



Division of Behavioral Health Services

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TO: RBHA CEOs and TRBHA Directors

FROM: Laura K. Nelson, M.D.
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Margaret Russell
Bureau Chief of Policy

SUBJECT: **POLICY CLARIFICATION: Non-Title XIX/XXI Funding**

DATE: April 7, 2009

This memorandum is intended to clarify the responsibilities of Tribal and Regional Behavioral Health Authorities (T/RBHAs) and T/RBHA providers in meeting the Arizona Department of Health Services/Division of Behavioral Health Services' (ADHS/DBHS) expectations regarding the following policies:

- [Provider Manual Section 3.1, Eligibility Screening for AHCCCS Health Insurance, Medicare Part D Prescription Drug Coverage, and the Limited Income Subsidy Program;](#)
- [Provider Manual Section 3.4, Co-payments;](#)
- [Provider Manual Section 3.5, Third Party Liability and Coordination of Benefits;](#)
- [Provider Manual Section 3.14, Securing Services and Prior Authorization;](#)
- [Provider Manual Section 3.18, Pre-petition Screening, Court Ordered Evaluation and Treatment;](#) and
- [Provider Manual Section 3.21, Service Prioritization for Non-Title XIX/XXI Funding.](#)

The following necessary actions have been identified by ADHS/DBHS to address the funding shortfalls for Non-Title XIX members across the state and will be implemented immediately:

1. **Require all individuals to comply with financial screening and eligibility process. Refusal to cooperate will result in ineligibility for services. T/RBHAs will not be required to serve individuals who refuse to cooperate with the screening and eligibility process.**
 - a. Arizona statute requires all persons, including individuals with a serious mental illness ([ARS § 36.550.06](#)), seeking state-funded behavioral health services to cooperate with financial screening and eligibility determinations. ([ARS § 36-3408](#)) Individuals who refuse to do so will no longer be eligible for services. An individual's inability to obtain documentation for eligibility determination cannot be considered a refusal to cooperate.

- b. Exceptional circumstances under which services may be provided for a limited time:
 - i. Emergency services, which are to be provided immediately, so long as within 5 days from the date of service, a financial screening is initiated; and
 - ii. When an individual is incapable of cooperating with the financial screening and eligibility determination process as a result of their mental illness, until or unless a representative capable of providing assistance is court appointed.
- c. The following ADHS/DBHS Provider Manual Section(s) will be revised to reflect these changes:
 - i. Provider Manual Section 3.1, *Eligibility Screening for AHCCCS Health Insurance, Medicare Part D Prescription Drug Coverage, and the Limited Income Subsidy Program*

2. Charge individuals who are non-TXIX, including non-TXIX SMI recipients, fees for services. Providers may request payment prior to the delivery of services and may refuse to provide services if co-pays are not collected.

- a. Arizona statute requires all individuals who are non-TXIX eligible to pay fees for services. A fee schedule, which will be established by ADHS/DBHS, includes, but is not limited to, a sliding fee schedule based upon the ability of the individual to pay for part or the total cost for services (i.e. some individuals will be expected to pay 100% for the cost of services). ([ARS §36-3409](#))
- b. The following ADHS/DBHS Provider Manual Section(s) will be revised to reflect these changes:
 - i. Provider Manual Section 3.4, *Co-payments*
 - ii. Provider Manual Section 3.5, *Third Party Liability and Coordination of Benefits*

3. No longer accept financial responsibility for court-ordered treatment services provided to individuals who are non-TXIX, non-SMI.

- a. The T/RBHAs are not financially responsible for court-ordered treatment services provided to individuals who are non-TXIX, non-SMI (see [Provider Manual Section 3.21, Service Prioritization for Non-Title XIX/XXI Funding](#)). T/RBHAs electing to take this position should notify the appropriate individuals, including Court Commissioners and treating hospitals, in advance and assist with identifying alternatives.
- b. The following ADHS/DBHS Provider Manual Section(s) will be revised to reflect these changes:
 - i. Provider Manual Section 3.18, *Pre-petition Screening, Court Ordered Evaluation and Treatment*

4. Eliminate coverage for Medicare Part D co-pays, premiums, deductibles, coinsurance, and non-formulary medications for non-TXIX members and dual eligible non-SMI

members. In addition, Non-TXIX individuals (including SMI) with other TPL are fully responsible for all out-of-pocket costs required by their insurer.

- a. With the exception of dual eligible SMI members, Medicare Part D co-pays, premiums, deductibles, coinsurance, and non-formulary medications will no longer be covered.
- b. The following ADHS/DBHS Provider Manual Section(s) will be revised to reflect these changes:
 - i. Provider Manual Section 3.21, *Service Prioritization for Non-Title XIX/XXI Funding*
 - ii. Provider Manual Section 3.5, *Third Party Liability and Coordination of Benefits*

5. Require Prior Authorization and Re-Authorization of Residential Services for all members, regardless of eligibility status:

- a. ADHS/DBHS will work with the T/RBHAs to develop and implement statewide prior authorization and re-authorization criteria for Level II, Level III, and Home Care Training for Home Care Client (HCTC). Once implemented, all T/RBHAs must utilize the same criteria.¹
- b. The following requirements and timeframes will apply:

	PA Required?	Re-Authorization Required?	Timeframe for Re-Authorization
Level I RTC	Yes (existing)	Yes (existing)	Every 30 days
Level II	Yes	Yes	Every 60 days
Level III	Yes	Yes	Every 90 days
HCTC	Yes	Yes	Every 90 days

- i. Level II Residential (Prior Authorization and Re-Authorization every 60 days)
 - ii. Level III Residential (Prior Authorization and Re-Authorization every 90 days)
 - iii. Home Care Training for Home Care Client (HCTC; Prior Authorization and Re-Authorization every 90 days)
- c. The following ADHS/DBHS Provider Manual Section(s) will be revised to reflect these changes:
 - i. Provider Manual Section 3.14, *Securing Services and Prior Authorization*

6. Relax Minimum Network Standards for non-TXIX SMI recipients to align with revenue reductions (Applies to Greater Arizona T/RBHAs only)

¹ Until these criteria are finalized, T/RBHAs may develop and utilize their own criteria as described in the letter from ADHS/DBHS dated February 19, 2009.

- a. ADHS/DBHS supports a reduction in the total number of Full Time Equivalents (FTEs) working within outpatient clinics or operating independently who serve non-TXIX SMI recipients as long as the clinical needs of enrolled non-TXIX SMI recipients can be met.
 - i. Staffing Types Include:
 - 1. Paraprofessionals
 - 2. Behavioral Health Technicians (BHT)
 - 3. Behavioral Health Professionals (BHP)
 - 4. Psychiatrists, Nurse Practitioners, or Physician Assistants
- b. It is the expectation of ADHS/DBHS that each T/RBHA continue to maintain an adequate and sufficient network. Any changes to the network must follow all applicable reporting requirements identified within each contract.

7. Avoid the use of Single Case Agreements (SCA) for non-TXIX members

- a. When alternative in-network providers are available to meet the need, these can and should be used.
- b. The following ADHS/DBHS Provider Manual Section(s) will be revised to reflect these changes:
 - i. Provider Manual Section 3.4, *Co-payments*
 - ii. Provider Manual Section 3.5, *Third Party Liability and Coordination of Benefits*