Behavioral Health Provider Eligibility Assistance Overview

AMPM 650 along with AMPM Policies AMPM 320-T1, AMPM 320-T2 and ARS § 36-3408 , establishes the requirements for behavioral health providers to assist individuals in determining and maintaining eligibility for public health benefits. These policies apply to all behavioral health providers and outline required actions for eligibility verification, application assistance, documentation, and handling refusals in accordance with Arizona law. Providers are responsible for supporting access to Arizona Public Programs, including AHCCCS (Title XIX/XXI), Medicare Savings Programs, Nutrition Assistance, Cash Assistance, and Medicare Part D, if eligible, (including Extra Help with Medicare Prescription Drug Plan Costs" low-income subsidy program as specified in ACOM Policy 201).

1. **Comprehensive Eligibility Verification Process**: Providers must verify an individual's current Title XIX/XXI eligibility using approved AHCCCS methods (web-based verification, IVR, Medifax, or the AHCCCS Verification Unit). Eligibility codes must be interpreted using official AHCCCS reference materials, and services must align with confirmed coverage. When eligibility cannot be verified electronically, providers must contact the Contractor or AHCCCS Verification Unit.

2. **Assistance with Applications at Intake and Ongoing** Providers are required to assist individuals with applying for all applicable Arizona Public Programs and Medicare Part D, if eligible, at intake at least annually while services continue, and whenever there is a significant change in financial circumstances. Applications and screenings must be completed through Health-e-Arizona PLUS (HEAplus), including support with required documentation.

3. **Screening, Documentation, and Access to Non-Title XIX/XXI Services**: If an individual is not currently eligible for Title XIX/XXI

    1) Providers must complete and document financial and eligibility screenings.
    2) Assist with the AHCCCS application process through Health-e-Arizona PLUS (HEAplus) at the time of intake.
    3) Maintain all application summaries and final eligibility determinations in the individual's medical record.
    4) Identify other available health coverage, including Medicare.
    5) Educate and encourage the individual to enroll in a qualified health plan through the federal health insurance exchange, as specified in ACOM Policy 434.
    6) If the individual is not eligible for Title XIX/XXI covered services, determine whether the individual may qualify for Non-Title XIX/XXI services.

    While eligibility is pending or if the individual is determined ineligible for Title XIX/XXI, providers may deliver covered Non-Title XIX/XXI services in accordance with EXHIBIT 300-2B.

    An individual who is not eligible for Title XIX/XXI covered services may still be eligible for Non-Title XIX/XXI services including services through the Substance Use Block Grant (SUBG), the Mental Health Block Grant (MHBG), or the Projects for Assistance in Transition from Homelessness (PATH) Program.

See AMPM Policy 320-T1 regarding non-discretionary federal grants and the delivery of behavioral health services. An individual may also be covered under another health insurance plan, including Medicare. Individuals who do not have any insurance or entitlement status may be asked to pay a percentage of the cost of services. Refer to ACOM Policy 406, Attachment A regarding copayments for Non-Title XIX/XXI individuals.

4. **Immediate Access to Crisis Services:** Individuals who present for emergency or crisis behavioral health services must receive immediate care without prior verification of Title XIX/XXI eligibility or U.S. citizenship/lawful presence. Providers must initiate a financial and eligibility screening within five days of service initiation, as specified in AMPM 650 and AMPM 590.

5. **Follow Required Procedures for Refusal to Participate**: Individuals who refuse to participate in AHCCCS screening/application or Medicare Part D, enrollment will be ***ineligible for State-Funded*** behavioral health services, except as protected for individuals with Serious Mental Illness (SMI).

   Providers must:

   1) Document any refusal to participate in the AHCCCS screening/application process or Medicare Part D enrollment, if eligible.
   2) Assess the individual's risk, decision-making capacity, and need for special assistance.
   3) Educate the individual on how non-participation may affect services, care, and case closure.
   4) Explain the provider's responsibility to offer help with screening, application, and enrollment.
   5) If the individual remains unwilling to participate, request a clinical consultation with a Behavioral Health Medical Professional.
   6) If refusal continues after consultation, request that the member sign the existing 650 Attachment A form.
   7) Do not treat the situation as refusal if the individual cannot obtain required eligibility documentation.
   8) Do not treat the situation as refusal if the individual is unable to participate due to mental illness and has no legal guardian.
   9) Before case closure or discharge, make and document all reasonable outreach and re-engagement efforts.
   10) Confirm clinical readiness for discharge.
   11) Develop a person-centered discharge plan that includes aftercare, supports, and follow-up.
   12) Address barriers such as housing or access to care and provide resources based on the individual's clinical needs.

13) Do not discharge solely because of non-participation without documented engagement attempts.

6. **Notice of Decision (NOD):** When a decision to reduce or terminate services is made, a Notice of Decision (NOD) is required and must be issued at least 30 days prior to the effective date, unless an exception applies, and must clearly outline the action, rationale, effective date, and the member's appeal rights. For additional guidance regarding discharge procedures and notification requirements, refer to Chapter 100 and Chapter 400 of the Mercy Care Provider Manual.