of evidence-based practices for pregnant and parenting women who use drugs. Along with Objective 3E, we will make concerted efforts to train providers who treat women who use drugs, as well as incorporate gender-informed principles in our general training.

7) Culturally appropriate services and resources; Through SPW, AHCCCS aims to implement the following:

a. Provide Spanish translations and culturally sensitive versions of services and resources. SPW has provided Spanish translations of educational and outreach materials, as well as offered peer support services in Spanish since 2019. SPW currently has Spanish-speaking outreach staff in five Arizona counties. All printed educational materials will be available in English and Spanish, and additional materials will be revised for cultural sensitivity when working with tribal nations.

i. *SPW reports that in CY2022, we offered a telephone translation service to our outreach staff, but it was never used, so we eliminated it to reduce program costs.*

ii. *SPW reports that during CY2024, one of our SSP staff enrolled in additional training to become more proficient in the Navajo/Diné language to assist him in working more effectively with tribal participants.*

b. Host at least 20 training sessions in Spanish and distribute materials to at least 1,000 Spanish-speaking clients.

8) Stakeholder relationship and capacity building to ensure long-term program sustainability. Through SPW, AHCCCS aims to implement the following:

a. Convene a Community Advisory Board (CAB) consisting of impacted individuals from across the state of Arizona. Through regular meetings, the CAB provides SPW with critical feedback and insights into program efficacy & accessibility, builds community capacity to prevent overdoses and overdose deaths, & mitigates stigma. SPW utilizes successes & lessons learned from the CAB to build, train, & sustain a statewide network of professional partners, including SSPs, state and local government agencies, Substance Use Disorder and behavioral health treatment

providers, health departments, health clinics and systems, correctional health, first responders, community-based organizations, mutual aid groups, local businesses, schools, colleges and universities, and neighborhood associations.

b. Evaluate and continuously improve the services provided through our program through regular data monitoring, performance reports, and quality improvement methods. A critical part of this project is collecting reliable data to assess performance, evaluate progress, and continuously improve services and internal control systems. Additionally, we will maintain and expand SPW's inventory tracking system to monitor the supply and distribution of naloxone, FTS, and related outreach supplies purchased with SUBG funds.
    i. *In CY2022, SPW subcontracted ASU CHS for evaluation services. Due to high costs associated with this subcontractor and no evaluations completed beyond those which SPW itself is capable of completing via SUBG-supported staff, the subcontract did not continue after CY2022. Instead, SPW continues to collect and report to AHCCCS program implementation data (e.g. reach, referrals, trainings completed, syringes collected, distributed, etc.)*
c. Identify and disseminate best practices and recommendations for sustaining and expanding the program. All project processes, protocols, tools, evaluations, publications, and reports will be documented for dissemination to sustain and expand our collective efforts.

Acquiring Syringes and Needles through Non-Federal Funds: The statewide contractor, SPW, understands they will not utilize federal funds to purchase syringes/needles. AHCCCS will continue to ensure compliance with state and federal regulations. SPW is dedicated to ensuring that participants have access to all the supplies they need to stay as safe and healthy as possible, including syringes and needles. In support of this project, SPW will continue to fund the purchase of syringes and needles through a combination of grassroots fundraising methods as well as grant funding from a diverse range of private and public funders. SPW has a long history of utilizing grassroots fundraising methods, including one-time and monthly sustaining donations and program service revenue to support the work and help to fund the purchase of program supplies. SPW is committed to seeking out a diverse range of funders who share our values, and can support the purchasing of lifesaving supplies, such as syringes and needles, for participants. For years, SPW has worked to build and maintain relationships with funders dedicated to supporting health and harm reduction services to people impacted by substance use, including Broadway Cares, the Gilead Foundation, AIDS United, and more. SPW has also received funding from county health departments, hospital systems, and foundations across Arizona. Additionally, SPW proactively seeks out and applies to new funding opportunities that can further support the purchase of syringes and needles.

Applicable MOUs with SSP Providers who can supply needles: SPW is the acquirer of the syringes and needles needed for the program, and therefore no MOU is needed for supplying needles. In lieu of an MOU, SPW has an executed contract that may be submitted if required.

3. TIMELINE FOR IMPLEMENTATION

Please refer to **Attachment A** at the end of this document for the timeline for implementation.

4. COPY OF EXISTING SSP PROTOCOLS OR GUIDELINES

AHCCCS, in consultation with SPW, will utilize the following protocols/guidelines, and applicable state law such as:

a) Arizona Revised Statutes (ARS) Title 36, Chapter 6, Article 15: *Title 36, chapter 6, Arizona Revised Statutes. ARTICLE 15. OVERDOSE AND DISEASE PREVENTION. 36-798.51. Overdose and disease prevention programs; requirements; standards*
b) Centers for Disease Control and Prevention: *Syringe Service Programs, A Technical Package of Effective Strategies and Approaches for Planning, Design, and Implementation (published 2020)*
c) NASTAD: *Syringe Services Program (SSP) Development and Implementation Guidelines for State and Local Health Departments (published 2012)*
d) National Harm Reduction Coalition: *Guide to Developing and Managing a Syringe Service Program (published 2010, updated 2020)*
e)

5. BUDGET, BUDGET JUSTIFICATION, AND PROPOSED ACTIVITIES, INCLUDING A PLAN FOR DISPOSAL OF INJECTION EQUIPMENT

Category	2025 SUBG annual and ARPA
Personnel	$971,572
Fringe	$257,952
Travel	$42,607
Equipment	$0
Supplies	$429,759
Contractual	$74,300
Other	$42,383
Total Direct Charges	$1,818,573
Indirect Charges or Administration	$381,876
Total Project Costs	**$2,091,359**

**Footnote: This is based on level funding from CY25 budget subject to change based on funding availability and has not yet been approved or obligated to the contractor.*

Proposed Activities:

1) Naloxone distribution, education, and training;
2) A statewide SSP;
3) Trainings for professionals and the broader community;
4) Peer support program to facilitate linkages to treatment and wrap-around supports;
5) Fentanyl testing strip distribution, education, and training;
6) Tailored programming and services for women, especially pregnant and parenting women (SUBG Priority Population);
7) Culturally appropriate services and resources; and

8) Stakeholder relationship and capacity building to ensure long-term program sustainability.

Plan for disposal of injection equipment: SPW provided a "Syringe Services Program Best Practices Manual" to both AHCCCS & Arizona Department of Health Services (AZDHS) in October 2023 and remains on record at AHCCCS. This document contains evidence-based standards for disposing of needles and hypodermic syringes. SPW aims to follow applicable Arizona law regarding the disposal of injection equipment *(SB 1250: Article 15: 36-798.51. Overdose and disease prevention programs; requirements; standards):*

> *"A program established pursuant to this section shall develop standards for distributing and disposing of needles and hypodermic syringes based on scientific evidence and best practices. the number of needles and hypodermic syringes disposed of through a program shall be at least equivalent to the number of needles and hypodermic syringes distributed through the program."*

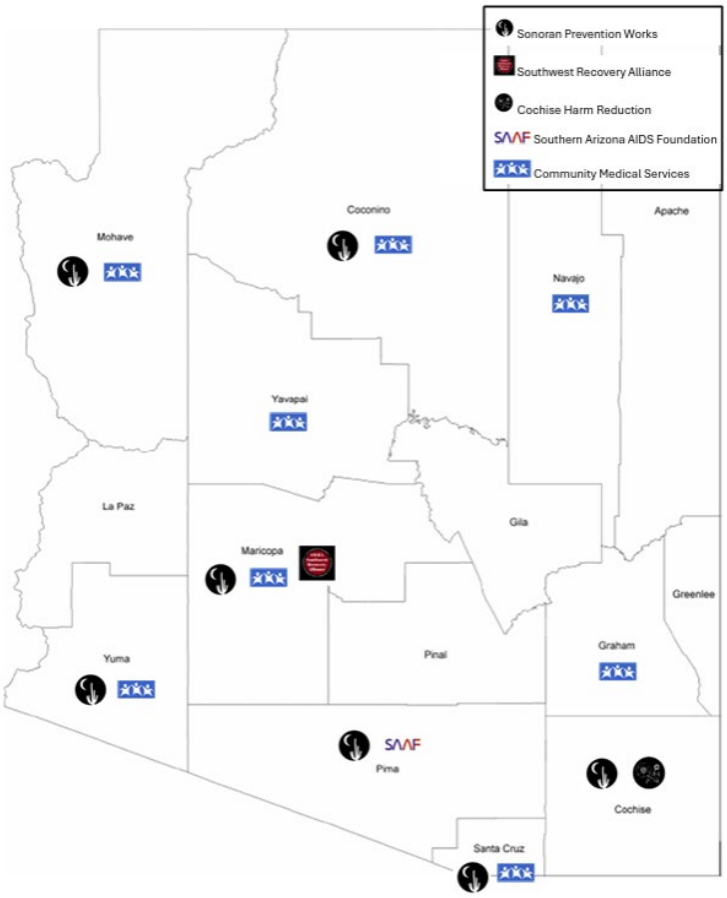
6. DESCRIPTION OF CURRENT TRAINING AND TECHNICAL ASSISTANCE NEEDS

Training/Technical Assistance Item	Description	Resource
None at this time		

7. LOCATION OF SSP RELATED ACTIVITIES TO BE SUPPORTED WITH FEDERAL FUNDS

AHCCCS will implement a statewide SSP to adequately address the needs of PWUD across the Arizona community. *Figure 2* (below) shows the statewide reach of our program, with SPW and its partners having a presence in a combined 10 of Arizona's 15 counties.

Figure 2.



8. SSP METRIC INFORMATION

SUBG sub-recipients (i.e., community-based organizations), implementing new or expanding existing SSPs will need to collect basic SSP metrics information (e.g., number of syringes distributed, estimated number of syringes returned for safe disposal, number of persons tested for HIV or viral hepatitis, and referrals to HIV, viral hepatitis and substance use disorder treatment).

AHCCCS developed an evaluation design into the method of approach to measure project performance, identify best practices, and facilitate continuous program improvement. Using the RE-AIM framework, the contracted provider, SPW, will gather data from program staff and participants through monthly programmatic reports. The data will track all measurable objectives, required reports, and reports for use by the advisory committee and executive team. All data collection methods will take into consideration the language, norms and values of the focus populations.

In compliance with SAMHSA guidance for State Block Grants, AHCCCS will collect the following information related to SSPs:

- Number of syringes distributed,
- Estimated number of syringes returned for safe disposal,
- Number of persons tested for HIV or viral hepatitis,
- Referrals to HIV/Viral Hepatitis testing and treatment, and
- Referrals to substance use disorder treatment.