# CBHS Policies and Procedures

City and County of San Francisco
Department of Public Health
San Francisco Health Network
BEHAVIORAL HEALTH SERVICES

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POLICY/PROCEDURE REGARDING: **Payer & Financial Information and UMDAP**

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References:
Welfare & Institutions Code Section 5718–5724;
MHP Contract with California Dept. of Health Care Services

**Technical revision**

**Purpose:**

The California Welfare & Institutions Code requires county behavioral health systems to obtain Payer and Financial Information (PFI) for all clients receiving Mental Health (MH) and/or Substance Use Disorder (SUD) treatment services. The PFI establishes the client's or family's healthcare benefits and insurance coverages, and patient fee amounts payable for behavioral health services received. This policy and procedure prescribe the process to be carried out by San Francisco County Behavioral Health Services (BHS) Organizational Providers and by Behavioral Health Services Access Teams to obtain clients' Payer and Financial Information.

**Policy:**

All BHS Organizational Providers, Behavioral Health Access Center (BHAC) - SUD Treatment Access Program (TAP) and Mental Health (MH) Access Teams are responsible for obtaining and verifying county behavioral health clients' Medi-Cal eligibility and benefits information, Medicare Part A, Part B, Part C , and Part D coverages, and other health insurance coverages; for the purposes of billing and for determination of the fees that clients have to pay, if any, for mental health and substance use disorder treatment services they receive. The State's Uniform Method of Determining Ability to Pay (UMDAP) process may be used when applicable, to determine a sliding fee payable by the Client or their Responsible Party, that is based on Clients' monthly adjusted gross family income, the number of dependents and State allowed expenses.

The PFI must be completed for County MH and SUD Clients at the beginning of their treatment episodes, and at least annually thereafter, on their Patient Account anniversary dates, for as long as their BHS program episodes remain open. The Avatar electronic health record's *PFI Due Report* lists clients of MH and SUD programs whose PFIs are about to expire (within 45 days of their Patient Account anniversary episode date) or whose PFIs have already expired.

PFIs are also required to be updated whenever there are changes in clients' Medi-Cal eligibility or benefits, health insurance coverages, or Medicare benefits; and, whenever there are significant changes in clients' or their families' financial status. Updated PFIs facilitate accuracy in BHS service eligibility and client financial information for patient accounts billing purposes. Changes in clients' financial status may

require redetermination of their UMDAP annual liability amounts and for their continued eligibility for county, state and federal entitlement programs.

Clients or Responsible Parties (RP) who refuse to provide accurate and complete PFI information will have to be billed the full cost of services they receive from BHS, at the San Francisco Board of Supervisors' (SF BOS) rates, in accordance with the W&I Code and Ca Dept. of Health Care Services (DHCS) Revenue Policy and Procedures. UMDAP fee amounts payable cannot be determined unless accurate and complete financial information is obtained from the Client or RP. Furthermore, it is against federal law, state regulations, and the San Francisco Department of Public Health's (SFDPH) Code of Conduct to automatically waive Patient Fees payable.

Uninsured BHS Clients should be referred to the Behavioral Health Access Center to meet with an Eligibility Worker, or to a San Francisco Health Access Coordinator at the Zuckerberg San Francisco General Hospital, or to the SF County Human Services Agency, to receive assistance with applying for Medi-Cal benefits or low-cost healthcare coverages and entitlements available to them. Uninsured clients who do not qualify for Medi-Cal benefits, regardless of their immigration status, may enroll in Healthy San Francisco.

## Episode Guarantor Information

BHS MH and SUD Providers complete an *Episode Guarantor Information* (EGI) form in the Avatar electronic health record to meet the state's annual PFI requirements. Providers complete the EGI in Avatar's CalPM not only at the time when new client episodes are opened in BHS treatment programs, but also annually for clients who continue to receive BHS services.

BHS services access teams – including eligibility workers in BHAC, Foster Care Mental Health, Family Mosaic Project, SFDPH Transitions Team, and Children, Youth and Families Access – are responsible for completing PFIs and determining applicable client fees based on UMDAP for clients accessing BHS Private Practitioner Network (PPN) services via these BHS central access programs. TAP is responsible for completing the PFIs and determining applicable client fees based on UMDAP for clients accessing BHS SUD services via TAP, including for clients availing of Drug Medi-Cal Organized Delivery System (DMC-ODS) residential treatment services. These BHS access programs directly enter clients' Financial Eligibility and Family Registration records into Avatar, including as part of issuing prior authorizations for treatment services within required timeframes.

Initially, financial and eligbility information can be gathered in ink on paper EGI client-fee determination forms. However, EGI information must eventually be data-entered by providers into Avatar to meet EGI completion requirements, and toward PFI finalization by the BHS Billing Unit. The initial use of EGI paper forms is optional. Forms are printed on NCR paper so a copy of the completed and signed form can be given to the client or their Responsible Party. The paper forms have fields that correspond to the EGI and Family Registration forms data-entry fields in Avatar/ CalPM. The *Client Authorization for Billing* and *UMDAP Sliding-Scale Fee Schedule* forms are available from BHS Forms Control at 1380 Howard Street, San Francisco, 2nd floor forms supply room.

The EGI forms completed in Avatar by BHS providers and by Access teams provide information to the BHS Billing Unit about Clients' guarantor and third-party funding source(s) who will be billed for the services clients' received. If the EGI is not completed, BHS services provided to Clients cannot be posted in or billed in the Avatar system. Unposted services due to missing EGIs are reported in the Avatar Billing Errors Report for the Providers to address.

The Client or their Responsible Party's signature on the *Client Authorization for Billing* form is obtained when the EGI is completed. This form documents client's consent for BHS to release their healthcare information for billing purposes. It also documents their assignment of healthcare benefits from third party payers, including Medi-Cal, Medicare, and Insurance, for SFDPH to be paid directly for the behavioral health services the Client receives.

Clients who have an UMDAP liability amount are also required to sign their agreement to pay SFDPH for the cost of services they received or their UMDAP-determined fee. The agreement form documents clients' or their Responsible Party's attestations of the accuracy of the financial information they provided – that is to be used to calculate their UMDAP-based fee amount –and their agreement to pay the fee amounts due. Fees agreed to be paid can include – aside from UMDAP-determined fees – insurance copayments and deductibles due, Healthy San Francisco (HSF) Point-of-Service (POS) fees, and monthly Medi-Cal share-of-cost amounts. Client agreement forms can evemtially be signed electronically in Avatar, beginning sometime 2018. Copies of forms signed in Avatar should be printed and given to the clients or Responsible parties for their records.

## Medi-Cal

Medi-Cal is a month-to-month benefit. For this reason, providers are required to verify their clients' Medi-Cal eligibility not only upon program admission but also on a monthly basis prior to provision of services for the month.

Beneficiaries may have either *full-scope* Medi-Cal benefits that will cover their healthcare services and medications; or, they may have *restricted* benefits that will cover only emergency services or pregnancy-related services for up to 60 days post-partum.

Some Medi-Cal beneficiaries have monthly share-of-cost amounts that must first be paid or be obligated to be paid, before Medi-Cal benefits become available. Medi-Cal Share-of-Cost amounts may vary from one month to another. (Refer to CBHS Policy/Procedures #2.03.12)

## Uniform Method of Determining Ability to Pay

Clients' annual UMDAP-based fee re-determination anniversary dates are established when their BHS Patient Accounts are first created. The UMDAP-based client-fee liability amount is valid for one year at the most and reassessed yearly by the BHS provider. Reassessment is typically done during the same time when the annual PFI is completed.

Per state regulations, the client or their Responsible Party pays the *UMDAP-based fee amount, **or*** the applicable monthly *Medi-Cal share-of-cost amount, Medicare or health insurance* deductible, copayments and fees, *whichever is less.* Clients or Responsible Parties who refuse to provide financial and health coverage information will be charged amounts based on SF Board of Supervisors' rates, the published fee schedule for public health services.

Clients' UMDAP sets the maximum amount clients pay for services they receive during their UMDAP year periods. Annual UMDAP-determined amounts are divided by twelve, to come up with the monthly UMDAP fee that will be billed by the CBHS Billing Unit.

The UMDAP fee amount may be adjusted for clinical reasons. A therapeutic adjustment can be made to increase or decrease clients' UMDAP fee liability amounts. The reasons for therapeutic adjustments must be documented in clients' charts via progress notes. UMDAP Adjustments are reviewed and approved by the director of the BHS program or designee. Therapeutically adjusted UMDAP amounts are entered

into clients' Avatar/ CalPM/ Family Registration forms and are effective during their one-year UMDAP periods. If a retroactive Therapeutic Adjustment to Clients' UMDAP amounts payable is needed, particularly after Services or Episodes are closed, notify the CBHS Patient Accounts Billing Manager by email and provide the Client's ID, Family Account Number and the UMDAP amount to be adjusted. The reason(s) for the retroactive Therapeutic UMDAP Adjustment must be documented in Clients' progress notes.

**Who does not have to be assessed for UMDAP-based fee-determination?**

The following types of clients are not required to have a completed UMDAP-based fee liability determination form. These clients are not charged patient fees for BHS services received. There is also no need to complete the Avatar/CalPM/Family Registration form for these clients.

1. Clients who have full-scope Medi-Cal with no monthly share-of-cost
2. Clients who are homeless[1] per City and County of San Francisco – SFDPH policy and procedures
3. Healthy San Francisco enrollees who have incomes that are less than **150%** of Federal Poverty Level (FPL)
4. Clients who are receiving Education-Related Mental Health Services as part of their Individualized Education Plan (IEP)
   (*NOTE:* However, any *additional* MH or SUD services provided by BHS that are not included in their IEP are subject to UMDAP-based fee-determination requirements.)
5. Clients of BHS special-funded programs that have been approved as exempt from patient billing and UMDAP-based fee determination. Examples include minor consent services, some Mental Health Services Act-funded programs, Intensive Home Based Services, and SB785 services for foster children placed outside their counties-of-origin. Refer to BHS policies and procedures for information and instructions about these specific fee-exempt services.
6. Insured Clients who are approved by the BHS Director or SOC Age Director for admission into a BHS treatment program; and, whose healthcare Insurance or HMO agrees to pay BHS for services the Client receives from BHS. A Single Case Agreement from the Client's Insurance carrier must be approved by the BHS Director. (Refer to CBHS Policy/procedure #2.03.24)

**AVATAR Family Registration Form**

BHS Providers and Behavioral Health Access teams enter their clients' PFI healthcare coverage information in the Avatar EGI form; and, for Clients who have an UMDAP Liability, enter their financial information in the Avatar/ CalPM/ Family Registration form to determine Patient fees payable. There is only one (1) BHS Patient Account record created for all family members who receive BHS services.

The BHS Billing Unit is responsible for sending MHS Clients monthly billing statements listing services received and patient fee amounts that are due, per CBHS Policy/Procedures: #2.03.27 on Client Billing.

BHS SUD programs use the same California Department of Health Care Services (DHCS) UMDAP Fee Schedule that MH programs use. However, SUD providers **do not** enter financial assessment and other information required for Clients' UMDAP in the Avatar/ CalPM/ Family Registration form. Substance Use Disorder treatment service Providers are required to determine Patient Fee amounts payable, collect these amounts, account for them and report Non-Medi-Cal and Private Pay Clients' fee amounts paid, and Medi-Cal clients' Share-of-Cost amounts collected. Revenues received from Medi-Cal and from Non-Medi-Cal SUDS Clients are required to be reported by Providers on fiscal year cost reports submitted to the SFDPH Fiscal Cost Reports Unit.

[1] Refer to the Federal definition on Homelessness, Title 42, Chapter 119, Section 11302

## Advanced Beneficiary Notice

The federal Center for Medicare and Medicaid Services (CMS) requires healthcare providers to notify their Medicare clients about services that are not covered by Medicare prior to these services being provided to them.. The Advanced Beneficiary Notice (ABN) provides an opportunity for the client to decide whether or not to accept services that are not covered by Medicare, for which they will be liable for paying. For example, rehabilitation services, particularly those that are rendered by non-Medicare-eligible clinicians or programs, and most SUD treatment services are not covered by Medicare.

For this reason, Medicare-only clients with Part B benefits and, dually-eligible Medicare and Medi-Cal Clients with a monthly Medi-Cal Share-of-Cost who receive services from BHS Providers must complete the Medicare ABN form as part of their annual PFI process. Clients will be liable for payment of the cost of Services received or their UMDAP amount, whichever is less, for behavioral health services that are not covered by Medicare. If applicable, Medi-Cal monthly Share-of-cost amounts cleared or their UMDAP may be payable if Medicare does not cover services received before Medi-Cal benefits are available.

The CMS Advanced Beneficiary Notice form in English and in Spanish languages, along with completion instructions, are available at http://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN.html.

## Healthy San Francisco Point-of-Service Fees

Healthy San Francisco (HSF) enrollees include working individuals whose employers chose the City and County of San Francisco's health plan for their employees. San Francisco residents may also sign up for the Healthy San Francisco plan. HSF enrollees who have incomes above 150% FPL have a Point-of-Service (POS) fee that is payable at the time of service. HSF POS fee amounts are determined based on financial information received by CBHS from the San Francisco Health Plan, the HSF plan administrator.

HSF enrollees who receive specialty services from BHS are assessed an HSF POS fee amount that is different than the HSF POS fee charged for services provided by primary care clinics. This is because all fees assessed for *BHS services* received – unlike fees assessed for *primary care services* received – are subject to the UMDAP, per California Department of Health Care Services (DHCS) regulations.

Furthermore, DHCS allows BHS to deduct the clients' HSF annual premium participation fee from their UMDAP-based annual liability amount. The resulting lower annual fee amount becomes the basis to calculate a *monthly* HSF POS fee for receipt of BHS services. Please contact the BHS Billing Unit's HSF Specialist at (415)255-3542 for any information assistance needed.

The HSF POS monthly fee amount is due at the time of BHS service. If the client neglects or is unable to pay their HSF POS Fee, BHS providers should make a note on the patient record via a progress note. If clients are unable to pay the HSF POS fee because of financial hardship, BHS providers should refer such clients to BHS Eligibility Workers to have fee amounts reduced or eliminated. Clients may also be eligible for other entitlement programs that do not include a patient fee. Otherwise, it is a requirement for these HSF POS fees to be collected.

All payments for services that are collected by BHS providers are processed according to CBHS Policy/Procedure 2.03-18, *Handling of Patient Payments Received in BHS Programs* and must be transmitted to the BHS Billing Office within 24 hour of receipt or the next business day.

**BHS Avatar Reports**

All BHS MH and SUD Organizational Provider programs and Central Access teams must appoint or designate Staffpersons who will be responsible for generating and reviewing, at least once a month, the *'Admissions with no EGI by Program Report* and *PFI Due Report by Program*, so they may comply with the State's PFI /UMDAP requirements and with this BHS policy.

The *Admissions with no EGI by Program Report* is generated by providers to identify the clients who are missing and in need of financial eligibility records in Avatar, which define the funding sources or guarantors for clients episodes of services, in order for services to be posted and billed via Avatar. Providers are required to complete the EGI form in Avatar for clients who are listed as missing such information in this report.

The *PFI Due Report by Program* lists clients whose annual PFI is due and/or whose UMDAP-based fee determination has expired or is about to expire within 45 days. Providers must complete a financial assessment to determine updated UMDAP liability amounts for clients listed on the report. The UMDAP fee amount determined will be effective during Clients'next, one-year UMDAP period. Avatar Users in the Program click on 'Add Item' to create the new UMDAP period in the Avatar/ CalPM/ Family Registration form to update /renew these Clients' UMDAP.

Please also note, BHS Providers are required to complete MH clients' annual periodic Client & Service Information data (CSI), or their SUD clients' annual periodic California Outcomes Measurement System data (CalOMS) in Avatar for DHCS mandated reporting at the same time when Clients' annual PFI /UMDAP are renewed.

**Contact:**

BHS Patient Accounts Billing Manager, (415) 255-3400

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