

**Arizona Department of Health Services  
Division of Behavioral Health Services  
PROVIDER MANUAL  
Community Partnership of Southern Arizona (CPSA Edition)**

**Section 3.13**      **Covered Behavioral Health Services**

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**3.13.1 Introduction**

The ADHS/DBHS system of care offers an assortment of covered behavioral health services to meet the individual needs of persons seeking behavioral health services. The continuum of available services includes supervised and semi-supervised facility-based care, an array of treatment services and support services. Covered services assist and encourage each person to achieve and maintain the highest possible level of health and self-sufficiency. The provision of covered services is contingent on each person's current eligibility status and, for some persons, may be 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](#)

[R9-22-1205](#)

[R9-31-1205](#)

[AHCCCS/ADHS Contract](#)

[ADHS/RBHA Contract](#)

[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 3.21, Service Prioritization for Non-Title XIX/XXI Funding Section](#)

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[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;
- All persons determined to have a Serious Mental Illness; and
- All other persons, based on available funding according to [Section 3.21, Service Prioritization for Non-Title XIX/XI Funding](#).

**3.3.4 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.

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.

**3.13.5 Definitions**

[Flex Funds](#)

[Medically necessary covered services](#)

**3.13.6 Objectives**

The intent of this section is as follows:

Behavioral health providers must provide medically necessary covered behavioral health services, within their scope of practice, based upon the needs of the person.

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

Covered behavioral health services must be available to family members of 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.

**3.13.7 Procedures**

**3.13.7-A: Covered services matrix**

[PM Attachment 3.13.1, Covered Services Matrix](#), lists the available covered behavioral health services for each population of T/RBHA enrolled persons. These services must be provided by AHCCCS registered providers or 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.

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**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/RBHA's and/or their subcontracted providers may provide flex funds up to or exceeding \$1525 per individual per year, 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 good and/or service 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, including arrests, delinquency, victimization and exploitation; 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](#) and 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 \$1525 per individual/family per year. Clinical teams may access flex funds through the Child and Family Team or Adult Recovery Team process.

Each Network will establish and maintain written procedures for accessing flex funds and assign oversight responsibility of flex fund expenditures to a designated supervisory level staff.

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The Network will develop a plan at the beginning of each fiscal year to allocate and set aside a set percentage of no less than 2% of their subvention funding to provide flex fund services.

The Network will document and track flex fund expenditures for enrolled children, adults and their families and will encounter each use of flex funds in accordance with the [ADHS/DBHS Covered Behavioral Health Services Guide](#).

Through the Child & Family Team or Adult Recovery Team process, the member's and/or family member's need for one-time goods or services will be determined. The identified goods or services must be directly related to achievement of identified outcomes and documented in the member's service plan.

The Child & Family Team or Adult Recovery Team will attempt to locate other existing funding sources. Examples of funding sources may include, but are not limited to state agencies, community resources, family or tribal services. The Network will document in the case file all attempts to secure other funding sources for the needed goods or service.

The annual limit available to families is \$1525 in a calendar year. A request for an exception to the limit is submitted in writing using the PM Form 3.13.1, Request for Flex Funds, to the CPSA designated representative to secure CPSA review and ADHS agreement to exceed \$1525/year annual limit. The CPSA designated representative must forward requests for approval of flex fund expenditures of \$1525 or more to the following offices within ADHS/DBHS for approval:

Director of Clinical Operations

Director of Recovery, Resiliency, & Wellness

The CPSA designated representative will notify the designated supervisor at the Network of the decision within three (3) business days of receipt from ADHS/DBHS.