June 14, 2012

Sent via electronic mail

Mick Pattinson, PhD.
NARBHA
1300 S. Yale Street
Flagstaff, AZ 86001

Re: FY 2013 Non-Title XIX SMI Allocation

Dear Dr. Pattinson:

This letter is to inform you of (a) NARBHA’s Fiscal Year 2013 (FY13) allocation of funding for crisis services and services for non-TXIX-eligible adults with serious mental illness (SMI) and (b) parameters and guidelines for submitting your proposed spending and oversight plan for these funds. Please note that separate correspondence pertaining to permanent supportive housing has been sent and requires submission of a separate spending plan for those funds.

In January, Governor Brewer released a proposed budget\(^1\) that included an additional $38.7 million for community-based, recovery-oriented behavioral health services for individuals with SMI. The Governor was successful in securing these funds and the FY13 budget\(^2\) was approved on May 7, 2012.

In collaboration with the Tribal and Regional Behavioral Health Authorities (T/RBHAs), providers, members, family members and advocates, the Arizona Department of Health Services, Division of Behavioral Health Services (ADHS/DBHS) gathered input and recommendations for the most efficient and effective use of these funds. A detailed presentation\(^3\) was developed and shared as part of this stakeholder input process. In addition to summarizing the funding sources and targeted services, this presentation re-emphasizes Arizona’s commitment to community integration, independence and self-sufficiency, individualized goals and outcomes, responsive services, natural supports, and recovery.

These funds must be strategically and responsibly utilized to support the individual needs of each eligible member. ADHS/DBHS’ intent is to establish a consistent approach statewide, but we also recognize the need for a certain amount of flexibility given the unique, regional challenges that should be addressed. The FY13 funding allocation for your T/RBHA is below; Attachment A explains the methodology used to calculate this allocation:

<table>
<thead>
<tr>
<th>Non-TXIX SMI Services Funds:</th>
<th>$7,847,727.00</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crisis Services Funds:</td>
<td>$1,623,930.00</td>
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Here are the parameters that must be incorporated into your plan for services for non-TXIX-eligible adults with SMI:

1. Case Management and Service Planning
   
a. Assigned Case Managers
   
i. Not all non-TXIX-eligible adults with SMI need or will have an assigned Case Manager. **Attachment B** outlines the criteria that shall be used statewide to determine which non-TXIX-eligible adults with SMI will have an assigned Case Manager.
   
   ii. Confirm that these criteria will be used during the next scheduled appointment with the member, and all non-TXIX-eligible adults with SMI will have this review completed and documented by September 30, 2012.
   
   iii. Specify how the T/RBHA will track the percentage of non-TXIX-eligible adults with SMI that have an assigned Case Manager. ADHS/DBHS expects the T/RBHA to be able to identify and intervene with outlier clinics/clinicians that assign Case Managers when criteria are not truly met. This percentage shall be made available to ADHS/DBHS upon request.
   
   iv. In conjunction with this Case Manager determination, specify how the T/RBHA shall ensure that members are provided a Notice of Decision and Right to Appeal, consistent with the requirements in ADHS/DBHS Policy and Procedure GA 3.5, "Notice and Appeal Requirements (SMI and Non-SMI, NXIX/XXI)."
   
   v. In collaboration with the member, the assigned Case Manager shall be responsible for development of and updating the Individual Service Plan per Provider Manual section 3.9 "Assessment and Service Planning."

b. Case Management Services
   
i. When there is not an assigned Case Manager, case management services can still be provided by other team members when needed and appropriate.
   
   ii. Specify how the T/RBHA will track and monitor the appropriate use of case management services for members that do not have an assigned Case Manager. ADHS/DBHS expects the T/RBHA to be able to identify and intervene with outlier clinics/team members that become overly dependent on case management services, because this decreases funding for other community-based support services.

c. Peer Support Services and the Service Planning Process
   
i. We have learned that many individuals can successfully be their own, best “case manager,” and these individuals should be encouraged and supported in this endeavor. Specify how this concept will be supported.
   
   ii. For those individuals without a Case Manager assigned, the existing process and requirements for documenting the service plan by the Behavioral Health Medical Professional (BHMP) can be used. However, members shall have the option of accessing peer support services to assist them in developing a peer-driven, self-developed proposed service plan to be shared with their BHMP.

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4 NOTE: expectations for case management and service planning are unchanged for TXIX-eligible members with SMI at this time
iii. Peer support is defined in the Behavioral Health Covered Services Guide as “assistance to more effectively utilize the service delivery system, including: assistance in identifying needs, developing plans of care, and accessing supports.” Peer Support (individually or in a group setting) can thus be used to assist the member with establishment of a proposed service plan. This self-developed service plan can then be shared with the individual’s BHMP for approval and implementation.

iv. Specify how local peer-run organizations and staff employed by peer-run organizations will be optimized to assist in proposed service plan development for members without an assigned Case Manager. For example, peer-run organizations and their staff can play a vital role in assisting individuals develop a proposed service plan.

v. Specify how services identified on the proposed service plan will then be advocated for, approved, coordinated, provided, and tracked.

vi. These peer-driven, self-developed service plans are not required to contain all minimum elements as outlined in Provider Manual section 3.9 "Assessment and Service Planning.” However, they should consider the member-specific need for and expected benefit from community-based support services as discussed below. These services should be incorporated into the peer-driven, self-developed proposed service plan as appropriate. It is recommended that a standardized process be used to develop the peer-driven, self-developed proposed service plan; several peer-run organizations have such tools/processes that are being adapted to meet this need and these organizations can provide training and mentoring for peer-support staff working within other settings to develop a proposed service plan using these tools.

vii. In addition, the peer-driven, self-developed proposed service plan should also address natural supports that can be leveraged and strengthened as well as outline crisis prevention approaches (e.g. warm line availability) and how the emergence of a potential crisis will be addressed.

2. Community-based Support Services
   a. Certain community-based support services foster member independence and self-sufficiency while decreasing long-term dependency on the public service system.
   b. Consistent with Provider Manual Section 3.21 "Service Package for Non-Title XIX/XXI Persons Determined to Have a Serious Mental Illness (SMI)” specify how the T/RBHA will consider historical utilization and network capacity to prioritize the availability of and efficient utilization of support services, including but not limited to:
      i. Supported employment
      ii. Peer support
      iii. Family support
      iv. Permanent supportive housing
      v. Living skills training
      vi. Health promotion
      vii. Personal assistance
      viii. Respite care
c. For each of the services listed above (i. through viii.), specify the ideal/target percentage of the total allocation of Non-TXIX SMI Services Funds that the T/RBHA hopes to expend in these community-based service areas. These targets will only be used to assist in tracking service utilization goals and to ensure the broad array of community-based services is available to members. However, significant deviation from the targets may require the submission of a new spending plan.

d. Specify T/RBHA expectations for providers in discharge planning and safe, prompt transition back to the community (with necessary supports) for non-TXIX-eligible adults with SMI who have been admitted to an inpatient setting.

3. Medication Management

a. **Attachment C** outlines the prior authorization criteria that shall be adopted statewide for the use of Abilify (aripiprazole). These criteria shall be used for both TXIX-eligible and non-TXIX-eligible recipients of behavioral health services. As noted in the criteria, those members currently prescribed Abilify shall be waived from the prior authorization process for as long as the medication continues to be prescribed. If the medication is discontinued, prior authorization would be required prior to the medication being re-started. ADHS/DBHS may discontinue the requirement for prior authorization of Abilify when generic formulations become available.

While behavioral health counseling/therapy services and other professional services (as identified in the [Behavioral Health Covered Services Guide](http://www.azdhs.gov/bhs/non-title19.htm)) are not available to non-TXIX-eligible adults with SMI beginning July 1, 2012, ADHS/DBHS will continue to consider criteria that could be established in order to make these services available in the future.

ADHS/DBHS has developed a page on our [website](http://www.azdhs.gov/bhs/non-title19.htm) where information regarding these funds and services can be shared with our stakeholders, including Frequently Asked Questions. Please feel free to share with your staff, members and providers. In addition, the following Provider Manual Sections are in the process of being updated as necessary to reflect the information contained in this correspondence:

1. Provider Manual Section 3.9 "Assessment and Service Planning"
2. Provider Manual Section 3.16 "Medication Formularies"
3. Provider Manual Section 3.21 "Service Package for Non-Title XIX/XXI Persons Determined to Have a Serious Mental Illness (SMI)"

Please submit the proposed FY13 T/RBHA Non-TXIX SMI Implementation and Oversight Plan to my attention and to the attention of the DBHS Compliance Office mailbox ([BHSCompliance@azdhs.gov](mailto:BHSCompliance@azdhs.gov)) by close of business on **June 22, 2012** for ADHS/DBHS approval. As part of the T/RBHA proposed Plan, in addition to addressing the specifics outlined above, please also describe your process for (a) monitoring expenditures to ensure that the funding is consistent and sufficient to last throughout the fiscal year, (b) bringing your budget into alignment if you discover the funding is insufficient for the budgeted expenditures, and (c) how you will notify ADHS/DBHS if there are any funding or programmatic changes necessary as a result of this monitoring. ADHS/DBHS will work collaboratively with you to get these plans approved as quickly as possible so you can begin implementation as close to July 1, 2012 as possible.
I appreciate the valuable input each of you has provided to date, as well as your willingness to plan for the successful implementation of these funds for the individuals we serve.

Sincerely,

Laura K. Nelson, M.D.
Deputy Director

Attachments

CC:  DBHS Senior Executive Team
     Compliance File
ADHS/DBHS applied the following logic/methodology to determine each T/RBHA’s allocation amount of the FY13 budget line item titled “non-Medicaid SMI services” consisting of $95,238,000.00:

1. **Permanent Supportive Housing**: $3 million was pulled out and set aside for Permanent Supportive Housing.
   a. Because T/RBHAs must submit to ADHS/DBHS at the beginning of each fiscal year their proposed Housing Plan for acquisition, improvements, subsidies, and other supportive housing services, ADHS/DBHS felt it necessary to set-aside and dedicate some amount of the $95.2m for supportive housing for non-TXIX SMI members.
   b. In looking at FY9 and FY10 expenditures for supported housing for non-TXIX SMI members (when this was a covered benefit), ADHS/DBHS estimated about $2m of state general fund dollars were used per year.
   c. Because inpatient and residential services are not covered benefits, and because ADHS/DBHS wishes to see a continued increase in the use of independent supportive housing, a set-aside of $3m housing was selected.
   d. This $3m will be added to the other funding sources for RBHA inclusion as they develop their annual Housing Plan. RBHAs can still opt to use some of the remaining allocation for supportive housing services. However, any proposed increase in housing expenditures above the allocated amounts must be preceded by submission of a revised housing spending plan for approval by ADHS/DBHS.

2. **TRBHA funding**: $800,000 was pulled out and set aside for TRBHAs for their non-TXIX SMI members.

3. **Crisis Services**: $16.3 million was pulled out and set aside for crisis services to reinforce that crisis services (for all individuals without other payor source, including Medicaid) are still covered. The numbers are essentially the same as they have been for the last two fiscal years, and the RBHAs will track expenditures for crisis services separately.

4. **Non-TXIX SMI Services**: The remaining funding (approximately $75 Million) was allocated using a blended expenditure/enrollment approach:
   a. First, ADHS/DBHS summed the non-Title XIX SMI actual expenditures for FY09 and FY10 by GSA for community-based treatment and support services; expenditures for Supported Housing and Crisis were excluded, as well as expenditures for residential and inpatient services. A ratio by GSA as a percentage of the total statewide expenditures was determined.
   b. Second, ADHS/DBHS summed the active enrollment numbers for non-TXIX SMI members for FY09 through FY12 YTD (February 2012) by GSA. ADHS/DBHS took into account the percentage of the total non-TXIX SMI population served in each geographic region. By using FY09-FY12 data, ADHS/DBHS was able to better consider the enrollment both before and after the benefit change took place in FY11. A ratio by GSA as a percentage of total statewide active enrollment was determined.
   c. Last, the expenditure percentage and the active enrollment percentage were blended together with a weighting of 25% expenditures and 75% active enrollment to establish a percentage by GSA. This percentage was then multiplied by the remaining funding to calculate the allocation amount. ADHS/DBHS used the 25% expenditures and 75% enrollment blended weights to emphasize outreach, engagement, and retention of non-TXIX SMI members receiving services.
The assignment of an identified Case Manager for non-TXIX adults with serious mental illness shall be based upon an objective and individualized determination of member need using standardized criteria as outlined below. Assigned Case Managers shall be Behavioral Health Professionals or Behavioral Health Technicians as defined by R9-20 (http://www.azsos.gov/public_services/Title_09/9-20.htm). The Behavioral Health Medical Practitioner (BHMP) shall make the final determination based upon both the criteria outlined below and clinical judgment. This determination shall be documented as follows:

- Document on the initial comprehensive assessment upon completion of the assessment;
- Document on the annual update to the assessment upon completion of the annual update;
- Document in the psychiatric progress note at any time between comprehensive assessments when it is determined that (a) the member qualifies for assignment of an identified Case Manager or (b) the member no longer qualifies for assignment of an identified Case Manager.

In addition, the BHMP shall ensure the member is notified of his/her appeal rights related to the determination consistent with the requirements in ADHS/DBHS Policy and Procedure GA 3.5, “Notice and Appeal Requirements (SMI and Non-SMI, NXIX/XXI).”

A Case Manager shall be assigned to non-TXIX-eligible adults with SMI when the member has been determined to be at-risk for safety and successfully managing themselves in the community due to treatment non-adherence, severity of symptoms, or inability to independently coordinate their own care or transition between systems. This may be evidenced by one or more of the following:

- Individuals that frequently access crisis services;
- Individuals in need of frequent hospitalization or inpatient services;
- Individuals under civil court – ordered treatment pursuant to Arizona Revised Statutes §36 – 501 et al;
- Individuals residing in the community under the jurisdiction of the Psychiatric Security Review Board (PSRB) as Guilty Except Insane (GEI);
- Individuals under the jurisdiction of the Arizona Community Protection and Treatment Center (ACPTC) that are living in the community;
- Individuals discharged from long term hospitalization or an institutional setting, including the Arizona State Hospital;
- Individuals with active involvement in the criminal justice system, including probation, parole or repeated arrests;
- Individuals that require ongoing assistance to access, maintain and monitor needed services;
- Individuals on an Assertive Community Treatment (ACT) or Intensive Recovery Team;
- Individuals that have been determined to need special assistance under ADHS/DBHS Provider Manual Section 5.4 "Special Assistance for Persons Determined to have a Serious Mental Illness" Policy Manual Section GA 3.4 "Special Assistance for Persons Determined to have a Serious Mental Illness".
Prior Authorization Criteria for Abilify (aripiprazole)

1. Bipolar I disorder:
   a. FDA-approved for (a) acute treatment of manic and mixed episodes, both as monotherapy and as an adjunct to lithium or valproate in adult and pediatric patients 10-17 years of age and (b) maintenance treatment, both as monotherapy and as an adjunct to either lithium or valproate
   b. Prior Authorization Criteria: Failure to respond (or intolerance) to an adequate trial (at least 30 days) of each of the following:
      i. Lithium,
      ii. Valproic acid, and
      iii. A combination of 2 mood stabilizers or a combination of one mood stabilizer and one atypical antipsychotic

2. Major Depressive disorder
   a. FDA-approved for adjunctive treatment in adults
   b. Prior Authorization Criteria: Failure to respond (or intolerance) to an adequate trial (4-6 weeks) of each of the following:
      i. Two different Selective Serotonin Reuptake Inhibitors, and
      ii. Venlafaxine or duloxetine, and
      iii. Mirtazapine or bupropion, and
      iv. Two combination trials of an antidepressant with any of the following adjunctive agents (lithium, thyroid hormone, bupropion, or mirtazapine)

3. Schizophrenia
   a. FDA-approved for adults and adolescents 13 to 17 years of age
   b. Prior Authorization Criteria for adults: Failure to respond (or intolerance) to an adequate trial (4-6 weeks) of 3 separate trials of any of the three following:
      i. Olanzapine and/or,
      ii. Quetiapine and/or,
      iii. Ziprasidone and/or,
      iv. Risperidone
   c. Prior Authorization Criteria for adolescents (ages 13-17): Failure to respond (or intolerance) to an adequate trial (4 – 6 weeks) of each of the following:
      i. Quetiapine and
      ii. Risperidone

4. Irritability associated with autistic disorder
   a. FDA-approved for pediatric patients 6 to 17 years of age
   b. Prior Authorization Criteria: Failure to respond (or intolerance) to an adequate trial (30 days) of Risperidone

For all above indications, prior authorization is not required for those individuals prescribed Abilify (aripiprazole) prior to July, 1, 2012. If Abilify is discontinued after July 1, 2012, however, prior authorization is required prior to Abilify being re-started.

For all of the above indications, prior authorization shall be approved for (a) individuals with a current diagnosis of Metabolic Syndrome or Diabetes Mellitus, (b) adolescents (13-17 years old) with a significant clinical concern for the development of metabolic syndrome or obesity, or (c) individuals with a body mass index (BMI) > 30.