

**Arizona Department of Health Services
Division of Behavioral Health Services
PROVIDER MANUAL
NARBHA Edition**

Section 10.6 **NARBHA Block Purchased Inpatient/Subacute and Chemical
Dependency (CD) Residential Facilities**

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10.6.1 Introduction

NARBHA block purchases adult inpatient/subacute Facility and CD residential services, in order to provide accessible and available inpatient/residential services to NARBHA members. These inpatient/subacute beds are located at Mojave Mental Health Clinic (MMHC) in Kingman, West Yavapai Guidance Clinic (WYGC) in Prescott, The Guidance Center (TGC) in Flagstaff, Mingus Center in Cottonwood and Community Counseling Center (CCC) in Show Low. CD residential beds are located at The Guidance Center (TGC) in Flagstaff, West Yavapai Guidance Clinic (WYGC) in Prescott, and Verde Valley Guidance Center (VVGVC) in Cottonwood.

Although each inpatient/subacute and CD residential facility has a defined primary service area, individuals may be admitted to any block-purchased NARBHA facility if the primary facility is full or, if in case of an emergency admission, to the nearest NARBHA block-purchased inpatient/subacute facility.

In the event that all block-purchased inpatient/subacute and CD residential facility beds in the NARBHA region are full, based on member eligibility, individuals may be eligible for admission to other in-network NARBHA fee-for-service inpatient/subacute Inpatient or CD residential facilities.

In no case may a NARBHA Inpatient/Subacute facility deny an emergency admission to an individual based on geographic, place-of-residence, financial or NARBHA-enrollment considerations. Additionally no individual who is determined to need emergency inpatient services and who is unable to pay for those services may be treated differently than individuals who have an inpatient benefit through NARBHA.

Unless a person requests an emergency admission to an inpatient/subacute facility that is different from the primary facility, the primary inpatient/subacute facility will accept the person regardless of the person's ability to pay or NARBHA enrollment status.

- An example of when a person may request a different inpatient/subacute facility includes having non-NARBHA insurance coverage for inpatient/subacute stays at a facility different from the primary facility.
- An inpatient/subacute facility may not permit a denial of payment or an uncertainty about payment to interfere with its obligations.
- Alternative payers or payment options including self-pay may be discussed and arranged once the emergency behavioral health condition has sufficiently resolved.

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For persons presenting outside of the NARBHA geographic service area and who require emergency inpatient/subacute psychiatric hospitalization, no prior authorization is necessary for admission to the closest inpatient/subacute facility. The eligible person should be transferred to a NARBHA inpatient/subacute block-purchased facility as soon as possible if the total length of stay is anticipated to be greater than 72 hours.

10.6.2 References

[R9-20-101](#)

www.emtala.com/oblig.txt. CMS Special Advisory Bulletin. June Gibbs Brown, Inspector General DATED: November 24, 1998

10.6.3 Definitions

[Emergency Behavioral Health Service](#)

[On-call](#)

[Licensed Capacity](#)

[Inpatient Treatment Program](#)

10.6.4 Did you know...?

Institutions of Mental Disease (IMDs) have more than 16 beds.

Limits of IMDs services:

- The maximum number of inpatient days allowed in order to retain Medicaid/TXIX-eligibility is up to 30 days per admission or 60 total inpatient days per contract year (July 1 to June 30).
- Limits are effective for members ages 21-64 only.

10.6.5 Objectives

To ensure the proper process for referral of NARBHA members to NARBHA block purchased inpatient/subacute facility and CD residential beds.

10.6.6 Procedures

Primary inpatient/subacute facility designations

- Individuals presenting in the MMHC catchment area are initially referred to MMHC facility.
- Individuals presenting in the TGC and Community Behavioral Health Services (CBHS) catchment areas are initially referred to TGC facility.
- Individuals presenting for inpatient care in the Verde Valley Guidance Center (VVGCC) catchment area are initially referred to Mingus Center facility.
- Voluntary individuals presenting in the WYGC catchment area are initially referred to WYGC facility. Individuals presenting for involuntary inpatient care in the WYGC catchment area are referred to the Mingus Center facility.

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- Individuals presenting in the CCC, Hopi Guidance Center (HGC), Little Colorado Behavioral Health Centers (LCBHC) and Apache Behavioral Health Services (ABHS) catchment areas are initially referred to CCC facility.

Primary CD residential facility designations

- Individuals presenting in the WYGC, VVGC and MMHC catchment area are initially referred to the WYGC facility.
- Individuals presenting in the TGC, CCC, Hopi Guidance Center (HGC), Little Colorado Behavioral Health Centers (LCBHC), Community Behavioral Health Services (CBHS) and Apache Behavioral Health Services (ABHS) catchment areas are initially referred to the TGC facility.
- Female individuals presenting from any area may be referred to the gender-based Verde Valley Guidance Center (VVGC) CD residential treatment facility.

Qualifications for prior authorization denials:

Denials for prior authorization of admissions and continued stays in inpatient/subacute facilities are the responsibility of SAA/TAA physicians.

A block-purchased inpatient/subacute or CD residential facility may not deny the psychiatric appropriateness for admission when an eligible person has been determined to need admission by a SAA/TAA behavioral health professional.

Concerns about medical stability or fragility should be satisfactorily concluded between the referring SAA/TAA medical practitioner and the accepting inpatient/subacute or CD residential facility medical practitioner.

When a person inquires about financial liability for emergency services and treatment¹.

- CD residential treatment is not considered an emergency service.
- While NARBHA SAA/TAA's are not subject to the Emergency Medical Treatment and Active Labor Act (EMTALA) rules, many individuals needing crisis services are evaluated by NARBHA providers at sites which are subject to EMTALA rules. Additionally, the general principles of EMTALA are good practice and for the most part are the standard of care for emergency services and referrals for inpatient/subacute care.
- If a person inquires about his or her obligation to pay for emergency services, such an inquiry should be answered by a staff member who has been well trained to provide information regarding potential financial liability. This staff member must clearly inform the person that, notwithstanding the person's ability to pay, the provider stands ready and willing to provide a crisis assessment and stabilizing treatment, if necessary.
- SAA/TAA and inpatient/subacute staff should encourage any person who believes that he or she may have an emergency behavioral health condition to remain for the crisis

¹ www.emtala.com/oblig.txt CMS Special Advisory Bulletin. June Gibbs Brown, Inspector General
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assessment and to defer further discussion of financial responsibility issues until after the assessment has been performed. If the person chooses to withdraw his or her request for assessment or treatment, a staff member with appropriate behavioral health training must discuss the behavioral health issues related to a "voluntary withdrawal."

- **Voluntary withdrawal.** If an individual chooses to withdraw his or her request for a crisis assessment or treatment at the presenting SAA/TAA or inpatient/subacute facility, the SAA/TAA or inpatient/subacute facility must perform the following:
 1. offer the individual further assessment and treatment within the staff and facilities available by the SAA/TAA or at the inpatient/subacute facility as may be required to identify and stabilize an emergency behavioral health condition, and which may include a detailed outpatient crisis plan;
 2. inform the individual of the risks and benefits of such assessment and treatment, and of the risks and benefits of withdrawal prior to receiving such assessment and treatment; and
 3. take all reasonable steps to secure the individual's written informed consent to refuse such assessment and treatment. The medical record should contain a description of the assessment, treatment, or both, if applicable, that was refused.
 4. consider and document if the individual meets the criteria for T36 Involuntary services.

Referral and admission procedures to block-purchased inpatient/subacute facilities

- Once a SAA/TAA behavioral health professional has determined the need for admission to an Inpatient/Subacute facility, the SAA/TAA designated staff contact the individual's primary facility's designated staff to arrange admission.
- Appropriate "on-call" staff from both agencies, including the medical practitioner of the referring facility and the accepting facility's medical practitioner, are available as necessary within 15 minutes of the referral to the facility to discuss the referral and to make necessary arrangements to facilitate the transfer and admission of the individual.

Referral and admission procedures to block-purchased CD residential facilities

- NARBHA SAAs and TAAs ensure timely transmission of clinical information relevant to the admission to the receiving CD residential facility.
- It is the responsibility of the SAA/TAA referring staff to determine the need for CD residential services.
- It is the responsibility of the CD residential facility to prioritize the admissions and give the first-available bed to the new referral as per the [3.21 Service Prioritization for Non-Title XIX/XXI Funding](#). The following populations are prioritized and covered under the Substance Abuse Prevention and Treatment (SAPT) Performance Partnership Block Grant Populations:
 - First...Pregnant injection drug users;
 - Then...Pregnant substance abusers;
 - Then...Other injection drug users; and
 - Finally...All other eligible persons (TXIX/TXXI adults and SMI) in need of substance abuse treatment. Persons with pending TXIX/TXXI eligibility may be considered as well.

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- Persons who are non TXIX/TXXI GMHSA (and are not priority populations) do not have a covered NARBHA benefit for residential CD services and should not utilize block-purchased beds.
- The CD residential facility must provide the SAA/TAA referring staff with the first available admission date for that referral within 24 hours of the referral.
- In the event that the first available admission date does not fully meet the treatment needs of the member, the referring SAA/TAA develops interim service plans until the admission date or refers to the other CD residential block-purchased facilities.

Referrals to inpatient/subacute and CD residential Fee for Service facilities when NARBHA block purchased facility capacity has been exceeded

- Eligible members who have an inpatient hospital or CD residential benefit may receive that service at an in-network inpatient or CD residential Fee-For-Service Provider when all NARBHA block-purchased Inpatient/Subacute or CD residential facility beds are at licensed capacity.
- The cost of care is assigned to the SAA/TAA Case Management Agency (CMA).
- In order to ensure that NARBHA or the SAA/TAA CMA does not incur expenses for a service that was already block-purchased, the primary inpatient/subacute or CD residential facility may be responsible for payment of the fee-for-service facility if it is determined that there was block-purchased bed availability at the time the referral was denied for lack of beds.
- Eligible persons in inpatient or CD residential fee-for-service facilities are transferred back to a block-purchased facility as soon as possible if their anticipated length of stay is going to be longer than 72 hours, unless the service is covered by a Medicare DRG payment which pays a lump sum for the entire episode of care.

Enrollment of un-enrolled individuals referred for inpatient/subacute facility services.

- In order to ensure receipt of service value and because of the depth of clinical information gathered during an inpatient/subacute stay, enrollment in the NARBHA system is the responsibility of the SAA at which the inpatient/subacute facility is located, unless otherwise arranged with the referring SAA/TAA.
- A completed DBHS Core Assessment is not required prior to admission in emergency situations as per Section [3.9 Intake, Assessment and Service Planning](#). In an emergency situation, the person's immediate clinical needs must be initially addressed.
- Members who are enrolled as seriously mentally ill by the inpatient/subacute facility's SAA physician are presumed to be seriously mentally ill by the member's "Case Management Agency" (CMA) for continued services until a new SMI determination is completed.

Inpatient/subacute and CD residential facilities' bed management

- NARBHA purchases Inpatient/Subacute and CD residential facility beds in diverse geographic regions in order to provide accessible and available inpatient/residential services to individuals in northern Arizona.
- NARBHA requires the inpatient/subacute and CD residential facilities to manage their bed capacity to ensure that their beds are available and accessible to NARBHA-eligible individuals. Each inpatient/subacute and CD residential facility provider must implement

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internal utilization review procedures to ensure that admission and continued stay decisions for acute inpatient/subacute services are based on DBHS admission and continued stay authorization criteria and for CD residential services on ASAM criteria for this level of care and that individuals are discharged from inpatient/subacute facilities when they no longer meet these criteria.

- Each facility has a licensed capacity based on the number of beds approved by licensure.
- Each inpatient/subacute facility may begin voluntary admission diversions when bed capacity is two or less than the licensed capacity.
- While NARBHA has an approximate number of beds per day that have been purchased as part of the block-purchase, this in no way should be construed as a daily census cap for NARBHA members. Eligible persons should be admitted based on need and overall bed availability, not on the approximate number of beds per day in the block-purchase.
- NARBHA has block-purchased bed-days on an annualized basis and may make mid-year adjustments either up or down dependent on actual utilization.
- Eligible individuals referred for admission to their primary inpatient/subacute or CD residential facility must be admitted to the primary inpatient/subacute or CD residential facility if a bed is available.
- Except in the case of T36 referrals, inpatient/subacute facilities may not preferentially prioritize or deny admissions before full licensed capacity has been met. (For example, beds may not be saved for unknown potential admissions when a known admission is referred).
- In all cases, Title 36 individuals have priority for inpatient/subacute facility beds in the county in which Title 36 proceedings were initiated.
- In the event that an inpatient/subacute facility is nearing licensed capacity or at capacity, the medical staff is responsible for decisions regarding capacity management to ensure availability and accessibility.
- Decisions to discharge or to transfer an individual should be based on the acuity of individuals affected by the decision, the legality and logistics of transferring new or existing inpatients and continuity of care considerations.
- Precipitous disruptions in the care of current inpatients in order to admit a new individual are to be avoided if at all possible. Current inpatients may be considered for transfer to accommodate a new admission when there is a need to accept a T36 referral, when a person is approaching an IMD limit and would be transferring soon anyway, when a person is from or will be relocating to the SAA of the secondary inpatient/subacute facility at discharge, when the clinical needs of the person can be appropriately met at the new facility and when the person agrees to the transfer.

Decisions to manage inpatient/subacute and CD residential facility capacity may include:

- Discharging current inpatients/residents considered discharge-ready to accommodate new admissions;
- Negotiating timing of admissions based on the safety level of the new admissions (for example, delaying admissions of individuals in secure environments briefly while an inpatient/resident is being discharged);
- Transferring current inpatients/residents to another NARBHA inpatient/subacute or CD residential facility; or

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- Referring new admissions to secondary NARBHA area inpatient/subacute or CD residential facilities.

Referral to secondary Inpatient/Subacute and CD residential facilities due to capacity issues

- Definition of “referring SAA/TAA”
 - If an individual has not been admitted yet, the “referring SAA/TAA” is the SAA determining the need for hospitalization or CD residential services;
 - If a current inpatient/resident must be referred to a secondary inpatient/subacute or CD residential facility, “the referring SAA (or Mingus Center)” is the inpatient/subacute or CD residential facility.
- The referring SAA/TAA is responsible for contacting and communicating with the receiving facility to arrange for admission, transfer and transportation to the facility.
- Distance, facility occupancy, and other considerations are taken into account in making decisions about which individuals to refer/transfer and in choosing which secondary Inpatient/Subacute or CD residential facility.
- When the primary inpatient /subacute or CD residential facility is unable to accept an eligible referral, the primary inpatient/subacute or CD residential facility contacts the other block-purchased inpatient/subacute facilities to determine alternate bed availability. This information with contact names and phone numbers is given to the referring SAA/TAA within 15 minutes of the referral for inpatient care or 24 hours for CD residential care. The referring SAA/TAA then completes the inpatient/subacute or CD residential referral process with the secondary inpatient/subacute or CD residential facilities.

Notification to other Inpatient/Subacute facilities when near bed capacity maximum

- When an Inpatient/Subacute facility is nearing its bed capacity maximum, the facility should put the other inpatient/subacute facilities on alert by contacting the directors of nursing or their designees at each Inpatient/Subacute facility so that they may begin to make accommodations.

Referral to secondary Inpatient/Subacute facility due to pending loss of member TXIX/TXXI status or Involuntary status.

- If a TXIX/TXXI member is approaching his/her IMD benefit limit, and the member still meets the ADHS/DBHS Inpatient Continued Stay Authorization Criteria then the IMD (TGC, WYGC) will plan for a transfer to a NARBHA block-purchased non-IMD facility (CCC, Mingus Center or MMHC) or a fee-for-service non-IMD facility depending on which facility serves the best psychiatric/medical interests of the member.
- The receiving facility's admitting medical practitioner must concur with the continued stay determination.
- The referring facility is responsible for arranging transportation to the receiving facility upon admission.
- The referring Inpatient/Subacute is responsible for notifying AHCCCS and NARBHA of the discharge from an IMD. (See Section [7.2 IMD Reporting.](#))
- Eligible WYGC members who were initially involuntary (T36) and convert to voluntary status while at Mingus Center, or who are WYGC members and have converted to court-ordered

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status (C36) and who are in need of continued inpatient/subacute services should be considered for transfer to the WYGC subacute facility if their projected length of stay is going to be longer than 72 more hours; otherwise the person should complete their inpatient stay at Mingus Center. In cases where WYGC subacute facility does not have an available bed or the WYGC member chooses to complete the voluntary inpatient/subacute care segment at Mingus Center, the member may remain at Mingus Center under the block-purchase.

Transportation Responsibilities

- For court-ordered evaluations (COE) or during a COE inpatient stay
 - County law enforcement agencies are responsible for the transportation of Title 36 individuals to and from Inpatient/Subacute facilities for court-ordered evaluations as per county contracts.
 - If the person requires transportation for evaluation of a medical condition, such as to an emergency room for evaluation of chest pain, seizure, etc, the responsible entity is:
 - AHCCCS Health Plan for TXIX/TXXI members,
 - Insurance plans for insured individuals.
 - County or inpatient/subacute facility for all other individuals.
- For transportation needs during voluntary treatment
 - The referring SAA/TAA (see above definition of “referring SAA/TAA”) is responsible for arranging and assisting the individual referred for inpatient/subacute or CD residential admission.
 - Arrangements for transportation are based on clinical acuity/dangerousness.
 - Medically necessary transportation is a covered service for Title XIX and Title XXI eligible persons. Transportation is arranged for by the referring SAA/TAA. The referring SAA/TAA may either arrange for or provide the medically necessary transportation.
 - Since timely discharges are frequently dependent on transportation issues, the arrangement of transportation of a person to his/her home community upon discharge is the responsibility of the inpatient/subacute or CD residential facility. The service value/costs of that transportation service are borne by the SAA/TAA in which the member is enrolled, or the individual, depending on the member’s benefits.
- During voluntary or COT inpatient/subacute stay for behavioral health purposes, such as transfers between inpatient/subacute facilities or to other agency facilities:
 - For enrolled or eligible TXIX/TXXI and SMI members:
 - the inpatient/subacute facility, in consultation with responsible SAA/TAA CMA, determines the type of transportation based on clinical needs (ambulance, supervised, locked, self, etc.)
 - the inpatient/subacute facility arranges transportation so that timing of transport and readiness of the individual is appropriate.
 - the responsible SAA/TAA CMA authorizes and pays for transportation.
 - emergency transportation is never prior authorized.
 - For non-enrolled and non-TXIX/TXXI eligible individuals:
 - the inpatient/subacute or CD residential facility determines and arranges transportation dependent on clinical needs.

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- the individual or other insurer pays for transportation.

Coordination of care between the Inpatient/Subacute and CD residential facility providers and outpatient providers

- It is the responsibility of the individual's Clinical Liaison to ensure coordination of care and maintenance of continuity of care between inpatient/subacute, and CD residential services and outpatient settings. (See Section [3.7 Clinical Liaisons](#)).
- It is the responsibility of the inpatient/subacute and CD residential facility to notify the SAA/TAA Clinical Liaison or designee about admissions and pending discharges.
- Discharge summaries should be completed within 14 days as per licensure and sent to the SAA/TAA Clinical Liaison or designee.

Medications

- Individuals in the community, who are referred for inpatient/subacute or CD residential facilities, are encouraged to bring their current medications in their original bottles to the facility in order to confirm medications, dosages and compliance.
- Inpatient/subacute and CD residential facilities may, at their discretion, request that members being transferred from one inpatient/subacute or CD residential facility to another arrive with enough medications to last until the next pharmacy delivery in order to ensure continued appropriate administration of medications.
- Prescriptions, when needed, are provided at discharge sufficient to last until the first post-discharge follow-up service with the outpatient medical practitioner.

Discharge Planning and Appointments

- Discharge planning is the primary responsibility of the inpatient/subacute and CD residential facility treatment team with input and collaboration from the individual's referring SAA/TAA and/or the SAA/TAA responsible for the person's aftercare.
- The person's SAA/TAA is responsible for the case management activities and tasks, which must be accomplished for appropriate aftercare.
- If at all possible, the inpatient/subacute and CD residential facility will notify the outpatient service provider of discharges 24 hours prior to discharge so that appropriate arrangements may be made.
- To determine if a person hospitalized at a secondary inpatient/subacute facility should be discharged from the secondary inpatient/subacute facility directly to outpatient services or transferred to the primary inpatient/subacute facility for continued inpatient services:
 - If the person was a transfer from a primary inpatient/subacute facility to a secondary inpatient/subacute facility, the primary inpatient/subacute facility must be contacted prior to discharge to determine if the person should be transferred back or discharge to outpatient services directly;
 - For all other persons, the person's SAA/TAA clinical liaison should be contacted prior to discharge for discharge planning.
- The first post-discharge follow-up face-to-face service with a behavioral health professional is scheduled prior to discharge at the outpatient provider as part of the discharge plan.

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- For inpatient/subacute services, the outpatient provider is obligated to provide this first post-discharge follow-up service in a timely fashion but no later than 7 days after discharge. See Section [3.8 Outreach, Engagement, Re-Engagement and Closure](#).
- The outpatient provider must schedule an appointment with a medical practitioner within a timeframe that ensures that the person does not run out of any needed psychotropic medications and within a timeframe indicated by clinical need, but no later than 30 days from the referral/initial request for services. See Section [3.2 Appointment Standards and Timeliness of Service](#).