Eligibility and Target Population Matrix

Mental Health Services	Substance Abuse Services	Co-Occurring Services

Eligibility for MH, SA, and Co-Occurring Services

Eligibility determination and enrollment of service recipients will be conducted at the provider level at the time an individual or family requests and/or presents for treatment. This may occur at any Department provider. The service provider will determine whether the service recipient meets the eligibility criteria established by Department and if the recipient is in need of behavioral health services funded by Department. **Department is the payer of last resort[i],** excluding the Indian Health Service**.**

All individuals are eligible for emergency services regardless of income level or other available payers. Eligibility for continued treatment or aftercare of crisis units, inpatient treatment facilities, and residential substance abuse treatment facilities (funded by Department) will be determined after immediate crisis stabilization and evaluation. Emergency services may include the following services if provided within the first 24 hours (a) crisis intervention, (b) mobile crisis services, (c) medical detoxification, (d) medically supervised detoxification, or (e) emergency detention (either community-based structured crisis care or acute inpatient services). Following eligibility determination, Contractor is expected to seek any other payment which may be available retrospectively for such emergency services prior to submitting such services to the Department for payment.

All children twenty years of age or younger in need of behavioral health services funded by the Department may be served regardless of income level. Other payment sources should be utilized to the extent they are available or willing to pay.

In determining a consumer's initial and ongoing eligibility for any service, the treatment provider may not exclude an individual based on the following factors:

1. The consumer's past or present mental health or substance abuse issues;
2. The presumption of the consumer's inability to benefit from treatment;
3. The specific substance used by the consumer;
4. The consumer's continued substance use;
5. The consumer's level of success in prior treatment episodes; or
6. The consumer's designation as a sex offender.

The eligibility criteria set forth by Department are as follows:

1. Individual must be in need of behavioral health services as defined by Department (see Diagnostic Criteria).
2. Individual must be (a) indigent and (b) uninsured or underinsured.

Indigent[ii] persons served and ordered to pay pursuant to a court order are not eligible.

If an individual does not meet the eligibility criteria, Department contracted funds will not be utilized for payment of services. At this time, the provider may choose to provide services to the ineligible individual through some other funding source or refer to another service/resource.

Mental Health Services	Substance Abuse Services	Co-Occurring Services
Geographic Criteria Each mental health center has a defined geographic service area determined by the Department for accountability purposes. However, any person meeting the defined diagnostic and income criteria, regardless of residence, must be served at the location of his or her choice. If the consumer requests, the CMHC of residence will assist the consumer in accessing services at an alternative site.	***Geographic Criteria*** Not Applicable	***Geographic Criteria*** Not Applicable

Income Criteria

Persons eligible for state-funded services must also meet defined income eligibility criteria. This is currently set at 200 percent of the federal poverty level[iii]. Individual insurance coverage is also a factor in determining a specific person's eligibility[iv]. No income criteria apply to persons in crisis or to children twenty years of age or younger.

No additional funds from the client or the client's family are to be sought or accepted for services purchased by the Department, except as otherwise provided below:

- The service provider may charge a fee (based on a client's ability to pay) for medications in addition to any payment received from the Department for such service, excepting clients also receiving Department-subsidized residential care services, not to exceed the cost of such, up to $5 per prescription or a maximum of $15 per client per month. The service provider may also solicit a co-pay for services provided to adults, not to exceed three dollars ($3) per service, as outlined in the contract boilerplate language. Refusal by the client to accept or pay for such shall not result in denial of services pursuant to a Department contract.

- Service providers operating specialized housing programs, independent of Department services, may collect rent based on policies allowed, prescribed, or approved by applicable authorities.

If an individual presents for treatment and appears to be Medicaid eligible, provider shall assist the individual in making application for Title XIX. If the individual is deemed to not be Medicaid eligible by the Oklahoma Health Care Authority but does meet Department eligibility criteria, services may then be eligible for reimbursement by Department. Services funded by Department that are not Medicaid reimbursable may also be eligible for reimbursement by Department.

With the exception of emergency and preadmission services, Contractor shall procure documentation of income prior to delivery of Department reimbursable services. Documentation of household gross annual income shall be included in the client's record on the same day or prior to delivery of reimbursable services. The facility must make documented good faith efforts to obtain <u>one</u> of the following:

Mental Health Services	Substance Abuse Services	Co-Occurring Services
• Federal Form W-2(s) (if client has been employed for an entire year on a full-time basis); • Federal income tax return(s); • Two recent, consecutive pay check stub(s) (showing pay date, hours worked, type(s) of pay, and gross rate(s) of pay); • Verification of income from current employer; • Medicaid card; or • Any government document that verifies income An income statement signed by the client/family member and a facility staff member will be accepted if none of the above documents are available. A review of the financial status of the client should be documented on an annual basis.		
Diagnostic Criteria Services will be available to persons who have a need for behavioral health services. Need shall be based on the following: • Individual has a diagnosable behavioral health condition, as defined by the most recent version of the DSM (excluding sole diagnosis of developmental disorders or dementia disorders); or • Individual has a presenting problem(s) that indicates a behavioral health illness or condition; or • Individual's level of functioning indicates the need for behavioral health treatment based on a standard assessment instrument utilized by Department; or • Individual is in behavioral health crisis. AND • Treatment is needed to stabilize the condition; or • Treatment is required to decrease or eliminate symptoms; or • Treatment is needed to prevent the condition from worsening. AND • System offers treatment needed based on diagnosis and level of need.	***Diagnostic Criteria*** Services will be available to individuals with substance use disorders to include substance induced disorders, substance abuse, and substance dependency. The ASAM criteria will be utilized to help determine placement within the continuum of care. See also substance abuse priorities for admission criteria (p. 4).	***Diagnostic Criteria*** Services will be available to persons with one or more mental health disorder and one or more substance use disorder who also meet criteria as established in the columns to the left.

Mental Health Services	Substance Abuse Services	Co-Occurring Services
Priority will be given to individuals as follows: **First Priority** Individuals with psychosis who have severe or extreme functional impairment. This includes persons with bipolar disorder with psychosis, major depression with psychotic features, schizophrenia, and schizoaffective disorders. Those who pose a danger to self or others as a result of mental illness ("imminent" danger is not a requirement for outpatient services). Aftercare for persons leaving psychiatric inpatient or crisis units. Persons at risk of institutional placement or homelessness (e.g. mental health, jail, prison, etc.) due to symptoms and behaviors resulting from a serious emotional disturbance or any mental illness. This includes adults being released from jail/prison or transition age youth who initiated services prior to their 18th birthday or who are aging out of other public systems (e.g. child welfare or juvenile justice). **Second Priority** Individuals with the diagnostic disorders described above who have mild or moderate impairment. Individuals with major mood disorders. Individuals with anxiety disorders who have severe or extreme functional impairment. Individuals not otherwise meeting the conditions noted above, but who have a mental illness and have children who are receiving	***Priorities for admission in priority order[v] (45 CFR 96.131):*** 1) Pregnant, injecting drug users 2) Pregnant substance abusers 3) Injecting drug users 4) Direct referral from a higher level of care based on medical necessity (i.e. withdrawal management, crisis unit, inpatient, hospitalization, residential substance abuse treatment, etc.) 5) Drug dependent persons with HIV/AIDS, if physically able to participate in the treatment program 6) Women with dependent children 7) Minorities 8) Other individuals with substance dependence, abuse, and/or use disorders	***Priority will be given to individuals based on service needs in the columns to the left.***

Mental Health Services	Substance Abuse Services	Co-Occurring Services
mental health services (for the purposes of promoting the overall health of the entire family and preventing a worsening of the child's situation). Individuals not otherwise meeting the conditions noted above, but who have a mental illness and are victims of domestic violence or other trauma (for the purposes of early intervention due to the potential impact of trauma and preventing exacerbation of the mental illness). This includes military veterans. **Third Priority** Individuals with anxiety disorders who have mild or moderate functional impairment. **Fourth Priority** Individuals with other diagnoses who meet the ODMHSAS criteria for serious mental illness. **Persons meeting the conditions of the First or Second Priority groups will be served.** CMHC's will utilize available funding to the maximum extent possible to serve consumers in the other priority groups described above. However, services to consumers in the lower priority groups may be restricted if funding levels are not sufficient to do so.		

ELIGIBILITY CHECKLIST

CRITERIA			COMMENTS
Individual is in need of behavioral health services. Must meet at least one of the four criteria below.			
1. Has a diagnosable behavioral health condition as defined by the most recent version of the DSM (excluding development disorders or dementia disorders); or	**YES**	**NO**	
2. Has a presenting problem(s) that indicates a behavioral health illness or condition; or	**YES**	**NO**	
3. Has a level of functioning that indicates the need for behavioral health treatment; or	**YES**	**NO**	
4. Is in a behavioral health crisis.	**YES**	**NO**	
Plus must meet one of the three criteria below.			
1. Treatment is needed to stabilize condition; or	**YES**	**NO**	
2. Treatment is needed to decrease or eliminate symptoms;	**YES**	**NO**	
3. Treatment is needed to prevent condition from worsening.	**YES**	**NO**	
System offers treatment need based on diagnosis and level of functioning. (Must meet)	**YES**	**NO**	
Individual is at or below 200% of federal poverty level. (Must meet)	**YES**	**NO**	
Individual is uninsured or underinsured for needed behavioral health services. (Must meet)	**YES**	**NO**	
Individual does <u>not</u> meet Medicaid eligibility criteria as documented by provider. (Must meet)	**YES**	**NO**	

All individuals who were receiving active treatment pursuant to a Department contract at the beginning of the FY98 contract year (July 1, 1997) and who continue to receive such treatment are automatically eligible for services funded by Department until treatment is no longer clinically indicated or discontinued by the service recipient. If such an individual presents for re-admission, he/she will then have to meet these eligibility criteria to receive further services funded by Department.

Endnotes

[i] **"Payer of last resort"** means seeking other third party reimbursement through eligibility determination, billing, and collection prior to the use of Department funds.

[ii] **"Indigent"** is defined as at or below 200% of federal poverty guidelines based solely on the individual's applicable income.

[iii] **Income Eligibility Criteria -** indigence threshold - (200% of Federal Poverty Guidelines). Note: The Federal Poverty Guidelines change annually, January 1. Please check the U.S. Department of Health and Human Services website (https://aspe.hhs.gov/poverty-guidelines) for updates in January):

Persons in Household	Household Gross Annual Income*
1	25,760
2	34,840
3	43,920
4	53,000
5	62,080
6	71,160
7	80,240
8	89,320

For households with more than 8 members, add $9,080 for each additional member.

NOTE: In the case of an adult client living with his/her parents or family (i.e. parents, aunts/uncles, or brothers/sisters), only the income of the client should be considered when calculating household gross annual income. The income of the parents or family members providing a home to the adult client should *not* be included as a part of calculated annual income. However, a spouse or child living with the client and providing income *should* be included in the annual income total. *For adjustments to income see Oklahoma Administrative Code Title 450:1-7-6.b.3.A through C.

[iv] **"Un-insured" or "Under-insured"** is defined as an individual 1) having no insurance (private or public) for behavioral health services; or 2) who has limited benefits for behavioral health services and those services specified within the needed level of care are not covered by the insurance plan.

Eligibility for services through the Indian Health Service shall not constitute insurance for the purpose of determining eligibility under this contract. Further, persons eligible for Medicare Part B may be provided outpatient services pursuant to this contract or may be served according to the Medicare reimbursement terms.

[v] **Substance abuse admission priority:**

a. Contractors shall notify the Deputy Commissioner within twenty-four (24) hours of when the Contractor reaches ninety percent (90%) of capacity.

b. All requests for services shall require a face-to-face screening.

c. Intravenous drug users shall be admitted for services within fourteen (14) days of the request for services; or within one hundred twenty (120) days, provided interim treatment services are provided within forty-eight (48) hours.

d. Interim Services: All contractors shall develop policies and procedures and implement interim services into the treatment program. Interim services are those services that are provided until an individual is admitted to a substance abuse treatment program. At a minimum, interim services should include substance abuse education, case management, and linkage to support groups. Counseling and education about HIV, HCV, and TB. Education about the risks of needle-sharing, the risks of transmission to sexual partners and infants, and about steps that can be taken to ensure that HIV, HCV, and TB transmission does not occur, as well as referral for HIV, HCV, and TB treatment services if necessary. For pregnant women, interim services also include counseling on the effects of alcohol and drug use on the fetus, as well as referral for prenatal care.