POLICY AND PROCEDURE

POLICY TITLE: Client Responsibility and Billing DSAMH for Uninsured Clients	**POLICY #:** DSAMH014
PREPARED BY: DSAMH Leadership	**DATE ISSUED:** 8/26/2019
RELATED POLICIES:	**REFERENCE:** Title 29, Chapter 79, Subchapter III DHSS Policy memorandum #37
DATES REVIEWED: 8/2/2023	**DATES REVISED:** 12/21/22 8/2/2023
APPROVED BY: DocuSigned by: Joanna Champney 1B71C05196B24CA... 8/23/2023 | 1:57 PM PDT	**NOTES:** (Check all that apply) ☐DSAMH Internal Policy ☐DSAMH Operated Program ☒DSAMH State Providers ☐Delaware Psychiatric Center ☐Targeted Use Policy (Defined in scope)

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 for a portion of the fees charged for services (per PM #37). As such, assessments should be completed for all non-Medicaid-covered clients upon admission into a provider program and billed on a sliding scale. 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" means no third-party payer exists; the client is considered indigent.

"Underinsured" means 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, when a service is not covered under their active plan, or when their insurance benefits have been exhausted.

IV. REQUIREMENTS:

A. DSAMH contracts with providers for the delivery of community-based and outpatient mental health and substance abuse services. Typically, DSAMH contracts with a direct service provider when:

1. The provider meets the requirements as outlined in the service request for proposal (RFP) and has been awarded a DSAMH contract which allows them to provide that service.
2. 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.
3. 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.

B. 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.

C. The Financial Coverage and Sliding Scale Determination: A sliding scale shall be used to determine the cost of service, based on the federal poverty level guidelines (PM37). 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 two (2) years. Should a client have a notable change in income, reassessment before two (2) years may be needed as the change may affect their sliding discount level, or their eligibility for Medicaid, or another third-party payor.

D. Sliding Fee Scale: This will be based on the current annual Federal Poverty Guidelines published annually, 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, paycheck stubs, etc.

V. **SCOPE:** This policy applies to all DSAMH-contracted providers.

VI. **PROCEDURES:**

A. If a provider seeks payment for third party-funded services for a client 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.

B. If a provider seeks reimbursement for an uninsured client, DSAMH:
   1. Will check for any possible third-party coverage using the appropriate platform. 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.
   2. May ask for proof that the provider is assisting the client in obtaining active insurance. Examples include a Medicaid 30-day denial letter.
   3. Will require the provider to submit a properly formatted invoice for services, if no active coverage exists.

C. 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:
   1. Will check for any alternative third-party coverage using the appropriate platform. 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.
   2. Will ask the provider to submit proof of claim for 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 for the non-covered service. Proof of claim for non-payment must be in the form of an Explanation of Benefit (EOB) from the third-party source. The EOB must include the client's name, DOB, code billed, amount billed, any contractual allowances, amount denied, as well as the corresponding denial code, and code definition.
   3. 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 whether corrections need to be made for a resubmission (e.g., the wrong rate was used to calculate the total amount due).

D. 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, 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:

1. DSAMH will check for any alternative third-party coverage using the appropriate platform. 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.
2. DSAMH may ask the provider to submit proof that they are compliant with the PM 37 Patient Collections guidelines, as stipulated in their DSAMH contract, with applicable sliding scale fees 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.
3. DSAMH may ask the provider to demonstrate they have active patient collections policies and procedures in place that:
    a. provide clients, or guarantors, with at least monthly patient billing statements.
    b. require at least three written notices of overdue balances.
    c. establish a threshold when outside collections may be utilized.
4. Where there is an active third-party payor who paid the provider nothing, 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.
    a. DSAMH will 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 EOB from the third-party source. The EOB must include the client's name, DOB, code billed, amount billed, any contractual allowance, amount owed by the patient, as well as the amount paid to the provider, if any.
    b. DSAMH will ask that the provider attach a provider-specific patient statement showing the amounts paid by the insurance 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.
    c. When appropriate, DSAMH fiscal staff, in consultation with a DSAMH clinical designee, will also consider the client's capacity to pay their balances.
        1) 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 the provider 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.
        2) 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 by the provider's clinical staff. The assessment will be sent to the DSAMH Chief of Addiction Services or Chief of Community Mental Health based on the nature of the contract.
    d. Based on the submitted documentation, DSAMH staff will either approve or deny payment of the unpaid client responsibility. Although DSAMH will make every effort to reimburse providers who care for 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.

E. Right to appeal: If a request for reimbursement is denied, the provider may ask for an appeal by the DSAMH Deputy Director or designee based on the nature of the contract. Appeals shall be submitted in writing within fifteen (15) business days of denial and DSAMH will respond with a decision within fifteen (15) business days of receipt of Notice to Appeal.

VI. **POLICY LIFESPAN:** This policy will be reviewed annually.

VII. **RESOURCES**: N/A