SOUTHERN HIGHLANDS COMMUNITY MENTAL HEALTH CENTER

POLICY AND PROCEDURE MANUAL

Date of Issue: 7/l/84 **Section Number: 360**
Date Revised: 11/2/93; l0/l/95; 7/2/96; l2/3/96; 3/l/98; 10/9/98; 12/05/00; 8/6/02; 4/1/03; 12/4/03; 6/17/04; 1/12/06; 1/26/06; 6/6/06; 1/8/07; 7/1/08; 6/16/09; 11/18/09; 3/30/11; 10/26/11; 7/2/12; 8/7/12; 7/30/14; 9/9/16; 9/13/17; 10/4/17

Policy 360 – Economic Assessment

I. POLICY

It is the policy of Southern Highlands Community Mental Health Center to provide services based on ability to pay to residents of West Virginia. Ability to pay is defined as 200% or less of poverty level. Crisis services other than Crisis Stabilization services will be provided at no charge.

II. DISCUSSION

The main function of economic assessment is to assist the consumer and family in financial planning for services received from SHCMHC. While the main concern is to ensure that treatment and service are available regardless of ability to pay, the manner in which this is accomplished may affect the consumer's acceptance of clinical care and his motivation to pay for the cost of that care.

Out-of-state residents seeking services from Southern Highlands will be encouraged to accept referrals to the mental health center serving their residential area in their respective state. If the non-state residents prefer receiving services from Southern Highlands, third party payers will be billed and the consumers will be expected to pay any amount not covered by the third party carrier at the time the services are rendered. In cases where no third party coverage exists, consumers will be responsible for payment of the total cost of services received at the time services are rendered.

Economic assessment is a process through which the assigned staff member determines the following:

1. Possible resources for third party reimbursement. **Eligibility for WV Medicaid including Managed Care Organizations will be verified through Molina for all consumers unless they present with a valid Medicaid card.**
2. Consumer's income (as defined by BHHF).
3. Consumer's family size (as defined by BHHF).
4. Eligibility for Community Care Program (Charity Care Program). Eligibility for the *Community* Care Program will be determined by staff completing the Financial Assessment.

Please refer to HIPAA Policy 507 – Designated Record Set for additional information.

III. PROCEDURES

A. DETERMINATION OF ECONOMIC ASSESSMENT

At the initial assessment, the consumer is given a SHCMHC schedule which is an hourly rate by discipline and by service (individual, group, etc.). At that time, if the consumer indicates that he or she wishes services, but cannot afford to pay the full cost, some services may be discounted based on family size and income as defined by WVBBHHF in lieu of a sliding fee scale. Payment is expected at the time of service unless a payment agreement is signed.

B. COMMUNITY CARE PROGRAM

Southern Highlands has limited resources and must allocate those resources to benefit the community. Any consumer who wishes services but does not have the ability to pay may qualify for Charity Care services. To qualify, the consumer must agree to the economic assessment and managed care process.

ELIGIBILITY FOR COMMUNITY CARE PROGRAM (CHARITY CARE)

Southern Highlands receives partial funding for its Community Care Program from the Department of Health and Human Resources. The Department's policy must be adhered to in order to justify these funds. Southern Highlands has incorporated all requirements of the DHHR policy including the forms into Southern Highlands' forms and policies. Information is entered directly into the computer and is printed to hard copy if requested. To be eligible for the Community Care Program, the following requirements must be met:

The consumer must bring verification that the income reported to the Internal Revenue Services is less than 200% of the poverty level. Financial Data Review Form lists the guidelines for this program. Income must be verified within the first week of service.

If the consumer is unable to verbally provide financial information, a member of the family or other responsible person may speak on the consumer's behalf.

Additional verification is required every year (12 months) when the fee is updated.

AND

The consumer must have a diagnosis that is eligible for services in the Medicaid Rehabilitation, Clinic, Targeted Case Management, Waiver or Managed Care Organization manuals. This diagnosis must be validated by Kepro through the Care Connection Form.

OR

The consumer has been discharged from an inpatient facility

OR

The consumer must be in crisis.

If the consumer meets the income criteria and any one of the other criteria, the consumer is eligible for the Charity Care Program. Attached is a schedule of income and dependents. The consumer must bring in verification of income within the first week of service and annually thereafter, at time of the update. **If income verification is not received at the time of the financial assessment, the staff that completes the financial assessment will begin completing the Standardized Justification Form (bottom portion of Financial Data Review Form).** When the Standardized Justification Form is completed, the completed Financial Assessment will be submitted to the Electronic Health Record.

DISCOUNT

Any consumer may receive a 40% discount if payment is made at time of service. This includes insurance deductibles but not co-pays. Services that do not qualify for a discount are DUI Evaluation and Education Classes, Drug Screen, Court Ordered Services, and Medical Records. The table that includes allowable services with discounted amount for each service is attached. If the payment is not paid at the time of service and the balance is greater than $100.00 a discount of 20% will be applied when the balance is paid in full.

MANAGED CARE PROCESS

Any consumer who qualifies for the Charity Care Program or reduced fees must comply with all requirements of the Department of Health and Human Resources. Failure to comply with these requirements will cause the consumer to pay full fee for all services (unless they qualify for the Charity Care Program).

SERVICES

All Medicaid services are included in the Charity Care Program. All other services require payment in full. The length of stay and eligibility for services will be the same as is used in the Kepro utilization management manual for Medicaid and Managed Care Organizations.

C. INSURANCE

Southern Highlands will work with consumers to bill third party insurers. If the insurance company has a contract with the Center, the company and consumer will be billed accordingly. If the consumer is part of a managed care agreement, the Center will pursue a preferred provider contract. If a contract cannot be negotiated, the consumer will be billed as though there is no third party coverage. When consumer also qualifies for Charity Care Program, OBHS/BHHF will be billed within the same accounting period that Explanation of Benefits (EOB) is received. The consumer will pay the amount due after the insurance payment along with any co-payment and deductible that is required.

Payments will be collected at each visit for the consumer's deductible, co-pay and services not covered by third party payors. The staff person will also request the consumer to contact his/her employer or insurance representative for complete and up-to-date information. Any overpayment made by the consumer will be refunded to the consumer upon termination.

D. MEDICAID

Consumers will be expected to comply with the prior authorization process. If they do not comply, full payment will be expected at the time of service or service may be refused.

E. MANAGED CARE CONTRACTS

Managed care contracted services are not eligible for a discount. The consumer will be expected to pay the co-pay for all managed care contracts at the time of service. After the consumer has used all the services available under the contract or the managed care company refuses to authorize additional services, the consumer will be evaluated for the Charity Care Program or will be responsible for payment if further services are necessary.

F. CONSUMER CONTRACTS

The outcome of Economic Assessment will be documented with Agreement to Pay for Treatment in the Electronic Health Record. This will be completed by the assigned staff member with the consumer. The consumer will be offered one copy for his / her own records.

G. PATIENT ASSISTANCE PROGRAM

Refer to Policy Section 152 Drug Handling

H. CONFIDENTIALITY

Consumers requesting confidentiality of billing and / or mailing statements, will be informed that if regular payments are not received, the Center will follow due process to collect their payments. The due process will include: l) billing the consumer's insurance company and 2) mailing monthly statements to the consumer (when the consumer has requested that neither of the above be done).

I. BUDGET PAYMENT CONTROLS

The following collection system and procedures encourage and keep controls on the payment system.

l. Monthly bills are sent to consumers and to all third party payers.

2. Re-assessment of financial capability of the consumer to pay may be requested by the consumer or SHCMHC at any appropriate time.

3. Letters requesting payment will be sent after thirty (30) days of no payment.

4. A second letter will be sent if there have been no payments for sixty (60) days. This letter will explain the collection process.

5. Special care will be taken not to harass the consumer, but to encourage payment.

6. If no payment is made after ninety (90) days, the collection procedure will be initiated. Continuation of services will be contingent upon regular payments. This collection procedure applies to all services for consumers who are responsible for the payment of these services. Please refer to HIPAA Policy 522 – Individual's Right to Accounting of Disclosures of PHI. The collection procedure will be as follows:

   a) The consumer will be notified that their account is delinquent and to avoid our taking further action to collect, they are to contact us within five (5) days in order to make arrangements for payments on their account.

   b) The above notice will be in writing and will only apply to account balances of $50.00 or more.

c) For closed cases the account balance will be sought.

d) For open cases the amount of payments in arrears will be sought (plus adherence to the agreed upon schedule of payments).

e) If the consumer fails to respond to this process, they will be notified that the account will be turned over to a collection agency.

f) At this juncture the Chief Executive Officer will be notified of all cases that are to be turned over to the collection agency.

g) Services will not be denied during this process, but efforts will begin to refer to other providers.

J. INTAKE AND RE-EVALUATION ECONOMIC ASSESSMENT PROCESS

All consumers will be evaluated at intake and re-evaluated every year (12 months) or at the time of their Care Connection re-assessment if their income has changed.

K. ROOM AND BOARD CHARGES

All room and board charges are due the first day of each month. Prorated charges will be done for the first and last months of residence. Any absences due to home visits, hospitalization, etc. where the bed is held for the resident are not prorated for the month.

L. EVALUATION ONLY REFERRALS (PSYCHIATRIC OR PSYCHOLOGICAL)

The Charity Care Program does not apply to evaluation (Psychiatric or Psychological) only referrals. This includes self referral, attorneys, etc. The consumer will be informed of the charges at the time of the appointment. The consumer will be informed they will be required to pay one half (1/2) of the cost on the day of service and the remaining balance to receive the report. If the consumer has private insurance, the accounts receivables staff will verify coverage prior to the actual treatment appointment. The consumer will pay any co-pays or deductibles at the time of service. The consumer will be responsible for any remaining balance after the insurance pays.

M. DUI PROGRAM

Consumers who reside in WV and receive a DUI citation in WV may qualify for the DUI Charity Care Program for the education component of the program. The consumer will be informed of the charges at the time of the appointment. The consumer will be informed they will be required to pay the full cost prior to

beginning the DUI education classes unless they qualify for the DUI Charity Care Program. The consumer must bring proof of residence in the state of WV and verification that the income reported to the Internal Revenue Service is less than 100% of the poverty level. Any services required in addition to DUI education classes must be paid in full prior to the submission of license release to the Department of Motor Vehicles unless they qualify for the DUI Charity Care Program. DUI Education Classes and Drug Screenings that are associated with the DUI Intake Process are not eligible for the Charity Care Program. Once DUI education classes commence, any necessary additional services are eligible for the Charity Care Program or the discounted fee scale, whichever applies. The Financial Data Review Form lists the guidelines for the Charity Care Program. Income must be verified at the time of the Intake appointment.

SOUTHERN HIGHLANDS COMMUNITY MENTAL HEALTH CENTER

INDIGENT CARE GROSS INCOME BY FAMILY SIZE

Effective July 1, 2016

AMOUNT OF DISCOUNT	1	2	3	4	5	6	7	8	9	10
200%	24,120	32,480	40,840	49,200	57,560	65,920	74,280	82,640	91,000	99,360

Add 8,320 for additional dependent @200%

	1	2	3	4	5	6	7	8	9	10
138%	16,643	22,411	28,180	33,948	39,716	45,485	51,253	57,022	62,790	68,558

Add 5,768 for additional dependent @138%

	1	2	3	4	5	6	7	8	9	10
100%	12,060	16,240	20,420	24,600	28,780	32,960	37,140	41,320	45,500	49,680

Add 4,180 for additional dependent @100%

Attachment A
Section 360

PROCEDURE FOR COMPLETION OF STATUS OF WV MEDICAID COVERAGE

Using the AVATAR Appointment Calendar – Practitioner Schedule Report for their location, the assigned staff member will query the Molina System to determine eligibility for West Virginia Medicaid Managed Care Organizations. This will be completed daily for all consumers who are listed for the next appointment date.

For those consumers who report to SHCMHC without their medical card, an individual Molina report will be completed. For those consumers who report to SHCMHC stating they are not eligible for a medical card, an individual Molina report will be completed.

WV Medical Cards, Managed Care Organization eligibility care**,** and Molina reports will be scanned into medical records by Front Desk personnel.

Attachment B
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PROCEDURE FOR COMPLETION OF ECONOMIC ASSESSMENT

The designated staff in each location is responsible for the completion of an Economic Assessment on each client receiving **any services** at that location. Fees are updated at yearly intervals for all consumers.

Eligibility for WV Medicaid and Managed Care Organizations will be verified through Molina for ALL consumers.

Staff responsible for entering the Financial Assessment Information in AVATAR must remember the following:

1. Annual Family Income (Gross) - Enter the family's gross (before taxes) income as defined by the IRS

2. Number in Family - Enter the number of members living in the household as defined by IRS.

3. Consumer's Discount Percentage - Enter the client's discount of 40% if paid at the time service is provided or 20% if balance is greater than $100.00 and paid in full. Otherwise, the discounts are limited to 100% or 0%.

4. Verification of Income - check either yes or no. All income must be verified by check stubs, W-2's, etc.

5. Monthly Payment Amount - Enter the client's monthly payment. If client's discount is less than 100%, a payment must be negotiated. If client is from another state, they must pay the amount in full at the time of service.

The Agreement to Pay for Treatment will be completed for each consumer. The consumer will acknowledge they have read the fee schedule. The consumer's discount, if any, will be entered on the form. One of the payment options will be checked. ***(Note*:** "Charges have been explained to me" must always be checked**)**. If the consumer agrees to pay in full, the charge will be the standard charge. If the consumer agrees to pay a monthly payment, they will continue to pay until the balance of the account is paid in full.

If the consumer has a third party payor, the Third Party Billing Authorization and payment assignment must be signed by the consumer or authorized person.

All the following statements must be discussed with the consumer and a check mark must be used to indicate this discussion.

> **( ) I agree to notify SHCMHC of any change in my income, billing address or insurance coverage as changes take place. If SHCMHC determines a change in payer source, I agree that they will take action to bill the appropriate funding source.**

( ) Charges have been explained to me. I have received a copy of the Fee Schedule and Billing Policies.
( ) I authorize the release of any medical information necessary to process any claims submitted.
( ) I authorize payment of medical benefits directly to Southern Highlands Community Mental Health Center for any services received.
( ) I authorize Southern Highlands to provide crisis intervention services.

Income Sources – **Check all sources of income for consumer and spouse. When consumers state they have no income, ask questions. For example: How do you pay your bills? Where do you get food? Please note exactly what the consumer says. For example:**

1. **Consumer states he has no income because he just moved to WV and does not have a job yet.**
2. **Consumer states he has no income. He lives with relatives.**
3. **Consumer states he has no income because he just lost his job and did not work long enough to collect unemployment.**
4. **Consumer states he has no income because he is a college student and relies on relatives for his finances.**

Income Sources - Enter total of all sources of income.

If unemployed, how long? If consumer is unemployed, how long have they been unemployed? Enter in number of months. **When unemployment is not part of monthly income, put N/A on this line.**

Dependents (IRS Dependents):

a) Enter the name of each dependent.
b) Enter each dependent's relationship to the consumer.

Verification of Income:

a) Most recent IRS Tax Form (1040 - must be signed, or W-2).
b) Check stub's for the past 30 days for all persons employed in the home.
c) Unemployment check stubs for past 30 days.
d) Proof of all other income received in the past 30 days.
e) Denial letter from Unemployment Compensation
f) Attach valid Medicaid card, QMB card, or Molina print out.

FEDERAL POVERTY GUIDELINES

Check box that corresponds to size of family. Check only the number of dependents that consumer would claim on their Income Taxes.

FINANCIAL DATA REVIEW (SH-304)

Name – Enter the consumer's first and last name.

Case Number – Enter the consumer's number (social security number or system assigned number).

Date – Enter the date that the financial data assessment is completed.

STANDARDIZED JUSTIFICATION FORM FOR COMMUNITY CARE PROGRAM

This section of the form will be completed only when the consumer does not bring proof of income.

Sign and date after seven day waiting period.

1. **Document steps taken to prove income is 200% below poverty level.**

   This section of the form must be completed by the staff member who is face-to-face with the consumer. Mark the appropriate boxes.

2. **Reason why official documentation could not be obtained.**

   This section of the form is completed by the staff member who completed the financial assessment face-to-face with the consumer.