TO: RBHA CEOs and TRBHA Directors  
FROM: Laura K. Nelson, M.D.  
Acting Deputy Director  
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:

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<tr>
<td><strong>Level I</strong> RTC</td>
<td>Yes (existing)</td>
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<td><strong>Level II</strong></td>
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<td><strong>Level III</strong></td>
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<tr>
<td><strong>HCTC</strong></td>
<td>Yes</td>
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   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:

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*