Department of Health and Human Services (DHHS)
Division of Behavioral Health (DBH)

POLICIES AND PROCEDURES

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Approved:

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DHHS Division of Behavioral Health

Subject: Financial Eligibility

Purpose: The Department of Health & Human Services Division of Behavioral Health has established Financial Eligibility Standards for consumers of behavioral health services. The Division of Behavioral Health will reimburse service providers for mental health and substance abuse services for consumers who meet clinical eligibility criteria and who meet the following financial eligibility criteria.

Rationale: Pursuant to Nebraska Revised Statutes §71-806; §71-804 and §71-838 as amended; to ensure compliance with same.

Policy:

I. Payer of Last Resort

A. The Division of Behavioral Health is the Payer of Last Resort for behavioral health services for consumers who meet:

1. The clinical eligibility criteria as specified in Behavioral Health Service Definitions;

2. Financial eligibility criteria as specified in this policy and attached Fee Schedule;

3. Citizenship/lawful presence as defined by Neb. Rev. Stat. §4-108 to 4-114 and living in the state voluntarily with the intent of making Nebraska his/her home; and,

4. For Individuals regardless of citizenship/lawful presence status receiving emergency services or inpatient or outpatient treatment mandated by Mental Health Board or for individuals mandated into the care of DHHS by a court order.

B. The Division of Behavioral Health will not reimburse:

1. For Medicaid eligible services provided to Medicaid consumers. If the consumer has accrued personal needs allowance and creates savings that disqualify him/her from a

benefit such as Medicaid, the full cost of the service must be assessed to the consumer until he/she qualifies for the Medicaid benefit.

2. For any portion of services required to be paid by a Medicaid recipient to meet a share of cost obligation.

3. For mental health, substance abuse or gambling addiction services that are eligible for or covered under other health insurance benefits, that were denied by an insurance company due to provider error or insufficient documentation, that were not submitted to the insurance company as outlined in Section II. B or that was not submitted to the insurance company by request of the consumer.

4. For any service in which the consumer is deemed eligible to pay the cost of the service.

II. Services Paid by the Division of Behavioral Health

A. For persons who meet the Division's clinical eligibility and financial eligibility criteria, the provider will be:

1. Paid the rate set by the Division of Behavioral Health for services provided which are pre-authorized with the Administrative Services Organization (ASO) or registered services that have a statewide rate established;

2. Paid a Region-determined rate for services provided which are registered with the Administrative Services Organization (ASO); or

3. Paid or reimbursed for allowable uncompensated expenses (expense reimbursement) for services provided which are registered with the ASO or otherwise documented as required by the Division of Behavioral Health, not to exceed the actual cost of the service less any copayment and third party payment received for the service.

B. The provider may bill the Region for services performed for consumers eligible for DHHS funded services after the denial of insurance benefit has been received as long as the denial is not due to provider error or for failure to submit required information. The provider may also, at the risk of violating any third party or insurance company agreement, bill allowable costs incurred in the performance of services that may be covered by the Division prior to billing any third party or insurance company. In doing this, the provider assumes all risk and penalties associated with any act that may be deemed a violation of a third party agreement or insurance company agreement, and may not bill any penalty or subsequent loss of revenue for services to individuals ineligible for DBH services to the Division. The Division reserves the right to seek reimbursement for any payment for which it would have been eligible for if the third party agreement or insurance company agreement had not been violated.

1. Except when it may pose a danger to the consumer (see II.B.7), before any cost incurred in the performance of services that may be covered by a consumer's insurance can be billed to the Division, all services performed must be submitted to the insurance company within 30 working days after the date of service and the date of submission documented for subsequent review and tracking.

2. After the service is billed to the Division, if the service is subsequently deemed to be covered by insurance and payment is remitted to the provider for the provision of the service, all funds received from the Division for the date of service being reimbursed must be reimbursed back to the Division on the next payment request to the Region.

3. If the service is deemed to be not covered by insurance or payment is denied due to the consumer's deductible not being met, a copy of the Explanation of Benefits must be placed in the consumer's file;

4. Once a consumer deductible has been met and the insurance company submits payment for services to the provider, no additional costs beyond this payment may be billed to the Division.

5. A provider may bill for services rendered to a consumer that has exhausted all insurance benefits if the person continues to meet financial eligibility criteria and it is deemed clinically eligible for treatment.

6. In the event a provider receives insurance payments after the end of the fiscal year for services paid by the Division in the previous year, the provider must reimburse the Division these funds on the next payment request to the Region.

a. In the event an agency is ceasing operation or will no longer be under contract with a Region prior to all insurance claims for DBH eligible consumers being processed, prior to the end of the contract, the Region must review all documentation to determine an estimated amount of funds that may be due to the Division and this amount be subtracted from the final bill submitted by the provider to the Region for payment by the Division. The Division also reserves the right to conduct this review and determine the amount to be reimbursed for any service provided by the Region or if a Region fails to conduct the review.

7. A provider may waive the filing of insurance forms if doing so will pose a danger to the consumer. Situations where this can happen include instances when domestic violence or child abuse is happening in the home.

III. Terms

A. For the purposes of financial eligibility:

1. **Taxable Income** is defined as alimony, wages, tips, or other money received for a good or service. This information can be obtained by review of, paycheck records, SSI/SSDI eligibility, Medicaid eligibility, and/or a signed statement from the client. For purposes of the Eligibility Worksheet, the taxable income of the consumer and other adult dependents should be used to determine Taxable Monthly Income.

2. **Liability** is defined as money owed to another person or agency to secure items such as housing or transportation, and is limited to liabilities included on the Eligibility Worksheet. The information can be obtained by review of previous monthly statements or a signed statement from the consumer.

3. **Client Fees** is defined as any Co-pay, Room and Board Fee that is required to be paid by consumer to receive the service.

b. **Co-pay:** Also known as copayment; fixed amount required to be paid for each appointment or unit of service. The co-pay amount may not exceed the amount designated by the DBH or the Region for the service. The DHHS Division of Children & Family Services may remit the copayment on behalf of the consumer.

c. **Room and board fee:** Fixed per day amount required to be paid by the consumer for meals and the use of a bed in residential facilities. The room and board fee may not be in excess of actual costs incurred for these services by the provider.

4. **Dependent**: Any person married or cohabitating with the consumer or any child under the age of 19 who depends on the consumer's income for food, shelter and care. Dependents may include parents, grandparents or adult children if the individual(s) are living with the consumer and they are dependent on the consumer's income for their food, shelter, or care.

5. **Daycare**: Refers to the funds paid to a place, program, organization or other third party for the care and well-being of one or more children under the age of 19 while parent(s) or other primary caregiver is working, in school, or in treatment.

6. **Rate** is defined as a) the rate set by the Division of Behavioral Health for services provided which are pre-authorized with the Administrative Services Organization or registered services that have a statewide rate established; b) a Region-determined rate for services provided which are registered with the Administrative Services Organization (ASO) or otherwise documented as required by the Division or Region.

7. **Cost** refers to the specific expenses incurred by an agency for providing a unit of service or the average costs of serving all customers within a given service when a Division or Region rate has not been determined for reimbursement purposes. This includes personnel, occupancy, supplies, administrative expenses, and similar types of expenditures. In determining the specific costs, a provider may include a substantiated allowance for uncollectible client fees but may not include funds in excess of actual cost (i.e., profit) per state regulations.

IV. Consumer Eligibility:

A. Prior to billing the Region and/or Department, the provider must determine if the consumer is financially eligible for the Division of Behavioral Health to pay for services. The Division of Behavioral Health and/or the Network Manager may request verification of consumers' financial eligibility from any provider.

B. To determine if a consumer meets financial eligibility criteria, on the HHS/Division of Behavioral Health Financial Eligibility & Fee Schedule:

1. Complete the Eligibility Worksheet for the consumer to determine the Adjusted Monthly Income amount.

2. Locate the adjusted monthly income amount on the schedule.

3. Locate the total number of family members dependent on the taxable income.

a) Consumers who by Adjusted Monthly Income and number of family members dependent on the taxable income fall within the shaded areas on the chart are eligible for services funded by Division of Behavioral Health. Costs (as defined in Section II) associated with performance of services to eligible consumers may be billed to the Division.

b) Consumers who by Adjusted Monthly Income and number of family members dependent on the taxable income fall within the un-shaded area of the HHS/Division of Behavioral Health Financial Eligibility Schedule are not financially eligible for payment by the State. No costs associated with performance of these services may be billed to the Division.

V. Copayment Amount:

A. To determine the maximum copayment to be requested from a consumer, on the DHHS/Division of Behavioral Health Financial Eligibility Schedule:

1. Locate the Adjusted Monthly Income amount on the appropriate schedule:

a) **Hardship Fee Schedule:** For individuals who have met one or more of the hardship criteria;

b) **Emergency Access Services Fee Schedule**: For individuals receiving assistance from Crisis Response Team, Emergency Community Support, Housing Related Assistance or 24-hour hotlines;

c) **Financial Eligibility Fee Schedule:** For all individuals eligible to receive DBH funded services but who are not eligible for other approved fee schedules.

2. Locate the total number of family members dependent on the taxable income.

3. The box in which the column and row intersect is the maximum amount of fee to be charged to the consumer for each appointment or unit of service.

B. The 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.

C. The assessment of a consumer's financial eligibility is an ongoing process. The consumer's financial eligibility status must be re-assessed annually or when known changes occur

such as changes in taxable income or number of dependents. The re-assessment may increase or decrease the co-pay obligations of the consumer.

D. Consumers who refuse to provide financial information shall be charged full cost of services. The provider may not bill the Division of Behavioral Health for any service for which the consumer is responsible due to failure to provide financial information or signed statement.

E. Any fees or copayments for Substance Abuse Education and Diversion programs are determined by the Region or other provider and are not subject to provisions of this policy.

F. Residential levels of care will receive payment based on the Division's established rates. In addition to room and board fees, a copayment may also be assessed. The room and board fee may not be in excess of actual costs (as defined in Section III.4) incurred for these services by the provider. All copayments charged must be in compliance with the DHHS Division of Behavioral Health Financial Eligibility and Fee Schedule.

G. For persons on whom payment of such fees would impose extreme hardship, an alternative fee schedule developed by the Division may be used following the same method as describe in Sections IV and V. Criteria for "hardship" will include:

1. Severe and persistent mental illness

2. Serious emotional disorder in youth 19 or under

3. Medical bills or medical debt in excess of 10% of the taxable annual income (as determined by taking (Taxable Monthly Income x 12) x 10%). A hardship may not be granted for non-medical related debt. If required, documentation of the debt may be obtained from statements or invoices from hospitals, doctors, labs, pharmacy, or similar medical related entities. Debt that is not medical in nature may not be used to determine eligibility for hardship.

Eligibility for the alternative hardship fee must be clearly documented on the Eligibility Worksheet.