CBHS Centralized Financial Eligibility
Frequently Asked Questions – Part I

1. What are CFE and EGI?

Centralized Financial Eligibility refers to the change, effective January 1, 2013, when the CBHS Billing Office will create, update, and maintain Financial Eligibility (FE) records in Avatar. CBHS Provider staff access to Avatar FE records will be changed to 'Read only'. MH Providers will continue to enter their Clients' financial information in Avatar Family Registration.

Providers will continue to obtain their Clients' episode Payer and Financial Information (PFI), in accordance with State and Federal regulations. Clients' payer information, (known as "Guarantors") will be entered by Program Staff into the Avatar/ CalPM/ Episode Guarantor Information (EGI) screen. CBHS Billing will access new Clients' and updates to existing Clients' EGI information by using Avatar reports which will be reviewed on a daily basis.

2. What is the purpose of this change?

Centralized FE will reduce third party billing and payment posting errors by ensuring the correct guarantor sequences are entered for all Clients; and, by improving the maintenance and management of every Clients' Avatar guarantor record.

3. When will CFE become effective in the Avatar system?

Centralized Financial Eligibility (CFE) is effective 1/1/2013 with the launch of the Episode Guarantor Information (EGI) screen as a 'stand-alone' form in Avatar CalPM. On 1/7/2013 go-live will be completed as the EGI screen is incorporated in the Avatar Outpatient Admission Bundle, for Intake Coordinators, and SFMHP Access Points. Mental Health and Substance Abuse Program Staff access to Avatar Financial Eligibility screens will be changed to 'Read-only'.

4. Can we continue to use the paper PFI form for Clients' financial and eligibility information? Why are there three different forms?

The 'old' PFI form is discontinued and its information does not correspond to the CBHS system. Please use the Episode Guarantor Information, UMDAP Sliding Fee Determination, and Billing Consent paper forms that were developed based on studies of different CBHS Providers' eligibility and UMDAP process flows, and for easier data entry into Avatar.

NOTE: *DO NOT send these paper forms to CBHS. Instead, retain these forms in respective clients' Charts or in your Program's files.*

The Episode Guarantor Information form is used when Program Staff want to gather a Client's financial and eligibility information prior to entering information in Avatar. The form corresponds to fields in the EGI screen for data entry. Note, using the paper EGI form is **optional.** Intake Coordinators may choose to directly enter Client's financial and eligibility information in the Avatar EGI screen.

CBHS and the SFMHP (San Francisco Mental Health Plan) primarily serve Medi-Cal beneficiaries and the Indigent as the part of the County's healthcare system safety net. Many of them do not have a Patient Fee Liability. In addition, Substance Abuse treatment programs do not enter UMDAP information in Avatar; only Mental Health programs enter UMDAP financial information in Avatar Family Registration screens[1]. For these reasons, a separate ***UMDAP Sliding Fee Determination*** form was developed to facilitate gathering Clients' information for the purposes of: determining a Client's UMDAP liability amount and to document the following: reason(s) for changing the Patient Fee amount payable, the Program Director's agreement with the adjustment made, and the Client or their Responsible Party's agreement to pay their UMDAP.

[1] Refer to AVATAR User Manuals and Training, CBHS policy/procedures on PFI and UMDAP.

The ***Client Consent for Billing*** form is used for meeting PHI requirements, per 42 CFR. The form is signed by the Client or their Responsible Party, to document their consent and authorization to release health information for billing purposes, agreement for coordination of healthcare benefits, and assignment of benefits (i.e., health coverage payments) to the SF Department of Public Health.

5. Can a single EGI be filled out if a client is treated simultaneously by two different programs or Reporting Units under the same agency?
Yes, if a client is seen in two different programs under the same agency during the same period, then a single EGI Form can be submitted. For example, if a client is admitted to an Adult Residential and an Outpatient Program (MH and/or ADP) under the same Provider, a single EGI Form will suffice, provided there is a notation on the EGI about the Client receiving services from two RU's in the same agency.

If a client receives treatment services from different programs, RU's or Provider agencies; or when the Client has different admission periods within the same agency, separate EGI Forms for each Client Episode must be completed to ensure Clients' services are billed correctly.

6. Will Intake Coordinators and/or Clinical Staff still have access to the Avatar Financial Eligibility form?
Yes, Intake Coordinators and Clinic Staff who are authorized in Avatar will continue to have access to Clients' Financial Eligibility records. However, this is changed to **READ/ VIEW** access only.

7. When do we need to do an UMDAP/ PFI and enter Family Registration info in Avatar?
If a client has an Out-of-Pocket expense, such as a monthly Medi-Cal Share-of-Cost, Medi-Cal annual deductible and Co-insurance amounts payable, Medi-Medi-SOC, HSF/ SFPATH, Medicare Part C or HMO or Private Insurance coverage, and is unable to pay these amounts, Providers use UMDAP to determine a Sliding Fee amount that the Client or their Responsible Party can pay for services received from CBHS Providers. Mental Health Programs complete the Avatar Family Registration form/screen to enter UMDAP for their Clients.

Substance Abuse Programs do not enter any information in the Avatar Family Registration, but use the same UMDAP Fee Schedule to determine their Clients' fees. SA Providers are required to maintain bookkeeping or accounting system for tracking their Patients' account receivables and amounts collected for year-end cost and revenue reporting, and for other purposes.

NOTE: *Clients enrolled with the SF Health Plan - Healthy Kids (HK), Healthy Families (HF) or Healthy Workers (HW) do not fill out Family Registration. (They do not have an UMDAP sliding fee.) SFHP enrollees have a $3 or $5 Co-pay amount per visit.*

8. **Why are co-pays collected?**
The Per Visit Co-pay or co-payment amount is required by their Healthcare Insurance Plan and must be collected by the Provider who renders services that are primarily paid for by the health plan (e.g. Kaiser, SF Health Plan, etc.). The Health Plan Enrollee agreed to pay their co-payment amount when they signed up with their healthcare insurance plan. We are required to collect Patient co-pays to be in compliance with the Health Plan Agreement or Contract. It is also against Federal laws, State regulations, and the SF-DPH Code of Conduct to automatically waive Patient fees.

9. What should a provider do, when he/she learns that a client has retroactive Medi-Cal or now has Insurance or OHC (Other Health Coverage) benefit?
Complete the EGI Form by selecting "Update for an Existing Client" option on the form.

10. What if a client has no healthcare coverage of any kind? In other words, they do not have Healthy SF or SFPATH, no Medi-Cal and are Uninsured.

The SFDPH policy requires Uninsured clients to be referred to its Health Access Program so they may complete an application for healthcare benefits. In addition, the Welfare & Institutions Code requires CBHS programs to assist their Clients in accessing entitlements that they may be eligible for. PRC and SFDPH Eligibility Workers assist Clients with their SSI, Healthy San Francisco and Medi-Cal applications. Please note on the EGI when Uninsured Clients are referred to PRC or to HSF for the CBHS Billing Office to track Client eligibility and guarantor changes.

11. Are Clinical Staff and/or Intake Coordinators still responsible for verifying and determining Client's benefit coverage and for contacting HMO insurance plans for authorization?

Yes, the Provider is responsible for verifying their Client's identity, for determining Medi-Cal and/or Medicare eligibility, and any healthcare coverage that their Clients may have.

Per CBHS policy, HMO Insured Clients, including those with Medicare Part C (aka Senior Advantage Plans) or Medi-Cal with OHC - other healthcare coverage, are referred to their HMO for health services they need. Medi-Cal is the payer of last resort and available only when their Medicare or insurance benefits are exhausted, or when their health plan does not cover these services.

12. Should all Medicare Clients sign ABN Forms, although ADP (Alcohol Drug Program) services are not payable by Medicare?

Yes, Medicare Clients (Part A, Part B, Part C, & Part D) must sign ABN Form annually as part of the PFI process because CBHS Programs render services that are not covered by Medicare. This applies to both MH and ADP clients.

13. Who is responsible for generating and reviewing the Avatar Missing Guarantor Report?

Providers must have a designated Staff person responsible for generating and reviewing the 'Missing Guarantor Report' in Avatar, at least once or twice a month. The report is generated to confirm all of their Clients have guarantor information in Avatar for services to be posted and billed timely.

In addition, the 'UMDAP Liability Due Report' must also be generated for Programs to identify Clients, whose annual PFIs are due. This allows the Provider and CBHS to be in compliance with the W&I Code and other State regulations. CBHS policy now require MH and SA programs to complete Clients' annual Periodic CSI data (for mental health Clients) or the annual periodic CalOMS (for substance abuse program Clients) data reporting when Providers renew their Clients' PFIs.

14. Are there any other reports available for Clinical Staff to support the CFE process?

Yes, "Loss of Medi-Cal Eligibility" report lists RU Clients whose Medi-Cal benefits are/were discontinued or terminated. The "Financial Eligibility Report by Program" lists all active Clients' in the RU and their guarantor information.

The 'Loss of Medi-Cal' report is especially helpful and should be run at least once a month (Medi-Cal is a month-to-month benefit) so that Clinic Staff can follow-up with their Clients and make Invoice or MC revenue adjustments as needed.

TIP: *'Review MEDS Information' tool is also available in the Avatar system, which is a very helpful to determine Medi-Cal client's monthly benefit coverage. Type 'MEDS' in the "Search Form" and it will take you to 'Review MEDS Information' Form. Type either, SSN without hyphen and DOB in two-digit day, two-digit month and two-digit year format (xx/xx/xx), or Medi-Cal Client Index Number in the input field.*

15. Why are anniversary dates for PFI, CSI, and CalOMS tied together?

The PFI (Payer Financial Information), CSI (Client and Service Information) for Mental Health (MH), and CalOMS (California Outcomes Measurement System) for Substance Abuse (SA) are all required annually. The CA Dept of Health Care Services (DHCS) requires annual reporting of Periodic CSI and CalOMS data. Similarly, PFI annual update is also mandated by the State. We are hoping Programs will find it easier to do these annual updates at the same time for their Clients.

16. What is the best way of communication between the Clinics and Billing Unit?

We found the best way to have timely and efficient communication between Clinics Staff and the Billing Unit is for the Clinic or program to have a designated Contact person for Billing. We will contact this Person about missing or incorrect Client FE information in Avatar. This person will contact Billing about Program staff questions or for clarifications related to Clients' Episode FE, UMDAP, or third party claims.

Please note, CBHS and CDTA are notified about non-compliance and about programs that require further training or assistance due to persistent errors or omissions that prevent timely SDMC claiming.

17. What are the differences between the old and new process?

Old Process:	**New Process:**
a) The Avatar FE information process was split into two components: Benefit Coverage Information and Guarantor Information. Providers needed to enter Guarantor sequence in the correct order.	a) The Episode Guarantor Information is entered by Staff (Front-end) for their RU Clients. Avatar FE and Guarantor Information are processed by the CBHS Billing Unit.
b) Avatar FE records entered by Clinic Intake Coordinators or Clinician Staff.	b) Avatar FE records are entered and maintained by the CBHS Billing Unit.
c) Intake Coordinators and Clinical Staff had the responsibility of entering guarantor information in the system.	c) CBHS Billing Staff are responsible for entering guarantor information in the system based on third party billing rules.
d) Intake Coordinators and Clinical Staff had access to ADD, EDIT and DELETE guarantors in the existing FE Form.	d) Intake Coordinators and Clinical Staff will have only READ/ VIEW access to Avatar Financial Eligibility (FE screen/form).
e) PFI or Payer Financial Information form used.	e) EGI form is used for the CFE process.
f) Clinics used '99999 Guarantor Clean-up Report' in Avatar.	f) Clinics use the 'Missing Guarantor by Program' Report in Avatar.
g) High error rates due to complex guarantor billing rules or funding source requirements; Clinic staff may have limited knowledge about Avatar FE entry	g) Provider Staff and CBHS Billing work together to minimize errors within the complex and integrated electronic health records system. Third party billing rules and processes may change as Healthcare Reform, Medi-Cal and Medicare Managed Care, HIPAA and other government initiatives are implemented.

18. Who benefits the most from this new process?

We believe the Centralized Financial Eligibility process is a Win-win for all parties involved. CBHS Mental Health (MH) and Substance Abuse treatment programs Staff will no longer need to worry about entering the correct Guarantor sequences or Avatar Financial Eligibilty. The CBHS Billing unit will benefit when claims are generated correctly for every provider.

19. Where can I obtain the Episode Guarantor Information form and two-part NCR forms for UMDAP Sliding Fee Determination and Client Billing Consent?

These forms are available at Forms Control Unit, 1380 Howard Street, Mail Room 2nd Floor, CA 94103. Telephone: 415.255.9313.

20. Is there a User Manual about the EGI screen and reports or PFI training for Clinic Staff?

Yes, you should have received (and read) the separate document describing EGI. It is available from CBHS Billing. PFI and UMDAP training for Clinic Staff is also available. Please contact Nanalisa Rasaily, by phone at 415.255.3610 or email at nanalisa.rasaily@sfdph.org. E-mail is preferred and recommended. Make sure you include your Clinic Name and whether you are a MH or ADP program. .