Delaware Health and Social Services

Office of the Secretary

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DHSS Policy Memorandum Number 37 **Effective: March 1, 2020**
Subject: Standard Ability to Pay Fee Schedule

I. PURPOSE

To establish a uniform ability to pay schedule and to supplement existing collection policy or agreements to standardize Departmental collection efforts for recovery of accounts receivable that amount to less than the full cost of care due, in accordance with Delaware Code, Title 29, Section 7940.

II. DEFINITIONS

1. The "Cost of Services Rendered" in this policy shall mean the "Cost of Care" as used in Delaware Code, Title 29, Section 7940 and DHSS Policy Memorandum Number 12.

2. Disposable income for determination of ability to pay shall be gross income less a standard deduction and taxes paid.

3. Standard deduction shall be based on 100% of the poverty level.

III. EXCLUSIONS

This Policy Memorandum is not applicable to persons supported by Medicaid, Medicare, CHAMPUS, or private insurance with the exception of deductibles, coinsurance and charges for non-covered services of those payers who have contracts with DHSS facilities.

IV. FOREWORD

1. Respective Divisions shall continue to pursue recovery of the full cost of services rendered in accordance with the Department of Health and Social Services Policy Memorandum Number 12, as applicable.

2. Facilities should make every effort to assure that clients and legally liable persons are aware of and understand their fiscal liability, their right to request an adjustment to that liability, and the procedures to appeal the ability to pay determination.

3. Division Directors will develop procedures under the guidelines in Section VI for implementation of this policy within their respective Divisions.

V. PROCEDURES

A. INPATIENT SERVICES

The facility administration shall request, preferably before or, in case of emergency, after the patient is admitted or treated, a written agreement with those persons receiving or to receive care and/or treatment from the facility and, where appropriate, of the liable person(s) for the recovery of the full cost of care.(Appendix A) Liability of persons other than the patient shall be governed by the provisions of 29 Del. C. 7940 (a).The following procedures shall be implemented when a written agreement for the recovery of the full cost of services rendered cannot be obtained.

1. DHSS Ability to Pay Worksheet (Appendix B) should be completed for the person receiving care and for any other person liable under 29 Del. Code, 7940 (a), to determine disposable income and the minimum annual fee due based on the ability to pay. (Instructions on completion of the worksheet are on Attachment I "DHSS Ability to Pay Worksheet Instructions".)

2. The liability will automatically be waived for anyone with disposable income less than $14,203.

3. The liable person shall be informed, in writing, of his/her liability, due dates of payment, and appeal procedures. (Appendix C).

4. All other payment agreements, in force prior to implementation of this Ability to Pay Fee Schedule, shall be gradually phased-out, for conformance, at the time of automatic review, which is at least every two (2) years. (Delaware Code, Title 29, Section 7940, Paragraph (d).

B. COMMUNITY-BASED & OUTPATIENT SERVICES

The Divisions shall determine the ability to pay of their clients for community-based and outpatient services and shall maintain a record of this information, which will be available at all service locations. The ability to pay will be determined, utilizing a sliding scale. The scale will be set using a range from 230% to 290% of the poverty level, with anyone whose gross income is at 230% or less of the poverty level, receiving the services free of charge. The percentage of charges to be paid will increase 20% for each 15% of the poverty level, the gross income increases with anyone whose gross income is above 290% of the poverty level paying 100% of the charge. The ability to pay sliding scale will be applied to the fees which are developed and implemented by the individual divisions of DHSS for each of the services they provide. The attached Table A shows the actual income levels to be used for family levels from 1 to 10.

VI. ADMINISTRATIVE DETERMINATION

Division Directors are authorized to make administrative adjustments to the monthly fee calculated by the facility in lieu of submission to the Appeals Committee, if circumstances justify such adjustments. Administrative adjustment should be made only where the individual(s) have extraordinary expenses over which they have no control (i.e., medical bills, etc.). The procedures for administrative determination shall be as follows:

Table A

Family Size	Federal Poverty Level	Annual Income Up to 230%	Annual Income Up to 245%	Annual Income Up To 260%	Annual Income Up To 275%	Annual Income Up to 290%	Annual Income Over 290%
1	$ 12,760	$ 29,348	$31,262	$33,176	$35,090	$37,004	$37,004
2	17,240	39,652	42,238	44,824	47,410	49,996	49,996
3	21,720	49,956	53,214	56,472	59,730	62,988	62,988
4	26,200	60,260	64,190	68,120	72,050	75,980	75,980
5	30,680	70,564	75,166	79,768	84,370	88,972	88,972
6	35,160	80,868	86,142	91,416	96,690	101,964	101,964
7	39,640	91,172	97,118	103,064	109,010	114,956	114,956
8	44,120	101,476	108,094	114,712	121,330	127,948	127,948
9	48,540	111,642	118,923	126,204	133,485	140,766	140,766
10	52,960	121,808	129,752	137,696	145,640	153,584	153,584

% of Charge to be Paid

0% 20% 40% 60% 80% 100%

Note: Federal guidelines related to specific programs take precedent over this policy.

1. Division Directors should establish a Review Panel, consisting of three members: the Division Director or Deputy Director, an Institutional Representative and a Community-Based Representative.

2. Upon receipt of a written request appealing the ability to pay determination, the facility administration shall notify the individual that the appeal has been received and will forward the appeal request to the Division Director's office within five (5) working days for administrative review.

3. The Review Panel will meet no less than once a month to review the appeals received and make their determination.

4. The Review Panel shall notify the facility and the individual who is making the appeal concerning their determination within five (5) working days of the review.

5. If the Review Panel concurs with the original determination, the appeal will be forwarded to the Appeals Committee for final review.

VII. APPEALS

After implementation of Ability to Pay Fee Schedule, any person aggrieved by any decision with respect to the payment of fees, refusal of admission or discharge for other than medical reasons, may appeal by petition to the Appeals Committee in writing, stating the substance of the decision appealed, the facts in support of the appeal and the relief sought.

The Appeals Committee consist of the Chairpersons of the:

- Advisory Council on Developmental Disabilities Services;
- Advisory Council on Substance Abuse and Mental Health;
- Advisory Council for Delaware Hospital f/t Chronically Ill; and
- Public (Physical) Health Advisory Council.

1. The Appeals Committee shall hold a hearing within sixty (60) days and shall render its decision promptly. The Committee's decision shall be final and binding.

2. The Secretary's Office will receive the appeal information, schedule the hearing and notify the Appeals Committee and the individual appealing of the date and location of the hearing.

3. The appeals hearings will be chaired on a rotating basis with each member of the committee serving as chairperson for a period of three (3) months.

Note: Appeals Committee - Delaware Code, Title 29, Section 7940, Paragraph (m).

VIII. COLLECTION

Collection efforts and write-off procedures shall be in conformance with DHSS Policy Memorandum Number 19.

IX. ADMINISTRATION

An Ability to Pay Committee shall be available to help resolve implementation/interpretation problems. It will set up such rules and regulations as are deemed necessary, pursuant to the authority granted by 29 Del. C. 7940 (j).

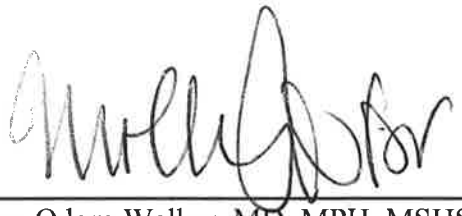
1. A permanent committee shall be assigned to monitor and administer the Ability to Pay Fee Schedule.

2. The Ability to Pay Committee shall consist of:
   (a) Two representatives each from the Divisions of Substance Abuse and Mental Health; Developmental Disabilities Services; and Public Health;
   (b) One representative from the Division of Management Services, who shall serve as Chairman.

X. EFFECT

1. This policy shall become effective on March 1, 2020.

2. Any part thereof which is inconsistent with any Federal, State or local law shall be null and void.



Kara Odom Walker, MD, MPH, MSHS
Cabinet Secretary
Department of Health & Social Services

Attachments

APPENDIX A
LETTERHEAD

Patient Name_____ Date: _____

Dear_____,

This is to advise you that the charge for services rendered at (facility) is $_____per day. The patient and/or any persons legally liable under Title 29, Section 7940 of the Delaware Code will be billed for these services.

Please complete and return this form to_____by_____.
Financial Services Rep. (Date)

Check if Applicable:

____ 1. I have the following insurance coverage, which should be billed:

------ Blue Cross
------ Medicare
------ Other Insurance
------ Medicaid

Group #_____Policy #_____
Name of Person Insured_____

____ 2. I will make full payment as billed.

____ 3. I am unable to pay the full amount.

Date_____ Signature_____

If #3 is checked, please submit the following information for our review to determine an appropriate payment based on your ability to pay.

1. A copy of your most recent Federal and State Income Tax returns.
2. A copy of all W-2 Forms submitted with your tax returns.
3. Other documents which show your current income.

You will be notified in writing of our determination. We will be unable to make any adjustments to the amount, which you are required to pay if the information is not submitted.

Thank you for your cooperation.

Sincerely,

APPENDIX B

PATIENT NAME: DATE:

ADDRESS: GUARANTOR NAME:

ADMISSION DATE: ADDRESS:

INSURANCE COVERAGE:

PREPARED BY: _____

APPROVED BY: _____

1. GROSS INCOME _____

LESS:

2. STANDARD DEDUCTION _____

3. TAXES WITHHELD
   - FICA _____
   - FEDERAL INCOME _____
   - STATE INCOME _____
   - CITY WAGE _____

4. TAX (REFUNDS)/PAYMENTS _____

5. TOTAL DEDUCTIONS (SUM OF LINES 2-4) $_____

6. DISPOSABLE INCOME (LINE 1 LESS LINE 5) $_____

7. MAXIMUM ANNUAL FEE DUE BASED ON ABILITY TO PAY. (10% OF LINE 6) $_____

8. MONTHLY PAYMENT. (LINE 7 DIVIDED BY 12) $_____

ATTACHMENT I

DHSS
ABILITY TO PAY WORKSHEET
INSTRUCTIONS

LINE 1. Gross income is obtained from a copy of the Tax Return, if one was filed, or from a copy of other payment sources (if non-taxable, such as Welfare payments, Pension payments, or other income).

LINE 2. Standard Deduction is shown below, (for families with more than 8 persons, add $4,480 for each additional person).

Family/Household Size	Amount	Family/Household Size	Amount
1	$12,760	6	35,160
2	17,240	7	39,640
3	21,720	8	44,120
4	26,200		
5	30,680		

LINE 3: Taxes withheld are obtained from a copy of W-2 forms.

LINE 4: Amount of tax refunds or payments are from Federal and State tax returns.

LINE 5: Total deductions equal the sum of Lines 2 through 4.

LINE 6: Disposable income is Gross income (Line 1) less total deductions (Line 5).

LINE 7: Maximum annual fee is 10% of disposable income (Line 6 X .1). (The maximum annual fee will be automatically waived if disposable income is less than $14,203.)

LINE 8: Monthly payment = Annual payment (Line 7) divided by 12.

APPENDIX C

LETTERHEAD

NAME: DATE:

ADDRESS:

PATIENT NAME:

DEAR_____:

We have reviewed the information which you supplied and have calculated your minimum monthly payment according to Delaware Law 29 Del. C. 7940 and Department of Health and Social Services Policy Memorandum Number 37. You are responsible for a monthly payment of $_____for the services rendered to the above named patient. A copy of our calculation has been enclosed for your benefit. Payments are due by the 20th of the month for the previous month's care.

You have the right to appeal the determination, in writing, to the Appeals Committee stating the substance of the decision being appealed, the facts in support of the appeal, and the relief sought.

Appeals should be submitted to:

Appeals Committee Administrator

_____(Facility Name)

_____(Facility Address)

Thank you for your cooperation in this matter.

Sincerely,