Final - Revised November 17, 2006

ILLINOIS DEPARTMENT OF HUMAN SERVICES
SYSTEM RESTRUCTURING INITIATIVE
ACCESS AND ELIGIBILITY

ELIGIBILITY FOR SERVICES

Levels of Care Matrix/Grid

The proposed Level of Care Grid provides a summary of recommendations from the Access and Eligibility Committee to the Systems Restructuring Initiative (SRI) Task Group. The purpose of the Grid is to define a framework for a suggested protocol for review that describes and defines access and eligibility of services and the review process for the Illinois publicly funded mental health system financed through Illinois Medicaid Rule 132 and General Revenue Funding (GRF) administered through the Illinois Department of Human Services Division of Mental Health Fee for Service System.

The Level of Care Grid is presented, based on the work of the Access and Eligibility Committee during FY06-07. The definition of Access to the publicly funded Mental Health System in Illinois is attached.

The Levels of Care grid assumes the following:

1. Decisions regarding access to services are guided by medical necessity and principles of Recovery and Rehabilitation.
2. Consumers should be afforded the same level, scope, array and quality of services regardless of whether services are funded through Medicaid or non-Medicaid sources.
3. For the purposes of clarity in the Financial Eligibility criteria, Medicaid includes those individuals that are eligible for state-funded Medicaid or Medicaid eligible programs, such as “All Kids”.
4. The publicly funded mental health system is the payer of last resort, and therefore Coordination of Benefits applies to all levels and all populations.
5. Individuals experiencing acute crisis are always eligible for assessment, including pre hospital screening and stabilization. (Never turned away).
6. Review levels are not intended to restrict access but rather identify points at which utilization is reviewed, either internally with the provider or through external review.

7. Medical necessity is determined through clinical assessments using standard assessments and movement between levels is based on continuity of care expectations. (Example, if access to step-down services from Level IV to Level III, and medical necessity/rehabilitation principle clinical assessment supports the decision, access to Level III will not unduly denied. It is noted that at the time of this submission, standard clinical assessment forms have not been identified. It is recommended that any clinical assessment tool used will incorporate evidenced based clinical assessment criteria and criteria that supports principles of recovery.
8. Availability of any type of service or access to any of these levels of care may be dependent on the amount of provider contracts, availability of qualified staff, or service provisions within the provider organization.
9. For individuals between the ages of 18-22 years, the diagnostic criteria will include all SED appropriate diagnostic categories (example: PTSD) as care is transitioned to the adult system. In the attached grid, all categories include Children and Adolescents as well as Adults.
10. Psychiatric services are excluded from this Grid, recognizing that billing for physician services are billed directly to HFS under Medicaid guidelines and DMH provides Psychiatric Services program funding (350) for the purposes of capacity and access. The Committee acknowledges that the Division of Mental Health may need to develop further guidelines for Program 350. It is also recognized that there may be an interface between accessing services identified in this Grid with other systems of care (i.e., inpatient, long term care; acute primary healthcare).
11. Data needs to be reviewed to verify the reasonableness of the suggested Review levels (e.g., 30 hours of service within 6 months in Level I). Also, the Committee acknowledges that the grid recommendations should be reviewed when more documentation is available regarding the definitions of Community Support, PSR, ACT, Residential and Respite.
12. Access to care for children may need to be further reviewed for the issue of Financial Eligibility. The Division may wish to consider other co-pay models as in ALL Kids to assist in this analysis. Further, the Committee recommends that access to care would not be denied for children when parents are unwilling to unable to apply for Medicaid, determine non-Medicaid Financial criteria or pay for services for any level of care available to children and adolescents.
13. The Committee strongly recommends that there is an appropriate appeals process and structure for consumers and providers in the implementation of this utilization review and access eligibility process. And that appropriate time for appeals is provided PRIOR to authorization of denials of care or authorizations between levels of care.
14. “Respite” services may also define a short term, emergency intervention. In these cases, consideration should be given to placing this service in the same level of care of Crisis response.
15. The Grid identifies “Eligible” and “Target” populations. The definitions for these populations is attached.

16. Financial eligibility is recommended to be applied when the clinical need is the same but prioritization is given to those who are most in need (200% of poverty or less).
17. Evidenced based treatment practices may require changes to the recommended Levels of Care Grid.
18. The grid assumes that specific service codes as defined by Rule 132 be added for more specificity.

Note: At its last meeting (11/15/2006), the SRI recommended that this grid be reviewed by a Child and Adolescent workgroup for additional comments.

Attachments:
Eligibility – Levels of Care Grid
Access Definition
Definition of Target and Eligible Populations - DMH

Eligibility - Levels of Care Grid

(Note: Coordination of Benefits Applies to All Cases/Levels)

DRAFT – November 17, 2006

*****Further definition is needed from services; ******Further consideration based on Locus placement and Residential Services Definition
*******Review when revised Rule 132 is available

	Level I	**Level II**	**Level III**	**Level IV**
Covered Services	Assessment, crisis stabilization Intake/Referral Linkage Case Management	Outpatient counseling Psychiatric Services (350) Community Support – Individual*** Community Support - Group*** Case Management***	Community Support Team*** Community Support Residential***	ACT PSR Residential** Respite*
Eligible Populations (Medicaid and Non-Medicaid)	All Populations	Eligible and Target Ages 18-22, accept SED criteria	TARGET Ages 18-22, accept SED criteria	TARGET Ages 18-22, accept SED criteria
Eligibility Criteria	No clinical criteria for assessment Crisis Stabilization as indicated on Crisis Assessment	DX + Functional Level + Level of Disability Impairment	DX + Functional Level + Level of Disability Impairment	See "Services Workgroup Recommendation"
ASO/DMH Pre-Approval	NOT Recommended	NOT Recommended	Recommended	Recommended
Recommended Review Level	Unlimited Intake and Referral Assessment Crisis Stabilization per Rule 132 Definition	Initial Duration Counseling 6 months and/or 30 hours Psychiatric Services (350) Subject to Review and Reauthorization	Each case reviewed every six months by ASO for re-approval; Service level dependent upon Medical Necessity, Rehabilitation and Recovery Guidelines	Each case reviewed every six months by ASO for re-approval; Service level dependent upon Medical Necessity, Rehabilitation and Recovery Guidelines

Financial Eligibility	None Required	Prioritize Persons at or below the 200% Poverty Level	Prioritize Persons at or below the 200% Poverty Level	Prioritize Persons at or below the 200% Poverty Level
Service Codes (To be determined)				