SAN MATEO COUNTY
MENTAL HEALTH SERVICES DIVISION

DATE: May 30, 2003

MENTAL HEALTH POLICY NO.: MH 03-12

SUBJECT: Client Insurance Information and Financial Participation

AUTHORITY: Divisional; State regulations

SUPERSEDES: MH Policy 96-16, Procedure for Collecting Insurance Information from Clients, and MH Policy 97-08, Client Financial Participation

ATTACHMENTS:

A. Uniform Method of Determining Ability to Pay (UMDAP) Fee Schedule and Asset Allowance Schedule

B. Roles and Responsibilities for Client Information and Financial Screening

C. San Mateo Mental Health Guide to Payor Financial Information (PFI) Requirements

D. Payer Financial Information: screenprints of the information system
   Page 1 Sample Guarantor and Insurance Information, Release of Information and Assignment of Benefits form
   Page 2 Sample UMDAP Information/Payment Contract form
   Page 3 Payor Financial Information/Guarantor/Insurance Coverage

E. What You Need To Know about Payment for Mental Health Services

   - English
   - Spanish

F. Therapeutic Fee Adjustment Request forms

INTRODUCTION

Public mental health programs are required by State law to manage the dollars available for mental health treatment as cost-effectively as possible and to assure that available resources are prioritized for treatment of mandated eligible seriously mentally ill and seriously emotionally disturbed populations. San Mateo County policy also requires programs to manage public financial resources efficiently. The collection of client insurance and financial information, and establishment and collection of client fees is a critical component of sound fiscal management.

POLICY

A. The Mental Health Services Division must follow minimum State requirements for gathering client financial information and establishing and collecting client fees. The Division has a responsibility to apply these rules carefully, uniformly and fairly to all clients except those specifically exempted under State law. The Division also has a responsibility to consider the unique clinical and financial circumstances of individuals/families in the application of these rules.

B. The procedure outlined in this document: a) determines a client or responsible family's financial status and maximum annual deductible for the cost of treatment; b) identifies a client or responsible family's health insurance coverage, if any; c) obtains a client's authorization for release of information for billing purposes and the assignment of insurance benefits, if any; d) records the initial amount paid by the client or responsible family towards the annual deductible, when applicable; and e) collects the information necessary to establish a mental health billing account for the client or responsible family.

C. Financial obligations as well as service expectations of clients should be established and communicated prior to the onset of treatment, at the point of initial assessment for service eligibility, except in urgent/emergent circumstances. A new financial assessment should occur annually and anytime there has been a change in the client family's financial or insurance status.

D. The Client Insurance Information and Financial Participation Procedure involves both administrative and clinical staff members. Their roles are described more specifically in Attachment B, *Roles and Responsibilities for Client Financial Screening.*

CLIENT INSURANCE INFORMATION AND FINANCIAL PARTICIPATION PROCEDURE

A. **When initial financial evaluation occurs:** ACCESS and other mental health sites including contractor operated sites that serve as the first point of contact with prospective clients will schedule clients to come to their first appointments 15 minutes early in order to meet with administrative staff to complete financial and insurance information and establish correct fees. These appointments are only scheduled for prospective clients after a phone screening has confirmed that the prospective client meets Mental Health Services Division initial clinical and other eligibility screening criteria.

There are extraordinary circumstances that arise with prospective clients who must be seen urgently and in those cases the financial evaluation process may be postponed to another visit or the information may be collected gradually as in the case of a frail, homebound older adult. Occasionally, as in the case of a youth placed out-of-county, there is no face-to-face appointment prior to placement. In these cases, the administrative staff of the Mental Health Services Division program charged with coordinating the care of that client will initiate the financial evaluation process in coordination with the out-of-county contractor and the responsible party for the client.

The financial evaluation process need not precede the outreach and indirect services (that may be recorded in the information system as "Initial Contact Information") that Mental Health Services Division and contractor staff provide to engage some mentally ill/emotionally disturbed individuals in treatment, for example homeless individuals, prior to opening those individuals in treatment.

B. **Documentation required of prospective clients:** All clients except full-scope Medi-Cal beneficiaries (without share-of-cost), whose status has been confirmed during the first phone contact, will be asked to bring or provide:

- Documentation of insurance if they have insurance: insurance/Medicare cards, insurance policy number, group number, or correspondence that includes these elements such as remittance advice statements.

In addition, all clients except full-scope Medi-Cal beneficiaries, homeless individuals, Health Plan of San Mateo Healthworx and Healthy Kids, Healthy Families, and the responsible parties for children/youth in the Assessment Center, Juvenile Hall, and Receiving Home will be asked to bring or provide copies of the following information that is used to establish the client's financial participation using the State-required *Uniform Method of Determining Ability to Pay (UMDAP)* procedure and fee schedule:

- Documentation that verifies amount of client, spouse, parent income or lack of income: pay-stubs, W-2 forms, tax returns, unemployment or General Assistance papers, bank statements.

- Bank/investment statements that verify amount of savings, bank balance, and assets.

- Documentation of monthly expenses: court ordered, childcare, dependent support, medical expenses, mandated retirement contributions, and housing (rental agreement, canceled check, receipt).

Attachment C is *San Mateo Mental Health Guide to PFI Requirements* a summary of the specific documentation that is required by eligibility category, since there are exceptions to the usual procedure. These include variations on the usual procedure for Medi-Cal beneficiaries, homeless individuals, homebound seniors, children/youth who are part of the 26.5/AB 3632 program, Healthy Families, and others.

Note regarding beneficiaries of the special education AB 3632/26.5 program: Under State law, the responsible party for a child/youth receiving services designated in the special education (AB 3632/SB 26.5) Individual Educational Plan (IEP) is not required to consent to insurance billing for those services or to pay a fee. Mental health services not designated on the IEP are subject to insurance billing and fees established through the financial evaluation process. Therefore the Mental Health Services Division does conduct the financial evaluation process described in this policy with the responsible parties of children/youth and always requests permission to bill insurance and documentation of insurance but only

requires the other documentation above for children/youth expected to receive services that are not designated on the IEP.

B. **Financial evaluation process:** When the client comes for the first appointment for either the initial or annual financial evaluation or upon change in client's financial/insurance status, administrative staff will review the documentation provided by the client in order to complete the *Payer Financial Information, Guarantor* and *Insurance Coverage* sections of the information system, and print out and obtain the client's signature for *Release of Information and Assignment of Benefits* as well as the *Payer UMDAP Information/Payment Contract* (samples of these computer screens and resulting print out forms are Attachment D).

The State formula for establishing the client's financial participation is integrated in the computer application the administrative staff (those clinics that do not use the electronic system use the forms in Attachment D) uses to establish the fee and requires:

1. Establishing the client family's monthly income;

2. Adding to the monthly income one-twelfth of the liquid assets (bank balances and other savings less an "asset allowance" the State sets based on the number of individuals dependent on the income—in Attachment A); and

3. Subtracting monthly allowable expenses (court-ordered obligations, monthly child care costs, dependent support payments, medical expenses in excess of 3% of gross income, mandated retirement contributions) from that amount, in order to establish an adjusted gross monthly income. Housing costs are not one of the allowable deductions. However, San Mateo's policy is to consider excessive housing costs along with other issues as part of the therapeutic fee adjustment process described further in this document.

4. The client family's adjusted gross monthly income (from #3 above) is compared to the State UMDAP fee schedule (Attachment A) to identify the correct maximum annual client family deductible. The monthly payment amount is the result of the annual deductible divided by twelve. The monthly fee is collected only up to the annual deductible amount. If the actual cost of services for the month is less than UMDAP obligation, only the actual cost of service will be billed.

After completing the financial evaluation process, administrative staff shall inform each client of the amount of the maximum annual deductible, confirm the monthly payment plan, and ask the client to sign the *Payment Contract.*

Clients should also be informed of the State requirement that they notify the Billing Office of any change in their financial circumstances or insurance status so that their maximum annual deductible and insurance billing can be adjusted accordingly. Attachment E is *Payment Information for Mental Health Consumers,* a standard information sheet that administrative staff should give to clients at the initial financial assessment and upon request.

Administrative staff will put copies of the *Release of Information and Assignment of Benefits* as well as the *Payer UMDAP Information/Payment Contract* and send copies of these forms and health insurance cards to the central Billing Office. Administrative staff will leave notes in the chart indicating if there are any items that require the clinician to follow-up with the client. Administrative staff may initiate the therapeutic adjustment process with the clinician if information revealed during the financial evaluation process indicates that therapeutic adjustment may be indicated.

C. All uninsured clients will be asked to apply for Medi-Cal eligibility, Healthy Families, or other entitlements. The documentation provided above will assist administrative staff to identify the most appropriate options. Administrative staff will assist clients in arranging for Medi-Cal and other eligibility appointments.

D. A client or responsible person has a right to refuse to give financial information; however, they are then liable for the full-cost of services received. Reluctance to provide the documentation necessary for the financial evaluation process will be interpreted as refusal to provide the information if, after two appointments, the information has not been provided. Administrative staff will notify the Billing Office at this juncture. The Billing Office will send a letter advising the client that if the information necessary for the financial evaluation process is not produced within 30 days, the client's financial status will be changed to full cost of service. Before changing the client's status, the Billing Office will send the client a letter informing them of the change and that it will remain in effect until receipt of the required information. These letters will be copied to the client's clinician.

E. There is just one annual deductible per client family, regardless of the number of providers serving members of that family.

F. The Billing Office will send out bills monthly. These may be sent to the clinic if the clinician feels a bill mailed to a client is counter-therapeutic. Administrative staff will request the monthly payment due as part of the usual protocol for clients to check-in for their appointments but will not adjudicate disagreements or refusals to pay. Delinquent accounts will be addressed as described in Mental Health Policy Number 96-05, Delinquent Accounts.

G. Therapeutic Fee Adjustments: The State requires county mental health systems to establish specific procedures to adjust client deductibles for therapeutic reasons with appropriate documentation. The therapeutic fee adjustment may be initiated by either administrative or clinical staff, using the appropriate *Therapeutic Fee Adjustment Request* forms (Attachment F). Fee adjustments that are made to incorporate documented excessive housing costs will be completed by the administrative staff and submitted directly to the Billing Office. No separate fee adjustment form is necessary. All other therapeutic fee adjustments must be completed by the client's therapist or physician, signed by the Unit Chief and submitted to the Billing Office for approval by Mental Health Director or designee following these guidelines:

1. Therapeutic fee adjustments should be requested only where there is a reasonable expectation, based on knowledge of the particular client and discussion with the client, that efforts to collect fees will directly and negatively impact his/her ongoing mental health status or care.

2. The written rationale for this expectation and the new recommended amount should accompany the request for a therapeutic fee adjustment. Writing off the entire debt should not be the only alternative considered. There may be a basis for reducing but not eliminating the maximum deductible. This possibility should be discussed with the client and the Unit Chief who is responsible for assuring uniformity and fairness in the application of this procedure across all the clients served by that clinic. Requests for fee adjustments will be returned if they lack sufficient supporting documentation.

   This Division policy defines "excessive" housing costs as those that exceed 30% of a client or responsible family's gross income. For example, if a client's gross income is $1,000 a month, "excessive" housing costs would be those that exceed $300 a month. If excessive monthly housing costs are the barrier to paying the maximum deductible, the new proposed maximum deductible should be calculated by subtracting the portion of monthly housing costs in excess of 30% of the gross income in addition to allowable costs to establish the adjusted gross monthly income (step B3 above). In the above example, if the client's rent is $600, then $300 (the amount in excess of 30% of the client's gross income) would be subtracted along with other allowable costs to establish the adjusted gross monthly income. See additional examples in Attachment A.

3. Requests for fee exceptions must be accompanied by a current *Payer UMDAP Information/Payment Contract*, which has been reviewed and signed by the client's clinician. If the request has been initiated as a result of a change in the client's financial status, the *Payer UMDAP Information/Payment Contracts* should reflect this change.

4. Therapeutic fee adjustments should not be made for Medi-Cal beneficiaries with a share-of-cost unless there are extraordinary circumstances. Share-of-cost Medi-Cal beneficiaries have that status because they receive more income monthly than the basic subsistence check from the Social Security Administration. The Mental Health Division has the option of "writing off" eligible services as long as they are not services funded by Medi-Cal, Medicare, or other third party payers, until the share-of-cost has been met (refer to Policy 92-4 Medi-Cal Share-of-Cost).

5. Requests for continuation of therapeutic fee adjustments (for clients who already have them and whose circumstances continue exactly as described in the approved adjustment but require annual renewal) should be submitted to the Billing Office for approval by the Mental Health Director or designee with a current *Payer UMDAP*

Information/Payment Contract and a copy of the prior approval, with a dated Unit Chief signature and the words "continuation requested."

6. Requests for fee adjustments for closed cases should be submitted to the Billing Office for disposition.

Approved: _____

Gale Bataille, Director
Mental Health Services Division