Section 3.13 Covered Behavioral Health Services

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3.13.1 Introduction

The Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) system of care offers an assortment of covered behavioral health services to meet the individual needs of persons eligible for behavioral health services. Covered behavioral health services assist and encourage each person to achieve and maintain the highest possible level of health and self-sufficiency. The type of behavioral health service covered is contingent on each person's current eligibility status and, for some persons, is based on available funding.

3.13.2 References

The following citations can serve as additional resources for this content area:

42 CFR Part 400
42 CFR Part 403
42 CFR Part 411
42 CFR Part 417
42 CFR Part 422
42 CFR Part 423
9 A.A.C. 21
R9-22-1205
R9-31-1205
AHCCCS/ADHS Contract
ADHS/RBHA Contracts
ADHS/TRBHA IGAs
Section 3.1, Eligibility for AHCCCS Health Insurance, Medicare Part D Prescription Drug Coverage, and the Limited Income Subsidy Program
Section 3.4, Co-payments
Section 3.19, Special Populations
Section 3.25, Crisis Intervention Services
Section 5.1, Notice Requirements and Appeal Process for Title XIX and Title XXI Eligible Persons
Section 5.4, Special Assistance for Persons Determined to Have a Serious Mental Illness
Section 5.5, Notice and Appeal Requirements (SMI and Non-SMI/Non-Title XIX/XXI)
ADHS/DBHS Covered Behavioral Health Services Guide

3.13.3 Scope

To whom does this apply?

All Title XIX/XXI (Medicaid/SCHIP) and Title XVIII (Medicare) eligible persons; and all Non-Title XIX/XXI persons determined to have a Serious Mental Illness and all other persons receiving services as part of the behavioral health system, based on available funding.

3.13.4 Did you know…?

The ADHS/DBHS Covered Behavioral Health Services Guide contains information regarding each of the covered behavioral health services that are available through the publicly funded behavioral health system including: a definition of each service; the requirements of individuals or agencies providing the service; and any limitations to using or billing for the service.

Providers must screen individuals for AHCCCS eligibility and, as applicable, assist individuals with applying for AHCCCS and/or enrolling in Medicare Part D (see Section 3.1, Eligibility Screening for AHCCCS Health Insurance, Medicare Part D Prescription Drug Coverage and the Limited Income Subsidy Program). Medicare eligible behavioral health recipients, including persons who are dually eligible for Medicare (Title XVIII) and Medicaid (Title XIX/XXI), receive Medicare Part D prescription drug benefits through Medicare Prescription Drug Plans (PDPs) or Medicare Advantage Prescription Drug Plans (MA-PDs). Prescription drug coverage for Medicare eligible behavioral health recipients enrolled in Part D is based on Part D plans' formularies. Individuals who refuse to participate in the AHCCCS screening and eligibility application process or to enroll in a Medicare Part D plan are ineligible for state funded behavioral health services. In addition, providers must obtain documentation from individuals during the screening process to verify lawful presence in the United States (see Section 3.27, Verification of U.S. Citizenship or Lawful Presence for Public Behavioral Health Benefits). Individuals unable to provide such documentation to verify citizenship or lawful presence are not eligible for state funded behavioral health services, other than crisis services. Crisis services are provided to any person presenting with a behavioral health crisis in the community, regardless of eligibility or enrollment status (see Section 3.25, Crisis Intervention Services).

Services for Non-Title XIX/XXI persons determined to have a Serious Mental Illness are subject to available funding, as appropriated by the Arizona Legislature. T/RBHAs must ensure that Non-Title XIX/XXI funding allocated by ADHS/DBHS for each geographic service area (GSA) is available for services throughout the fiscal year.

Decisions made with respect to the coverage and provision of services are subject to Notice and Appeal requirements (see Section 5.1, Notice Requirements and Appeal Process for Title XIX and Title XXI Eligible Persons and Section 5.5, Notice and Appeal Requirements (SMI and Non-SMI/Non-Title XIX/XXI). Behavioral health services must be medically necessary, based upon the needs of the person, and providers must operate within their scope of practice.

Services must be provided in collaboration with other agencies to coordinate the culturally appropriate delivery of covered behavioral health services with other services and supports provided to the person and the person's family.

Covered behavioral health services may be available to family members of Title XIX/XXI eligible persons enrolled with a T/RBHA to the extent that services are provided in support of the treatment goals of the identified eligible or enrolled person.

3.13.5 Definitions

Flex funds

Medically necessary covered services

3.13.6 Objectives

The intent of this section is to identify the covered services available to behavioral health recipients based upon their eligibility status.

3.13.7 Procedures

3.13.7-A: Covered services matrix

PM Attachment 3.13.1, Covered Services Matrix, lists the available covered behavioral health services for T/RBHA enrolled persons and Non-Title XIX/XXI, persons determined to have a Serious Mental Illness. These services must be provided by AHCCCS registered providers, ADHS-only providers or Medicare registered providers. PM Attachment 3.13.1, Covered Services Matrix is a condensed summary of available behavioral health services and related funding sources. Behavioral health providers may reference the ADHS/DBHS Covered Behavioral Health Services Guide for more detailed information.

3.13.7-B: Medicare Part D Prescription Drug Coverage

Persons eligible for Medicare Part D must access the Medicare Part D prescription drug coverage by enrolling with a Medicare Prescription Drug Plan (PDP) or Medicare Advantage Prescription Drug plan (MA-PD). Persons eligible for both Medicare Part D and Title XIX/XXI (AHCCCS) will continue to have coverage of the following excluded Part D drugs through Title XIX/XXI, if not included in the PDP or MA plans' formulary:

- Benzodiazepines;
- Barbiturates; and
- Certain over the counter drugs.

3.13.7-C: Flex Funds

T/RBHAs and/or their subcontracted providers may provide flex funds based on available funding.

When can flex funds be used?

Flex funds may only be used for goods and/or services that are described in the person's service plan that cannot be purchased by any other funding source. The goods and/or services to be provided using flex funds must be related to one or more of the following outcomes:

- Success in school, work or other occupation;
- Living at the person's own home or with family;
- Development and maintenance of personally satisfying relationships;
- Prevention or reduction in adverse outcomes; and/or
- Becoming or remaining a stable and productive member of the community.

When can flex funds not be used?
Flex funds must not be used for:

- Inpatient or other covered behavioral health services;
- The purchase or improvement of land;
- The purchase, construction or permanent improvement of any building or other facility (with the exception of minor remodeling consistent with this Section); and
- The purchase of major medical equipment.

T/RBHAs and/or their subcontracted providers must use flex funds for the direct purchase of goods and/or services and may not provide flex funds as direct cash payments to behavioral health recipients or their families. See the ADHS/DBHS Covered Behavioral Health Services Guide for additional information regarding flex funds and applicable billing limitations.

How are flex funds accessed?
Each T/RBHA may approve flex fund services of up to $1,525 per individual/family per year. Clinical teams may access flex funds by: informing the WMABHS Child and Family Team lead clinician that specific items are required. The Clinical Supervisor will submit a flex fund request form to the Clinical Director who will submit it to the Management Team for final approval.

T/RBHAs must forward requests for approval of flex fund expenditures exceeding $1,525 per individual/family per fiscal year to **flexfunds@azdhs.gov**.
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WMABHS receives very limited flex funds and the funds are only available for the children's population.