POLICY AND PROCEDURE

POLICY TITLE: DSAMH Client Responsibility and Billing DSAMH for Uninsured clients	**POLICY #: DSAMH014**
PREPARED BY: DSAMH Leadership	**DATE ISSUED:** 8/26/2019
RELATING POLICIES:	**REFERENCE:** Title 29, Chapter 79, Subchapter III DHSS Policy memorandum #37
DATES REVIEWED:	**DATES REVISED:**
APPROVED BY: Gregory A Valentine Digitally signed by Gregory A Valentine Date: 2019.08.26 11:03:54 -04'00'	**NOTES:**

I. PURPOSE:

Per Title 29, Chapter 79, Subchapter III of the Delaware Code, any person committed to accepting the services of any hospital, home, clinic, or other facility of the Department of Health and Social Services, and that person's spouse or parents in the order named, except for persons committed to a prison or correctional institution, shall at all times be jointly and severally liable for the full cost of the care, treatment, or both provided such person, except as may be specifically set forth in the Policy. This also applies to all providers of fee-for-service community-based and outpatient services that are contracted with the Division of Substance Abuse and Mental Health (DSAMH).

II. POLICY STATEMENT:

It is the policy of DSAMH to require that contracted providers utilize a sliding scale to determine the client's ability to pay the full cost of care, where there is a client responsibility portion of the fees charged for services (per PM #37). As such, sliding fee discount assessments should be completed for all non-Medicaid-covered clients upon admission into a provider program.

Furthermore, it is the policy of DSAMH to arrange for payment for fee-for-service community-based or outpatient services approved by the appropriate DSAMH unit (i.e., EEU; PROMISE) and delivered by a contracted DSAMH service provider when the client is uninsured. In some cases, DSAMH will also consider payment for services when the client is underinsured. This policy will act as a guide for determining when that reimbursement will take place. Typically, these payments are made to service providers using state general funds appropriated to DSAMH for this purpose. More rarely, the funds are grant funds DSAMH receives for this purpose only.

III. DEFINITIONS

Uninsured: No third party payer exists, the client is considered indigent.

Underinsured: A third party payer exists, but the insured lacks the resources to secure services due to the inability to pay the "patient responsibility" such as co-pays, deductibles, and/or co-insurances, or when a service is not covered under their active plan.

IV. REQUIREMENTS:

1. DSAMH contracts with providers in its behavioral health system of care for the delivery of community-based and outpatient mental health and substance abuse services. Typically, DSAMH contracts with a direct service provider when:

    a. The provider meets the requirements as outlined in the service RFP and has been awarded a DSAMH contract which allows them to provide that service.
    b. The provider is authorized to be paid, on a fee-for-service basis for uninsured or, in some cases, underinsured clients. The DSAMH contractual arrangement is not an arrangement for Third Party (Commercial, Private, Medicare and/or Medicaid) service reimbursement. DSAMH is the payor of last resort. Where active third party coverage exists, third parties should be billed.
    c. The provider is Medicaid certified to provide the contracted services. Depending on the type of service provided, the provider may also need to have active provider contracts in place with the Medicaid Managed Care companies as well as Medicare (CMS) and the major commercial plans covering beneficiaries in their respective service area.

2. Following the contracted procedure for invoice submission, the provider will submit invoices to DSAMH for direct reimbursement at the contracted rate of services delivered to the uninsured. In some cases, these clients are not aware that they have Medicaid or other third party coverage, so DSAMH will use its database to check eligibility or enrollment before authorizing payment for services. The contracted providers are expected to do the same before initial invoice submission.

3. The Financial Coverage and Sliding Discount Determination Form: This may be used by providers to help in assessing their client's potential for discounts (Appendix A). The service provider shall maintain a record of the cost discount calculation at all service locations. The discount calculation for each client shall be reassessed at least every 2 years. Should a client have a notable change in income, reassessment before two years may be needed as the change may affect their sliding discount level, or their eligibility for Medicaid, or other third party payor.

4. Sliding Fee Scale discount: This will be based on the current annual Federal Poverty Guidelines published annually, around the third week in January, by the Federal Department of Health and Social Services. The scale will be set using the **household size** and **gross** income range from 230% to 290% of the current poverty level, with those having annual income of 230% or less receiving the services free of charge. The percentage of charges to be paid will increase 20% for each 15% increase in the poverty level, with anyone whose gross income is above 290% of the federal poverty

level paying 100% of the charge or allowable rate, where patient fees are based on a third-party payor's patient liability. Gross income is determined based on official and verifiable documents such as income tax returns, tax withholding forms, bank statements, pay check stubs, etc.

V. **PROCEDURES:**

1. If a provider seeks payment for third-party-funded services for a beneficiary that has active third-party coverage, DSAMH will not reimburse the provider. The provider is expected to ensure the existence of processes with the third party, including that of Medicare and Medicaid (or their affiliated fiscal agents) as well as the major commercial carriers, to secure payment.

2. If a provider seeks reimbursement for an uninsured client, DSAMH:
    a. Will check the DMES system for any possible third-party coverage. Should the client have active third-party coverage for services provided, reimbursement will be denied and communication of such a denial will be made back to the provider.
    b. May ask for proof that the provider is assisting the client in obtaining active insurance. Examples include a Medicaid 30-day denial letter.
    c. Will require the provider to submit a properly formatted invoice for services, if no active coverage exists. (See Appendix B for Tips and Tricks for Faster Processing of DSAMH Invoices)
3. If a provider seeks reimbursement for a client that has active third-party coverage, but whose coverage does not include reimbursement for the particular services provided (payment was completely denied as a non-covered service), DSAMH:

    a. Will check the DMES system for any alternative third-party coverage. Should the client have a secondary active third-party coverage source for services provided, reimbursement will be denied and communication of such a denial will be made back to the provider.
    b. Will ask the provider to submit proof of claim non-payment with the properly formatted DSAMH invoice, where there is an active third party payor who paid the provider none of the billed amount. Proof of claim non-payment must be in the form of an EOB from the third party source. The EOB must include the client name, DOS, code billed, amount billed, any contractual allowances, amount denied, as well as the corresponding denial code and code definition.
    c. May not reimburse all denials. Claims denied for Timely Filing or Provider Not Enrolled, for example, will not be reimbursed by DSAMH. Claims denied for no active coverage at the time of service, or service not a covered benefit under the plan, will be paid. DSAMH-approved claims will be paid according to the contract terms. Claims denied by DSAMH will be sent back to the provider with communication of why it was not paid and if corrections need to be made for a resubmission. (For example, the wrong rate was used to calculate the total amount due.)

4. If a provider seeks reimbursement for a client with active third-party coverage that includes a patient responsibility such as a co-pay, co-insurance and/or deductible (underinsured), but whose patient responsibility portion of the claim has gone unpaid by the client, DSAMH will consider

reimbursing the provider for the unpaid portion, up to the contracted service rate, keeping the following in mind:

a. DSAMH will check the DMES system for any alternative third-party coverage. Should the client have a secondary active third party coverage source for services provided, reimbursement will be denied and communication of such a denial will be made back to the provider.
b. DSAMH may ask the provider to submit proof that they are compliant with the PM 37 Patient Collections guidelines, as stipulated in their DSAMH provider contract, with applicable sliding fee discounts in place to reduce the liability to those clients who fall below 230% of the poverty line to owe $0.00, and those who fall above 290% being charged the full fee.
c. DSAMH may ask the provider to demonstrate they have an active patient collections policy and procedures process in place that provides clients (or guarantors) with regular (at least monthly) patient billing statements, includes at least three written notices of overdue balances, and considers the need for outside collections.
d. Where there is an active third-party payor who paid the provider none, or less than the amount billed, due to the patient having an obligation to pay a co-pay, co-insurance or deductible amount on the claim, DSAMH will
    i. Ask the provider to submit **Proof of claim non-payment or underpayment** with the properly formatted DSAMH invoice. Proof of claim non-payment or underpayment must be in the form of an Explanation of Benefit (EOB) from the third-party source. The EOB must include the client name, DOS, (should this be DOB???) code billed, amount billed, any contractual allowance, amount owed by the patient, as well as the amount (if any) paid to the provider.

AND

    ii. Ask that the provider attach a provider-specific **patient statement** showing the amounts paid by the insurance (if any) and the amounts owed by the client, with billing codes (or service descriptions), application of the sliding scale when appropriate, dates of service, and any pertinent billing correspondence showing the number of attempts to collect from the patient what is owed the provider.

    iii. When appropriate, DSAMH fiscal staff, in consultation with a DSAMH clinical designee, will also consider the client's capacity to pay their balances by:
        1. Determining if the client has the mental capacity to pay, but is just refusing or **unwilling** to pay the balance,
            a. For clients who are **unwilling** to pay their balances, services will be covered only by the provider until the client can be referred to another in-network provider **or** may inform the patient in writing and with enough notification, that services will be discontinued for non-payment of care. These actions must be executed consistently across all provider programs and according to agency written policy.

or

2. Determining if the client lacks the mental capacity, and is categorized as **unable** to pay their balance,
    a. For clients who lack the mental capacity to pay their bills and are therefore deemed **unable** to pay open balances, DSAMH will consider payment upon receipt of a clinical assessment of the client's capacity to manage their own funds using the attached form. After completion by the organization clinical staff, this form will be sent to the DSAMH Associate Deputy Director of Community Behavioral Health.

iv. Based on the submitted documentation, DSAMH staff will either approve or deny payment of the unpaid patient responsibility.

NOTE: Although DSAMH will make every effort to reimburse providers who care for DSAMH clients that lack the ability or willingness to pay unmet portions of their patient responsibility, DSAMH reserves the right to deny requests based on budgetary restrictions at any time. As such, all providers will be notified in writing that reimbursement for the Underinsured is no longer available.

5. Right to appeal.
   In the event a request for reimbursement is denied, the provider may ask for an appeal by the DSAMH Chief of Administration and/or designee. Appeals may be put in writing within fifteen days of denial and DSAMH will have a decision within fifteen days of receipt of Notice to Appeal.