Financial Eligibility Policy
Frequently Asked Questions

Q. Implementing this procedure mid-month creates double work for those in residential treatment (for example, currently for a client in residential treatment we would have one self-pay charge for the whole month which would include all the days they were in service for that month. We now have to create two charges – July 1 to 17 and July 18 to 31 – our work just doubled. Any way this could be pushed back to 8-1-12?

A. The new law that changes how financial eligibility and copayment amounts are assessed becomes effective on July 18, 2012. Providers should prepare for implementation as directed by their Regional Behavioral Health Authority. The Division of Behavioral Health will be conducting a trial implementation project to review the impact of the new law.

Q. Considering the time and resource burden in implementing the new policy, providers would like to request a minimum of 90 days for implementation?

A. The eligibility of a consumer to receive services funded by the Division of Behavioral Health must be assessed annually or when known changes occur such as changes in taxable income or number of dependents.

Q. Will professional partners have to assess financial eligibility for all of their families?

A. Yes. All consumers must be assessed for eligibility to receive services funded through the Division of Behavioral Health.

Q. Will providers be required to use the proposed DBH worksheet or can they incorporate the liabilities portion into existing financial eligibility forms?

A. Providers can incorporate the information on the DBH worksheet into their existing forms as long as they do not expand or alter the number, amounts, or types of liabilities used to determine financial eligibility.

Q. Are all current clients to be assessed using the new policy/fee schedules/worksheets on or by July 1st or just new clients admitted after July 1st?

A. The eligibility of a consumer to receive services funded by the Division of Behavioral Health must be assessed annually or when known changes occur such as changes in taxable income or number of dependents.

Q. Are providers to base co-pays on reimbursement rates or their cost of service?

A. If the service is paid by DHHS or Region by a rate, the reimbursement rate must be used. If the service is paid via expense reimbursement, the cost of service is used to determine the copayment amount.

Q. Are the RBHA(s) responsible for determining any of the percentages for co-pays for services?

A. Per statute, the Regional Behavioral Health Authority (RBHA) shall adopt a policy for use in determining the financial eligibility of all consumers and shall adopt a uniform

schedule of fees and copays, based on the policy and schedule developed by the Division, to be assessed against consumers utilizing community based behavioral health services in the region. Each RBHA shall assure that its policy and schedule of fees and copays are applied uniformly by the providers in the region.

Q. Can providers waive/adjust co-pays for clients not on the hardship schedule?
A. Per statute, the Regional Behavioral Health Authority (RBHA) shall adopt a policy for use in determining the financial eligibility of all consumers and shall adopt a uniform schedule of fees and copays, based on the policy and schedule developed by the Division, to be assessed against consumers utilizing community based behavioral health services in the region. Each RBHA shall assure that its policy and schedule of fees and copays are applied uniformly by the providers in the region.

Q. Are providers required to collect established co-pays?
A. Rates for services and expense reimbursement are not intended to pay 100% of the cost of a service. Fees from consumers and other third party payments should be collected to make up this difference.

Q. Will the provider's co-pay be deducted from the rate prior to service reimbursement?
A. No

Q. Will this policy and procedure apply to Hospitals/Acute Inpatient?
A. Hospitals must assess consumers to determine if they are eligible for DHHS funded services.

Q. Historically providers have been able to not bill insurance in instances of domestic abuse and consumer safety. Will that continue?
A. Yes.