Policy Overview

About the Application:

Delaware Department of Health and Social Services - Division of Substance Abuse & Mental Health (DHSS DSAMH) has implemented a document management and workflow solution in DocuWare to gain better control of processes for submitting, approving and storing invoices. DocuWare automation replaces the previous manual solution where invoices were either physically scanned or being monitored from an email inbox and tracked in multiple spreadsheets from ingestion through approval.

DocuWare for Invoice Processing provides a seamless solution for invoice management by digitizing paper invoices, capturing other electronic invoices, and subsequently triggering approval workflows based on business rules to ensure accurate and rapid processing and payments.

The solution delivers many productivity benefits to the DSAMH, including the following:

- Capture, sort and archive invoices processed into DocuWare using an easily searchable file structure.
- Extract details from all invoices, easily enter your GL accounts and cost centers with DocuWare's Intelligent Indexing.
- Approve workflows to accelerate the process based on your business rules.
- Record notes directly on the invoice image with annotation functionality.
- Maintain compliance and a complete audit trail with transparent approval history, automatic document filing and encryption.
- Maintain a secure, organized, and searchable invoice archive for audits and budget planning.

Beginning July 1, 2023, all invoices (CR, Fixed Rate, Fixed Rate SUDS NARR (1-3), FFS-IMD, FFS-SUD, FFS-PROMISE, Operational, and GSS) are submitted through email to the Business Operations Mailbox and will be manually uploaded into DocuWare by OSEC staff.

Terms and Definitions:

Fee-for-Service (FFS): A payment model is one in which a specific amount is paid when a particular service is delivered. The term FFS is often short for FFS Medicaid but should not be limited to Medicaid billable services. For this training, "FFS Medicaid" refers to a payment for an individual who is enrolled in Medicaid but not assigned to an MCO, so DMMA is paying for the service. This could be for a service provided and service paid (aka FFS) or a daily rate (aka per diem).

Fixed-Rate: A payment model is one in which a specific amount is paid when a particular service is delivered. This term is used for services that are NOT Medicaid billable. For example, the new transportation (service) with PTSDel provides transports from the ER to the IMD for patients on an involuntary hold. We pay them mileage to transport the person and a fixed rate if they go over the county line.

Per Diem Rate: A payment rate that is made for each calendar day on which one or more services are provided to a particular patient. For example, if a payer pays a hospital for inpatient care on a per diem basis, the total payment to the hospital for an individual patient would depend on how many days the patient spent in the hospital before being discharged, but not on how many services were delivered on any of those days. Another example is for intensive outpatient programs (IOP) where several services are provided for a set amount of time and all the services are covered by a single payment.

Room and Board is a service that is paid per diem. Medicaid cannot pay for room and board in community-based settings. Except in certain limited and regulated circumstances, room and board may be

paid when associated with eligibility for Medicaid community-based long-term care and assessed need for support based on limitations in the ability to perform activities of daily living. The costs that compromise room and board cover the costs of the living environment, food, living incidentals, heat, etc.

Cost Reimbursement: Services or supports provided and/or incidentals to run a program for which the provider is reimbursed for the actual and allowable costs, included but not limited to staffing, rent, heating etc. For example, Targeted Case Management is not a Medicaid billable service, and we want to have it for SMI under and uninsured clients to support them leaving the IMDs and to support their transition to a provider. DSAMH pays for the cost to maintain this program from the rent for the building to staff working with the clients. May pay a portion of the cost. This is paid by program (whole program or partial) and not by individuals served.

Deliverable-Based Payment: An activity that has been completed, or a product has been delivered (for example: an education campaign product, completion of a report).

Service Examples:

To better understand the common definitions of payment methodologies, this table of service examples includes the applicable payment methodologies as well as who may pay for the services.

Service Examples	***Payment Methodologies***	***Payable by Medicaid***	***Payable by DSAMH***
Community Behavioral Health Outpatient Treatment PROMISE SUDS (ASAM 1.0, 2.0-3.7) IMD* Integrated Housing *	Fee for Service *paid on service per diem rate	*x*	*x*
Consultant Contracts GSS Operational Invoices	Deliverable Based Payment		*x*
Transportation NARR (Sober Living)	Fixed Rate		*x*
Peer Recovery Centers	Cost Reimbursement		*x*

Policy Overview

Policies:

Delaware State Code is a selection of statutes, or laws, arranged by subject (titles). The State Code governs all that we do, and the following sections contain specific information related to policies and procedures for this project. https://delcode.delaware.gov/

Policy Memorandums are the Department of Health and Social Service (DHSS) clarifications to and links between specific state and federal codes. For this training, the PM of note is the PM37: https://www.dhss.delaware.gov/dhss/admin/policy/files/pm37.pdf

DSAMH Provider Policies can be found on the DHSS website at: https://dhss.delaware.gov/dsamh/policies/ProviderPolicies.html

DHSS Regulations, Policies, and Guidance:
https://dhss.delaware.gov/ddds/ddds_policy_main.html

Procurement Codes (Title 29, Chapter 69):
http://delcode.delaware.gov/title29/c069/index.shtml

Budget, Fiscal, Procurement and Contracting Regulations (Title 29, Chapter 65):
https://delcode.delaware.gov/title29/c065/index.html

Related Policy Memorandums

PM5 – Client Confidentiality
http://www.dhss.delaware.gov/dhss/admin/files/pm5.pdf
Recognizes client confidentiality and respect of privacy. Assures access to data on a need-to-know basis and client's right to know the Departments policies and procedures regarding their information. Covers obtaining, safeguarding, and releasing information as well as providing client access to records.

PM24 – Safeguarding & Management of Resident/Client funds
http://www.dhss.delaware.gov/dhss/admin/files/pm24.pdf
Establishes guidelines that provide accountability for property and the management, receipt, and disbursement of each resident/client's funds. To support resident/client independence and self-management, DHSS shall safeguard and help manage the personal property and finances of those residents/clients housed and cared for in state operated programs or programs operated by a contracted provider.

PM40 – Criminal Background Check Policy
http://www.dhss.delaware.gov/dhss/admin/files/pm40.pdf
Recognizes that Delaware State Code requires criminal background checks of all individuals seeking work in long term care facilities. The policy establishes that DHSS conducts criminal background checks for all persons hired or promoted into any permanent or temporary position with any long-term care or psychiatric facility operated by the DHSS. The Delaware Psychiatric Center is licensed as a hospital and while the Code does not require criminal background checks for employees of the DPC, long standing policy and practice mandates a criminal background check on all prospective employees at the Psychiatric Center.

PM46 – Responding to Reportable Incidents/Allegations

http://www.dhss.delaware.gov/dhss/admin/files/DHSSPM/pm_046-8-22-16.pdf
Recognizes that individuals receiving residential services at the Delaware Psychiatric Center, and/or attend a DHSS funded day program shall be free of abuse, neglect, mistreatment, significant injury and financial exploitation.

PM70 – Inclusion Policy
http://dhss.delaware.gov/dhss/admin/files/PM_70.pdf
Provides standards for the incorporation of inclusive practices in all State Plans, Federal grants, sub-grants, DHSS services specifications and contracts with vendors originating within DHSS.

Other policies for reference:

Policy Memorandum #7 – Client Service Waiting Lists
http://www.dhss.delaware.gov/dhss/admin/pm7.html

Policy Memorandum #13 - DSAMH Discharge from Services
http://www.dhss.delaware.gov/dhss/dsamh/files/DSAMH013.pdf

Policy Memorandum #36 – Standardized Requirements During the Development Phase of Community Based Residential Homes for the DHSS/Division
http://www.dhss.delaware.gov/dhss/admin/files/pm36.pdf

Policy Memorandum #55 – Human Subjects Review Board
http://www.dhss.delaware.gov/dhss/admin/pm55.html

Policy Memorandum #66 – Reporting Suspected Financial Exploitation of an Elderly Person to DHSS
http://dhss.delaware.gov/dhss/admin/files/PM_66.pdf

DE Office of Management and Budget – Budget and Accounting Policy (Procurement)
https://budget.delaware.gov/accounting-manual/documents/chapter05.pdf?ver=0316

Policy Memorandum 37 (PM37)

Policy Memorandum 37 is defined by the Department of Health and Social Services (DHSS) and clarifies Delaware State Code Title 29, Section 7940, to establish a uniform ability to pay schedule. The PM37 also supplements existing collection policy or agreements to standardize the Departmental collection efforts for recovery of accounts receivable that amount to less than the full cost of care due. **At this time DHSS is enforcing this policy on inpatient providers only and will work through the coming year to develop similar procedures for outpatient and community-based services**.

PM37 states that facilities should make every effort to assure that clients and legally liable persons are aware of and understand their financial liability, or Responsibility to Pay, their right to request an adjustment to that liability, and the procedures to appeal the ability to pay determination.

What is 'Responsibility to Pay'? This is the financial liability of any person committed to or accepting the services of the Department, and that person's spouse or parents for the full cost of the care, treatment, or both.

Policy Overview

These policies:

- **Stipulate** that DSAMH is the payor of last resort and defines the process for determining a client's Responsibility to Pay.
- **Define** the fiscal liability of persons served by the Department.
- **Establish a sliding fee scale** for uninsured or underinsured clients based on location of service, income, and ability to pay. PM37 policies will not hold up treatment to client but may delay payment.

Insurance Note: If insurance is billed and service payment denied, the EOB with denial must be submitted with the invoice. Providers are required to bill insurance even if services are considered out of network.

PM37 in Action

This scenario explains the use of the PM37 in an inpatient setting.

Client A is admitted into the IMD:
Prior to discharge, the facility administration will provide Client A with a written agreement regarding the full cost of care (Appendix A). The facility administration will fill out the patient's name, date, client name, financial services rep, and date due. The client, or responsible party, will then indicate as applicable, insurance coverage, ability to pay in full, or their inability to pay in full. The facility administration will sign the completed form.

If Client A indicates in the agreement that they are unable to pay the full amount, they will be asked to submit available documents which show their current income to assess their Ability to Pay.

Examples of available recent Federal and State Income Tax returns, a copy of all W-2 Forms submitted with their tax returns, pay stubs, and any other documents which show their current income.

Once the facility administrator receives a completed appendix A, they will fill out the DHSS Ability to Pay Worksheet (Appendix B) to calculate the client responsibility to pay. This includes client information, insurance status, income details, ultimately the client's monthly payment.

PM37 in Action - Inpatient

1. GROSS INCOME	75,000
LESS:	
2. STANDARD DEDUCTION	32,470
3. TAXES WITHHELD	10,000
FICA	
FEDERAL INCOME	
STATE INCOME	
CITY WAGE	
4. TAX (REFUNDS)/PAYMENTS	
5. TOTAL DEDUCTIONS (SUM OF LINES 2-4)	$ 42,470
6. DISPOSABLE INCOME (LINE 1 LESS LINE 5)	$32,530
7. MAXIMUM ANNUAL FEE DUE BASED ON ABILITY TO PAY. (10% OF LINE 6)	$3,253
8. MONTHLY PAYMENT. (LINE 7 DIVIDED BY 12)	$271.08

LINE 2. Standard Deduction is shown below. (for families with more than 8 persons, add $4,720 for each additional person).

Family/Household Size	Amount	Family/Household Size	Amount
1	$13,590	6	37,190
2	18,310	7	41,910
3	23,030	8	46,630
4	27,750		
5	32,470		

Let's assume the client's **gross income** is $75,000 and they are a family of 5 (line 1). The **standard deduction** for a family of 5 is $32,470 (line 2). Assuming total **taxes withheld** in $10,000 (line 3), this means the **total deductions** are $42,470 (line 5) and the **disposable income** would be $75k minus $42,470 or $32,530 (line 6). This means that the **MAXIMUM annual fee** that the client is responsible for is $3,253 (line 7), resulting in a **monthly payment** of $271.08 (line 8). Note that the maximum annual fee cannot exceed 10% of the disposable income.

With the average daily rate of $800, a 7-day stay would cost $5,400 but since this client's **MAXIMUM annual fee** is $3,253, that is what they are responsible for paying. It is the responsibility of the provider to collect these fees from the client and repay DSAMH.

The final step in the PM37 process is to notify the client of their responsibility to pay using Appendix C. This letter informs the client that their minimum monthly payment was calculated and their responsibility to pay.