

Mental Health and Substance Abuse Services in Medicaid and SCHIP in Arizona

As of July 2003, 952,682 people were covered under Arizona's Medicaid/SCHIP programs.¹ There were 779,682 enrollees financed by the traditional Medicaid program and 51,027 by the separate SCHIP program. In Federal fiscal year 2001, Arizona spent about \$2.5 billion to provide Medicaid services.

Arizona obtained a §1115 waiver for comprehensive State health reform in 1982 that enabled the State to establish the Arizona Health Care Cost Containment System (AHCCCS), serving program participants through managed care. Eligibility for AHCCCS has been modified through amendments to the original §1115 waiver and the granting of a new Health Insurance Flexibility and Accountability (HIFA) waiver in September 2001. As of July 2003, AHCCCS-contracted health plans now serve families and individuals with incomes of 100 percent Federal Poverty Level (FPL) or less under Medicaid, and families with incomes of 200 percent FPL or less under SCHIP. All non-American Indian participants with incomes over 100 percent FPL must pay a premium that ranges from \$10–\$35 depending on family income and size.² Medicaid or SCHIP funding finances the cost of caring for program participants. This document will explain how participants are assigned to those programs.

In Arizona, low-income children may be enrolled in the AHCCCS Medicaid program or a separate SCHIP program (called KidCare), based on the child's age and the family's income.

- The Medicaid program serves children under age 1 from families with incomes of 140 percent FPL or below; children aged 1–5 from families with incomes of 133 percent FPL or below; and children aged 6–18 from families with incomes of 100 percent FPL or below.
- The separate SCHIP program serves all children from families with incomes of 200 percent FPL or below who do not qualify for Medicaid. All non-American Indian program participants with incomes over 100 percent FPL must pay a premium that ranges from \$10 to \$35 depending on family income and size.

Arizona operates a managed care program. All AHCCCS and KidCare program participants are served through managed care. For acute care members, acute medical care is delivered through a Managed Care Organization (MCO). Behavioral health care is delivered through a behavioral health prepaid inpatient health plan (PIHP). For long-term care (LTC) members, acute, long-term, and behavioral health care are delivered through an MCO. Service choices for American Indians participating in acute or LTC are described below.

¹ Includes eligibility groups other than SCHIP and traditional Medicaid.

² Increased to \$10–\$35, effective 2/1/04.

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- Acute care participants receive care through a comprehensive MCO.
- Acute care participants receive mental health and substance abuse services through a specialty PIHP.
- Acute care American Indian participants can choose to receive services through managed care or through Indian Health Services on a fee-for-service basis.
- LTC participants receive services through an MCO, including mental health and substance abuse services.
- LTC American Indian participants may receive services through an MCO or may choose to receive services through Indian Health Services on a fee-for-service basis. Mental health and substance abuse services may be provided through Indian Health Services or through the MCO in which the member is enrolled

Medicaid

Who Is Eligible for Medicaid?

Families and Children

1. Low-income families with incomes of 100 percent FPL or less.
2. Children under 1 year from families with incomes of 140 percent FPL or less.
3. Pregnant women and children aged 1–6 from families with incomes of 133 percent FPL or less.
4. Children aged 6–18 from families with incomes of 100 percent FPL or less.
5. Recipients of adoption assistance and foster care under Title IV-E of the Social Security Act.
6. Recipients of State adoption subsidy programs.
7. Children under age 21 who were in foster care on their 18th birthday and continue to receive services under the Foster Care Independence Act of 1999.

Aged, Blind, and Disabled

1. Individuals receiving Supplemental Security Income (SSI) cash.
2. Aged, blind, and disabled persons with incomes at or below 100 percent FPL.
3. Working individuals aged 16–64 who meet the SSI definition of disability and have an income of 250 percent FPL or less.
4. All individuals with incomes of \$1,656 or less whom the State determines are at immediate risk for institutionalization may enroll into the AHCCCS long-term care program.
5. Individuals who are in institutions for at least 30 consecutive days with incomes of no more than 300 percent of the maximum SSI cash benefit (\$1,600 per month if single or \$2,100 per month if a married couple).

Medically Needy

Arizona does not have a medically needy program. However, according to a feature in its §1115 waiver, Arizona does cover individuals with recent medical expenses that reduce income to no more than 40 percent FPL.

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Waiver Populations

Arizona's entire Medicaid program operates under a §1115 waiver. In addition to those groups previously described, the §1115 waiver enables Arizona to cover childless adults with incomes of 100 percent FPL or less under the AHCCCS acute care program. Participants in the AHCCCS program can receive mental health and substance abuse services.

What Mental Health/Substance Abuse Services Are Covered by Medicaid?

Medicaid must cover some types of services (mandatory services) and may cover some other types of services (optional services). The information presented here identifies the types of services Arizona Medicaid covers and the coverage requirements. These services are presented as they are grouped in the Medicaid State plan that Arizona must maintain under Medicaid law. Only those types of services that include mental health or substance abuse services are discussed.

Mandatory State Plan Services

Inpatient Hospital Services		
Service	Description	Coverage Requirements
Inpatient psychiatric care	Inpatient psychiatric care includes all services, accommodations and staffing, supplies, and equipment needed to treat episodes of mental illness.	<ul style="list-style-type: none"> Beneficiaries may receive services from a general acute care hospital, a behavioral health unit of a general acute care hospital, or a mental hospital. Inpatient services provided by an institution for mental diseases (IMD) to beneficiaries aged 21–64 may be reimbursed for no more than 30 days per admission and 60 days per contract year. All admissions and requests for additional days must be preapproved by the behavioral health contractor, except if the admission is an emergency. Emergency services do not require prior authorization and are provided per the prudent layperson standard. Retrospective utilization review will be performed. A physician must direct services.
Inpatient substance abuse care	<ul style="list-style-type: none"> Inpatient substance abuse care includes all services, accommodations and staffing, supplies and equipment to treat episodes of mental illness or substance abuse disorders. Services include medical detoxification. 	<ul style="list-style-type: none"> Beneficiaries may receive services from a general acute care hospital, a behavioral health unit of a general acute care hospital, a mental hospital, a subacute facility or a residential treatment center. Inpatient services provided by an institution for mental diseases (IMD) to beneficiaries aged 21–64 may be reimbursed for no more than 30 days per admission and 60 days per contract year. All admissions and requests for additional days must be preapproved by the behavioral health contractor, except if the admission is an emergency. Emergency services do not require prior authorization and are provided per the prudent layperson standard. Retrospective utilization review will be performed. A physician must direct services.

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Outpatient Hospital Including Rural Health Center and Federally Qualified Health Center Services		
Service	Description	Coverage Requirements
Outpatient hospital	Outpatient hospital services may include any substance abuse or mental health services that may be provided by any other Medicaid - certified provider.	<ul style="list-style-type: none"> The service must be within the provider's scope of practice as defined in State law. All services must be authorized by an appropriate agency, which for mental health and substance abuse services is the regional behavioral health contractor.
Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs)	FQHCs and RHCs may provide substance abuse or mental health services that could be provided by another Medicaid-certified provider.	<ul style="list-style-type: none"> The service must be within the provider's scope of practice as defined in State law. All services must be authorized by an appropriate agency, which for mental health and substance abuse services is the regional behavioral health contractor.

Physician Services		
Service	Description	Coverage Requirements
Physician services	Services include— <ul style="list-style-type: none"> Evaluation and screening Individual, group, and/or family therapy and counseling Psychosocial rehabilitation Psychotropic medication adjustment and monitoring 	<ul style="list-style-type: none"> All services must be authorized by an appropriate agency: for mental health and substance abuse services, this is the regional behavioral health contractor. Only psychiatrists and physicians who have qualified as a behavioral health medical practitioner may provide these services.

Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Services to Children Under 21		
Service	Description	Coverage Requirements
Personal care services for behavioral health problems and conditions	Services that assist beneficiaries in performing daily living tasks	<ul style="list-style-type: none"> The service may only be provided to a child under age 21. The service may only be provided if needed to treat or ameliorate a behavioral health condition identified in an early and periodic screening, diagnostic, and treatment (EPSDT) screening visit (similar to a well child visit).
Case management for patients with behavioral health problems and conditions	Coordination of services	<ul style="list-style-type: none"> The service may only be provided to a child under age 21. The service may only be provided if needed to treat or ameliorate a behavioral health condition identified in an EPSDT screening visit.
Local Education Agency (LEA) services	A LEA is defined as a public school district, a charter school, or the Arizona School for the Deaf and Blind. LEAs may provide— <ul style="list-style-type: none"> Behavioral health services Individual/group therapy Counseling and training Behavioral management Psychosocial rehabilitation emergency and crisis stabilization 	<ul style="list-style-type: none"> Only children who are eligible for school-based services under the Individuals with Disabilities Education Act (IDEA) Part B may receive these services. The service must be part of an Individualized Education Plan (IEP) or needed to determine whether the child qualifies for IDEA services or to develop an IEP. The service may only be provided to a child aged 3–21. The service may only be provided if needed to treat or ameliorate a behavioral health condition identified in an EPSDT screening visit.

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Optional State Plan Services

Other Licensed Practitioners		
Service	Description	Coverage Requirements
Psychologists	Mental health or substance abuse services that would be covered by Medicaid in another setting. These may include— <ul style="list-style-type: none"> • Evaluation and screening • Individual, group and/or family therapy and counseling • Psychosocial rehabilitation 	<ul style="list-style-type: none"> • Services must be within the practitioner's scope of practice, as defined in State law. • Services must meet the same requirements as those provided in another setting. (See Rehabilitation Services.)
Physician assistants	Mental health or substance abuse services that would be covered by Medicaid in another setting	<ul style="list-style-type: none"> • Services must be within the practitioner's scope of practice, as defined in State law. • Services must meet the same requirements as those provided in another setting. (See Rehabilitation Services.)
Psychiatric nurse practitioners	Mental health or substance abuse services that would be covered by Medicaid in another setting	<ul style="list-style-type: none"> • Services must be within the practitioner's scope of practice, as defined in State law. • Services must meet the same requirements as those provided in another setting. (See Rehabilitation Services.)
Social workers and other professional counselors	Mental health or substance abuse services that would be covered by Medicaid in another setting	<ul style="list-style-type: none"> • Services must be within the practitioner's scope of practice, as defined in State law. • Services must meet the same requirements as those provided in another setting. (See Rehabilitation Services.)
Behavioral health technicians	Mental health or substance abuse services that would be covered by Medicaid in another setting	<ul style="list-style-type: none"> • Services must be within the practitioner's scope of practice, as defined in State law. • Services must meet the same requirements as those provided in another setting. (See Rehabilitation Services.)

Clinic Services		
Service	Description	Coverage Requirements
Ambulatory Clinic	Services provided in an ambulatory clinic. They may include— <ul style="list-style-type: none"> • Individual, group, and/or family counseling/therapy • Psychotropic medications • Psychotropic medication adjustment and monitoring • Emergency/crisis services • Behavior management • Psychosocial rehabilitation screening, evaluation, and diagnosis • Case management services • Laboratory and radiology services 	<ul style="list-style-type: none"> • Coverage requires a treatment plan. • Services must meet the same requirements as those provided in another setting. (See Rehabilitation Services.) • Psychotropic medication, laboratory, and radiology services may be billed by providers specifically registered to provide those services (e.g., laboratory services by physicians and laboratories).

Inpatient Psychiatric Facility Services (for persons under the age of 21)		
Service	Description	Coverage Requirements
Inpatient psychiatric facility services	Services provided in a residential treatment center or subacute facility under a service plan that includes active treatment	<ul style="list-style-type: none"> • The service must be provided under the direction of a physician. • All admissions, requests for additional days, and requests for therapeutic leaves, must be preapproved by the behavioral health

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		<p>contractor, except if the admission is an emergency. Emergency services do not require prior authorization and are provided per the prudent layperson standard. Retrospective utilization review will be performed.</p> <ul style="list-style-type: none"> • The service plan must include an integrated program of therapies, activities, and experiences designed to meet individual treatment objectives. • Services may only be provided by facilities that maintain a current license as a hospital, residential treatment center or subacute facility. Hospitals providing inpatient psychiatric services to individuals under 21 must be accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Residential treatment centers and subacute facilities must be accredited by JCAHO, the Council on Accreditation (COA), or The Rehabilitation Accreditation Commission (CARF).
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Rehabilitative Services		
Service	Description	Coverage Requirements
Community service agency	<p>A community service agency is a provider of behavioral health services that is not licensed but is certified by AHCCCS or its agent. Services may include—</p> <ul style="list-style-type: none"> • Psychosocial rehabilitation • Behavior management • Supervised day programs • Respite care • Transportation 	<ul style="list-style-type: none"> • All services provided by a community service agency must meet the same criteria as those provided by another entity. (See requirements for Individual Services in this table).
Rural substance abuse transition agency services	<p>Rural substance abuse transitional agencies are licensed agencies located in a county with fewer than 500,000 residents. Services may include—</p> <ul style="list-style-type: none"> • Screening and assessment • Nursing services • Living skills training and health promotion • Behavior management • Transportation 	<ul style="list-style-type: none"> • Rural substance abuse transitional agencies may not provide counseling. • All services provided by a community service agency must meet the same criteria as those provided by another entity. (See requirements for Individual Services in this table.) • Beneficiaries must be intoxicated when they present for services or have a substance abuse problem to receive services.
Evaluation and screening	<ul style="list-style-type: none"> • Screenings determine the need for further evaluation, care, and treatment. • Evaluations assess whether a behavioral health disorder exists, and if so, are used to establish a treatment plan for all medically necessary services. 	<ul style="list-style-type: none"> • Behavioral health professionals and behavioral health technicians privileged and credentialed to do so may provide evaluation/assessments. • Rehabilitative employment assessments may only be provided by— <ul style="list-style-type: none"> – Rehabilitation counselors/vocational evaluators associated with a community service agency – A tribal or regional behavioral health authority – An outpatient clinic

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Rehabilitative Services		
Service	Description	Coverage Requirements
Individual, group, and/or family therapy and counseling	Services to address the therapeutic goals identified in an individualized service plan developed according to findings from an evaluation	<ul style="list-style-type: none"> • Services must address the therapeutic goals outlined in the service plan. • Services may be provided to an individual, a group of persons, a family, or multiple families. • Family counseling may include, but does not require, the presence of the beneficiary. • Groups cannot be larger than 15 unrelated persons for group therapy, or 20 individuals for family therapy. • Group and/or family therapy and counseling services may be provided by— <ul style="list-style-type: none"> – Outpatient clinics licensed to provide individual/group/family counseling – Psychologists – Behavioral health medical practitioners (including psychiatrists) – Independent master's-level therapists
Psychotropic medication adjustment and monitoring	Services include— <ul style="list-style-type: none"> • Prescriptions for psychotropic medications • Review of the effects and side effects • Adjustment of the type and dosage of psychotropic medications prescribed 	<ul style="list-style-type: none"> • Psychotropic medications and adjustments may only be prescribed by— <ul style="list-style-type: none"> – Qualified physicians – Registered nurse practitioners – Physicians' assistants (if the service is within their scope of practice) • Registered nurses may provide psychotropic medication monitoring.
Partial care	A package of therapeutic services and activities that are provided on a daily basis and may include— <ul style="list-style-type: none"> • Supervised behavioral health day program • Therapeutic day program • Medical day program 	<ul style="list-style-type: none"> • An outpatient clinic community service agency or regional behavioral health authority may provide supervised behavioral health day program services. • Only a clinic may provide therapeutic day program and medical day program services. • Individual services that make up the package may only be provided by staff whose scope of practice includes that service.
Behavior management	Services an individual needs to help them remain in the community and may include— <ul style="list-style-type: none"> • Peer support • Family support • Behavioral health personal assistance 	<ul style="list-style-type: none"> • Community service agencies, regional behavioral health authorities, tribal behavioral health authorities, outpatient clinics, and rural substance abuse transitional agencies may provide behavioral management services. • A beneficiary's parent may not provide behavioral health personal assistance unless the beneficiary is at least 21. • A beneficiary's spouse may not provide behavioral health personal assistance.
Emergency behavioral health care crisis intervention services	Immediate and intensive, time-limited, face-to-face services available 24 hours a day. These services may include— <ul style="list-style-type: none"> • Screening, evaluation, and counseling to stabilize the situation • Crisis management counseling • Psychotropic medication stabilization • Other therapeutic activities to reduce or eliminate the emergency situation 	<ul style="list-style-type: none"> • Emergency services are provided per the prudent layperson standard. • Services must be provided by, or under, the direction of a behavioral health professional.

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Rehabilitative Services		
Service	Description	Coverage Requirements
Psychosocial rehabilitation	<p>Services designed to maximize a beneficiary's ability to live and participate within the community. Services may include—</p> <ul style="list-style-type: none"> • Living skills training • Prejob training, job coaching, and employment support • Health promotion 	<ul style="list-style-type: none"> • Only an outpatient clinic, a community service agency, or a rural substance abuse transition agency may provide living skills and health promotion. <ul style="list-style-type: none"> – The staff that provides living skills services must be behavioral health professionals, behavioral health technicians, or paraprofessionals. – The staff that provides health promotion services must be either behavioral health professionals or behavioral health technicians. • Only a clinic or community service agency may provide supported employment services.
Behavioral health case management	<p>Supportive services provided to enhance treatment compliance and effectiveness. They include assistance in—</p> <ul style="list-style-type: none"> • Accessing, maintaining, monitoring, and modifying covered services • Assistance in finding resources, communication, and coordination of care • Outreach and followup of crisis contacts or missed appointments 	<ul style="list-style-type: none"> • Beneficiaries may receive case management services only from— <ul style="list-style-type: none"> – Their primary behavioral health professional or assigned clinician – A behavioral health professional, behavioral health technician, or behavioral health paraprofessionals working under the primary's direction • Only those affiliated with an outpatient clinic, regional behavioral health authority, or tribal behavioral health authority may provide services. • Beneficiaries may receive these services while an inpatient of a hospital, subacute, or residential facility.
Behavioral health residential services	<ul style="list-style-type: none"> • Residential services providing a structured treatment setting available 24 hours, including— <ul style="list-style-type: none"> – Supervision and counseling or other therapeutic activities for persons who do not require onsite medical services – Supervision and intermittent treatment in a group setting to persons who are determined to be capable of independent functioning but still need some protective oversight • Room and board are not covered. 	<ul style="list-style-type: none"> • These services may only be provided by a licensed agency. • All services must be approved by AHCCCS or its agent.

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Rehabilitative Services		
Service	Description	Coverage Requirements
Therapeutic foster care home services	Services provided in a therapeutic foster care home to a person residing in the home, to implement the in-home portion of the person's behavioral health service plan. Services include continuous protective oversight, observation, assistance, or supervision in activities to maintain health, safety, personal care or hygiene, living skills training, and some transportation. Services do not include room and board.	<ul style="list-style-type: none"> • A beneficiary may receive other behavioral health services (except inpatient or residential services) on the same day as s/he receives therapeutic foster care. • Services may only be provided by a licensed foster care home that meets specified training requirements. For children, the foster care home must be licensed as a professional foster home. • Services may only be provided that are— <ul style="list-style-type: none"> – Part of the individual's plan of care – Authorized by the regional behavioral health authority or the AHCCCS administration
Opioid Agonist Treatment	Administration of prescribed opioid agonists to reduce physical dependence on heroin and other opiate narcotics	<ul style="list-style-type: none"> • The drugs may be administered in the medical office or at home. • Methadone/LAAM or other opioid agonists may only be prescribed by a medical practitioner with both of the following qualifications: <ul style="list-style-type: none"> – A scope of practice that includes those services – Is registered with AHCCCS as an authorized service provider
Respite care	Short-term or intermittent care to provide an interval of rest and/or relief to a family member or other person caring for the beneficiary.	<ul style="list-style-type: none"> • Respite care includes activities and services to meet the social, emotional, and physical needs of the beneficiary during the respite period. • Respite care may only be provided by providers who are affiliated with a licensed behavioral health clinic, regional behavioral health authority, or community service agency. Respite services are limited annually to 30 days or 720 hours.

SCHIP Medicaid Expansion Program

Arizona does not have a SCHIP Medicaid expansion program.

Separate SCHIP Program

Who Is Eligible for the Separate SCHIP Program?

The separate SCHIP program covers the following children:

1. Uninsured children under age 1 from families with incomes between 140 and 200 percent FPL.
2. Uninsured children aged 1–5 from families with incomes between 133 and 200 percent FPL.
3. Uninsured children aged 6–18 from families with incomes between 100 and 200 percent FPL.

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In addition, Arizona obtained a HIFA §1115 waiver for its separate SCHIP program (called KidCare) that enables it to use SCHIP funding to cover—

1. All parents of Medicaid- and SCHIP-eligible children from families with incomes of 100–200 percent FPL.
2. All childless adults with incomes of 100 percent FPL or less.

All non-American Indian program participants with incomes over 100 percent FPL must pay a premium that ranges from \$10 to \$35, depending on family income and size.³

What Mental Health/Substance Abuse Services Are Covered by the Separate SCHIP Program?

Benefits in separate SCHIP programs must meet a benchmark selected by the State. Arizona has elected to use the Medicaid benefit package as the benchmark. Therefore, mental health and substance abuse service coverage in the separate SCHIP program is the same as coverage in the Medicaid program, as described in the previous section.

³ Increased to \$10–\$35, effective 2/1/04