

Frequently Asked Questions
Charges for Community-based Services Rule
August 2016
(Rules of DSHS in Texas Administrative Code,
Title 25, Part I, Chapter 412, Subchapter C)

1. Could there be clarification on who counts as “Family Members” and whose income counts. Apparently there was information sent out to some centers who chased the answers over the years, but not all around this matter. This clarification had something to do with Family Code, etc.

Also, the phrase “residing in same household” appears under “Family Members” for the “unmarried person under the age of 18.” Should this same phrase appear in all definitions of “Family Members”? If not, does that mean we do NOT count dependents or spouses who do NOT live in the same household as the client? This gets very confusing.

Also, this phrase does not appear when the rule talks about whose income to count. It is unclear if we are supposed to count the income of a spouse or parent who does NOT live in the same household as the client. This presents problems when we have situations where there is a separation or divorce involved in dealing with child clients. There is also the whole issue of step-parents, according to Texas Family code step parents are not financially responsible for step children, the whole concept of the family code seems to reduce countable family members to biological and adoptive relationships only.

Also, we have received conflicting information as to whether or not we can count the SSI or other income of a child.

DSHS Response. The definition of “family members,” while not meeting everybody’s wishes, is clear. Since the rule has been adopted, we cannot change the rule language. The questioner is correct that in cases of children, we do not count family members who live outside the home. [§412.103(5)]

DSHS Response. Step-parents are not financially responsible for their spouses’ children unless they adopt them. This is Texas law. Divorced parents fulfill their financial obligations through court-ordered child support. Child support is not considered income. If a parent is not living in the home because of separation, it is not the intent of the Department to hold the parent caring for the child alone responsible for both parents’ financial obligations. SSI is considered for a child, if the child is the client. If the child has a job, his or her wages are not counted as income, since he or she is not responsible for payment for care and treatment.

2. Under “Accountability” section, what is an acceptable level of documentation required for financial documentation?

DSHS Response. A current paystub, W-2, tax return, or SSI determination are adequate levels of documentation. Additionally, if the consumer has insurance, a copy of the insurance

card or Medicaid or Medicare card is acceptable. If a client has no income, a signed statement from the consumer is adequate. [§412.105]

3. What is considered adequate documentation for someone to prove they have been denied Medicaid? Can we have a screening process at the financial assessment that would suffice for this?

Concern: Are our clerical/financial staff going to be put in the position of deciding someone does or does not qualify for Medicaid? This will be a significant training and operational issue.

DSHS Response. The financial assessment is adequate preliminary screening for Medicaid/SSI. If the financial assessment does not identify the consumer as potentially Medicaid eligible, there is no need to continue to further screen for eligibility. Once a consumer is identified as meeting financial screening criteria, local authorities should be developing a clinician managed screening process of determining who should apply for SSI. It is not the department's intent for local authorities to complete spurious SSI applications. A denial letter, depending on the date, could be proof that a person does not qualify. However, a person's financial situation could have changed since he or she applied and an SSI denial does not necessarily mean a consumer does not need help applying for SSI. [§412.105(c) and (g)]

4. What level of assistance must we provide for making a person apply for Medicaid or CHIP? If they don't comply, what action do we take? Deny services?

DSHS Response. The department expects persons to receive necessary assistance to apply for CHIP, Medicaid, and SSI. This assistance will vary depending on the needs of the individual or family. If persons choose not to apply, the rule provides that they are to be charged the standard charge for services. All provisions of the rule are to be followed with these individuals and families. [§412.105(c) and (g)]

5. Given the fact that the sliding fee scale will change drastically, should we redo financial assessments on all clients on Sept. 1st? If not, is there any concern that some client's MMF will be based on the old scale therefore not being uniform and equitable?

DSHS response. The changes to the fee schedule do not affect the assessment requirement. It is only necessary to reassess consumers annually or if a significant financial change occurs. Consumers' monthly maximum fee should be adjusted to reflect the current schedule. A new financial assessment is not required to adjust the MMF due to fee schedule modifications. [§412.106]

6. If a new person simply inquiring about services (has not been admitted; is not in crisis) has private insurance that will be out-of-network at our center and we refer them back to their insurance company to help them find an in-network provider, do we have to give them the information on the appeals process? In this situation would be still be technically denying them services?

DSHS response. Yes, because section 412.106(c)(2)(B) of the rule states that if a person is referred to his or her third party coverage, he or she must be given written notification of the appeals process. The rule also requires the local authority to assist the person in identifying a provider for which the third-party coverage will pay.

7. Could there be elaboration on “extraordinary expenses”?

DSHS Response. Extraordinary expenses include major medical expenses, casualty losses, or child care expenses from the past year or for the next 12 months. Anything not in this category that is considered an expense which would have a negative impact on the consumer’s ability to pay could be treated as a hardship. Generally expenses in this category are expected to affect the consumer over the 12-month period and have the impact of loss of income. [§412.106(b)]

DSHS Response. Daycare is considered an extraordinary expense. Hospitalization with bills that impact income over a twelve-month period would be considered extraordinary. When determining major medical extraordinary expenses, it is important not to think in terms of diagnosis, but rather in terms of level of care and how much expense over a period of twelve months is expected to be incurred. Casualty loss is property loss or damage. Again, it is important to consider the impact of the damage and expense incurred rather than type of damage exclusively. The objective is to determine whether the damage or loss is expected to affect the person’s available income for the next 12 months or if there was a major impact in the previous 12-month period. [§412.106(b)]

8. Can the LA charge more than the cost to provide a service? (This has to do with us being a non-profit entity?)

DSHS Response. The rule requires local authorities to set reasonable standard charges for services. It is not the practice of DSHS to give legal advice to local authorities about specific issues. Seek the advice of legal counsel on issues regarding non-profits. [§412.107]

9. It seems like there are two amounts - cost sharing for covered services AND non-covered service charges up to the MMF. For example, a client has an MMF of \$40. For this month, they have a cop-pay of \$30, a deductible of \$50. They also received non-covered services in the amount of \$100. So, I would bill their copay and deductible total of \$80. And I will also bill them \$40 of the \$100 of their non-covered services because their MMF is \$40, for a total of \$120.

DSHS Response. No, the client must be billed the \$80 in cost sharing, but since that total exceeds their MMF of \$40, the non-covered services are not billed. [§412.108(d)(3)]

10. We need the definition of "non-Medicare, third-party coverage."

DSHS Response This would include a variety of coverages and was written to be broad enough to expand with changes in our healthcare system. Included in this definition are the

Marketplace plans, private insurance, Medicare Advantage plans, Tricare, CHIP, and others such as these.

11. Traditional Medicare third-party covered individuals do not get charged more than their MMF, correct?

DSHS Response. Yes. [§412.108(d)(3)(A)]

12. Individuals with non-Medicare, third-party coverage may have copays, coinsurance and deductibles higher than the MMF. Do we charge them all cost sharing if it exceeds MMF?

DSHS Response. Yes. [§412.108(d)(3)(A)]

13. Are we required to actually collect all copays, coinsurance, and deductibles?

DSHS Response. Centers are required to bill for them. Collecting them is addressed in the rule, allowing you to set Center policy related to hardships, payment plans, and decisions about writing off service charges at a later point. [§412.108 (billing) and §412.109 (collecting)]

14. In the Performance Contract, Special Conditions, Section 7.02, it states "Cost sharing must not exceed the MMF as determined by the TAC." That is confusing.

DSHS response. For FY17, this language in the Special Conditions has been deleted and replaced with the following "systems must provide for billing and collection policies that comply with 25 Tex. Admin. Code, Chapter 412, Subchapter C, Charges for Community Services."

15. In the scenario mentioned in question 6 occurs but we are unable to find an in-network provider and it is clinically indicated that the person needs services and we admit them and begin providing the services, how do we charge them? (pg. 7 of the rule) Would they be charged MMF for covered services (covered by insurance—just not to at our center) and non-covered? Or, since this fits the definition on Page 6 of the rule (regarding allowing client to pay standard charge for needed services) would we charge them full standard charge for covered and MMF for non-covered?

DSHS Response. If the local authority is assisting the consumer and is unable to locate an in-network provider and it is clinically indicated that the person needs services, the local authority is to charge the consumer according to his or her MMF and the service provided would be considered not covered by third-party coverage unless an in-network provider becomes available or payment can be negotiated with the consumer's third-party coverage. In this scenario, the consumer is not choosing the local authority despite the availability of an available in-network provider. Therefore charging the standard fee is not applicable. [§412.106(c)(2)(D)(ii) and §412.108(d)(1)]

16. Clarification: If a client has a “Medicare Replacement” / Medicare + Choice insurance policy, should this be classified as non-Medicare third-party coverage? They no longer have Medicare in this circumstance.

DSHS Response. Yes, this would be considered non-Medicare third-party coverage for the purposes of the rule. [§412.108(d)(3)]

17. Clarification: This rule does not make the distinction between Medicare Part A and Medicare Part B. According to DSHS, the financial assessment requirements are different for each one. This needs to be addressed. The distinction needs to be entered into the rule.

DSHS Response. Local authorities are required to meet the assessment requirements laid out in the rule to be in compliance with the performance contract. There are no additional financial assessment requirements to waive copays. This applies to Medicare Part A services as well as Medicare Part B services when services are provided by the local authority. [§412.108(d)(2)]

18. **a.** Clarification: Section 412.108(d)(3) Non-Medicare third-party coverage, (A) and (B) is very confusing specifically around collecting cost-sharing for covered services plus the MMF for non-covered. Could this be clarified please?

DSHS Response. Copays may be collected with the third-party coverage, even if it exceeds the MMF. Non-covered services covered by this rule may only be charged up to MMF, including what has already been collected in copays for services covered by third-party. Fundamentally, unless a person is paying more than his or her MMF in copays alone, he or she should never pay more than his or her MMF. [§412.108(d)(3)]

b. This section also presents significant operational issues. If private insurance takes months and months to pay, we can't really collect the MMF for the non-covered services at the time of service. If we do collect the MMF for non-covered at the time of the service, we run the risk of collecting too much if once the private pays and the cost-sharing amount goes over the MMF. (In that situation, we should not have collected the MMF for non-covered and will have to refund it or apply to another month.)

DSHS Response. The issue is the patient portion, not the insurer portion. If you are charging copays, co-insurance, or deductibles at the time of service, then charges for non-covered services, if any, should be able to be calculated. If a the local authority collects a copay from a consumer for a covered service that is not allowed by the third-party payer, the local authority can refund the consumer if his or her charges have exceeded his or her MMF. [§412.108(d)(3) and §412.109]

19. If the client has 3rd party insurance, and it has a co-pay, but insurance does not cover service coordination and rehabilitation services, do we collect for the uncovered services up to the MMF, count the co-pays as part of the MMF? What if the co-pays exceed the MMF, should we collect those?

DSHS Response. Collect the copays for covered services first, then collect for non-covered services only up to the MMF. [§412.108(D)(3)]

20. Where does it say we cannot charge non-Medicaid clients less than we bill Medicaid? DSHS has already forced us into that situation with CHIP. We have had to take contracts from MHNET that are less than Medicaid rates.

DSHS Response. Medicaid does not allow Medicaid providers to charge non-Medicaid clients less for services than they charge Medicaid. [§412.108]

21. In the Performance Contract, Scope of Work, Children's Services, page 39, g) (4) says that Centers shall "allow clients that are eligible for DSHS services, but that cannot pay a deductible required by a third-party payor to receive services up to the amount of the deductible and to use DSHS funds to pay for the deductible." This is language also conflicts with the TAC.

DSHS response. This language was deleted from the FY16 PCN during contract amendments.

22. Lack of definition for "Financial Hardship."

DSHS Response. Financial hardship is not narrowly defined to allow for flexibility for individual circumstances which could otherwise limit assistance to consumers and their families. [§412.109(b)]

23. Under "Financial Hardship" there is no instruction given on how we deal with the person who has voluntarily agreed to pay the full standard charge for services because his insurance is out-of-network? Do we defer and use the MMF for non-covered service as a guide as indicated in §412.109(b)(2), (A) and (B)?

DSHS Response. No, the person paying full standard charge would fall under the provisions in §412.109(b)(1), since third-party coverage is not being billed for services. The consumer is responsible for providing documentation that a hardship exists and the local authority *may* arrange for the person to pay a lesser amount each month.

24. The flow charts have "Financial Hardship" included indicating that this is a part of the process for every client. Could this be clarified? Also, there is a concern that "advertising" the option of declaring "Financial Hardship" will cause clients to take advantage of this option. There is a concern that we will be put in position to settle for "good faith effort" collections.

DSHS Response. The flowcharts in the pilot training are being revised for the training in August. Financial hardship is not a method of erasing the balance. It is a payment arrangement, or a method to make a lesser payment. For consumers who do not have insurance, the burden is on the consumer to provide documentation of a financial hardship with the local authority having the final determination. For consumers who have private

insurance, financial hardship does not have to be determined by the local authority, because financial hardship does not affect the contract between the local authority and the third party coverage and this group will in no case pay less than the MMF. [§412.109(b)]

DSHS Response. It is the department's policy to inform consumers of all rights regarding services. For the purposes of 412-C, this will be done through the development of a brochure detailing the rule in plain language, as required by the rule in §412.112. It will explain rights and responsibilities, as well as the appeals process.

25. What exactly constitutes financial hardship? Other than a change in countable extraordinary expenses or income which would trigger a new financial assessment anyway what other circumstance would affect a person's ability to meet his or her assessed financial responsibility? Could you please provide us with some concrete, real world examples?

DSHS Response. A financial hardship is a crisis poverty situation. The difference between an extraordinary expense and a financial hardship is that an extraordinary expense brings you into a different category in the fee schedule where you are expected to remain at least for the next 12 months, whereas financial hardship is shorter term in nature. Examples could include a single parent having to miss work due to having to stay home with a child or needing to suddenly move and requiring deposit and start-up expenses. Other hardships could include major car repairs, probation fees, or medication for an acute illness. Any sudden loss of income or sudden expense that does not constitute a financial change or is not expected to last 12 months and does not meet the definition of an extraordinary expense, but would affect the consumer at least one level on the fee schedule should be considered when determining whether a hardship exists. [§412.106(b) and §412.109(b)]

26. The terminology "discontinuing" of charges seems to take the "teeth" out of this rule with centers trying to enforce collections. Why couldn't this have been "deferred" or "reduction" in charges? There is concern that this gives every client an "out." With this terminology in the rule we still don't seem to have any power to enforce collections.

DSHS Response. The decision to discontinue charges is a clinical determination by the local authority. This guarantees an individualized process with determinations made on a case-by-case basis. Additionally, if charges and statements are suspended, the clinical determination must be reassessed every three months and the local authority is responsible for developing and implementing a plan for addressing the consumer's refusal or rejection of needed services. This highlights an area of need to balance collection efforts with clinical responsiveness, demonstrating the necessity to train clinicians and reimbursement officers as a team. [§412.109(c)]

27. Could the terminology "serious deterioration" of a person's mental or physical health be defined? §412.109(d).45(2) under "Involuntary reduction or termination of services for non-payment by person..."

DSHS Response. Serious deterioration language references commitment criteria in the Mental Health Code. The full deterioration criteria states, "experiencing substantial mental or

physical deterioration of ability to function independently, which is exhibited by inability, except for reasons of indigence, to provide for basic needs including food, clothing, health, safety.” [THSC §574.034]

28. Similar question around this issue: Do we (LA) have the option to not accept private insurance?

DSHS Response. There is no requirement in current rules or in the performance contract for a local authority to accept a particular private insurance plan.

29. The terminology “reasonable effort” is used several times throughout this rule regarding the collection of money. Could this be defined in more detail?

DSHS Response. “Reasonableness” is determined by department review of local written policy, implementation, and outcome. Reasonableness will be a balance of effort to collect and fairness to consumers. Generally, a policy which systematizes adherence to this rule, particularly, regular efforts to collect while ensuring the rights guaranteed in this subchapter is considered reasonable.

30. Could TDMHMR elaborate more on “clinical determination” process under the section “Discontinuing charges to person for services”?

DSHS Response. A clinician is required to assess whether a consumer or the family of the consumer would refuse or stop coming to services if it is determined that it could cause psychological harm. Where business and clinical worlds interface it will be necessary for you to work with your clinical staff to understand and develop a process for meeting the requirements of this section of the rule. [§412.109(c)]

31. Could we have clarification on “Respite” services under the definition of “Community Services”?

DSHS Response. Respite services are defined in Information Item V, Crisis Service Standards.

32. Which part of the rule applies (Medicare third-party or Non-Medicare, third-party) to the person that has both kinds of coverage? This is a big concern since each one is treated differently in the rule. There are many instances when consumers have both. It gets even more confusing depending on which type of coverage is primary.

DSHS Response. Generally, the insured or the LAR will know which coverage is primary.

33. So many things in the rule are left up to the discretion of the LA. One of the many reasons for the overhaul of this rule was to insure uniformity throughout the state. How does DSHS propose we accomplish uniformity when so many things are decided at the local level?

DSHS Response. The rule provides a framework for a uniform financial assessment, a uniform maximum monthly fee schedule, and an appeals process, all of which allow for equity and ensure persons aren't denied services based on an inability to pay. Because we work with persons with serious mental illness clinical judgement will play a critical role in decision making with the population we serve in the clinical and business settings.

34. What does the state insurance board state regarding collection of the MMF vs. co-pay and deductible? Why do we collect the co-pay instead of the MMF?

DSHS Response. Texas Department of Insurance states that the issue of whether to waive co-pay and deductibles is a policy issue to be determined by the DSHS. DSHS in consultation with TDI established policy that determined that consumers with 3rd party coverage that is not income-based would be billed by local authorities in accordance with the agreement between the 3rd party coverage and the local authority. DSHS rules were developed in this manner so that policy would not infringe on the local authority' to engage in and maintain a contract with third-party payors.

35. Does DSHS have an opinion or a problem with centers accepting credit card payments from consumers?

DSHS Response. DSHS has no concerns with local authorities accepting credit card payments from consumers.

Please contact Avril Hunter by telephone at 512-206-5758, if you have additional questions or require further assistance.