Easterseals Michigan			
CHAPTER:	Business Practices – Insurance and Billing	POLICY NUMBER:	A11.001
SUBJECT:	Sliding Fee Discount Program & Ability to Pay Determination	PAGE (S):	Page 1 of 22
APPLICATION:	■ Behavioral Health Programs ■ Medical Rehabilitation Programs ☐ Subcontract Providers ☐ Other:		

I. PURPOSE

To outline policy and protocol for determining Ability to Pay and Sliding Fee Discount Program for persons receiving services through Easter Seals Michigan (ESM). The Sliding Fee Schedule Discount program will be administered to all individuals in accordance to the US Federal Poverty Guidelines by DHHS and applicable contractual agreements as noted in this policy. The following practices are to be used without deviation unless approved in advance by Oakland County Community Mental Health Authority (OCCMHA) for Oakland County individuals served. ESM will also use forms promulgated by OCCMHA unless changes or variations are approved by OCCMHA. Persons receiving services from ESM through other contracted community mental health agencies i.e. Genesee Health System (GHS), Macomb County Community Mental Health (MCCMH), and Network 180 must follow all practices and forms referenced in those counties individual policies: GHS Policy 05-010-97: Ability to Pay, MCCMH MCO Policy 7-001: Determination of Financial Liability; and Network 180 Policy: Financial Intake and Ability to Pay.

II. POLICY

Persons receiving services at ESM are assessed fees in accordance with The Michigan Mental Health Code, Department of Community Health (DCH) Administrative Rules and the US DHHS Federal Poverty Guidelines. If the codes, rules or regulations (e.g. mileage reimbursement rates) used in computing Ability to Pay are changed or modified, this policy statement is to be considered amended to comply with those changes.

III. PROTOCOL/PROCEDURE

1. All individuals seeking healthcare services at ESM are assured that they will be served regardless of ability to pay. **No one is refused service because of lack of financial means to pay.**
2. Persons receiving services through ESM are assessed a fee for services they receive according to their Ability to Pay or Sliding Fee Discount Program.
3. The charge for services is the cost of those services, up to the Ability to Pay or Sliding Fee Discount Program amount.
4. There is only one Ability to Pay or Sliding Fee Discount Program determination for a person, regardless of how many providers the person is receiving services from. In the case of minors, there is only one Ability to Pay or Sliding Fee Discount Program per family, regardless of how many children in that family may be receiving services.
5. Preliminary determination of the Ability to Pay or Sliding Fee Discount Program amount is made at the time of initial screening based on the persons'/parent's/guardian's estimation of income.
6. The final Ability to Pay or Sliding Fee Discount Program is determined as near as is practical to the initial assessment/intake appointment(s) date for any services that are authorized thereafter.
7. The final amount and information regarding appeal mechanisms, as applicable to CMH individuals, and timeframes, are communicated in writing to the person at the time of the initial intake appointment or subsequent redetermination.

8. The Ability to Pay or Sliding Fee Discount Program is determined annually for all persons served, except those being served under the Adult Benefit Waiver or MIChild program.
    a. Persons receiving services at Common Ground are not assessed Ability to Pay for those services.
    b. **Oakland County Only:** Persons found eligible at Common Ground for CMH services at ESM receive an estimated Ability to Pay while at Common Ground. Common Ground uses Exhibit A and bases the estimated Ability to Pay on the person's state taxable income. For all other contracted CMHs: Persons found eligible for CMH services with other contracted CMHs i.e. Macomb, Genesee and Network 180, an Ability to Pay will be determined by those entities. (Please also reference the following Policies for additional information: GHS Policy 05-010-97: Ability to Pay, MCCMH-MCO Policy 7-001: Determination of Financial Liability, and Network 180 Policy: Financial Intake and Ability to Pay. Once these individuals are seen at ESM, they will determine the actual Ability to Pay, as described below under determining financial liability.
    c. Persons being served under the Adult Benefit Waiver or MIChild program are not to be asked any financial questions and do not receive a Total Financial Determination. They receive an Ability to Pay filled in with zero liability. *(See Total Financial Determination section below).*
    d. Persons being served under the home and community based children's waiver (administrative rule R330.8239) or Medicaid (administrative rule R330.8239) are not to be asked any financial questions. They receive a Total Financial Determination filled in with a zero liability.

2. For CMH contracted persons with state taxable income of $10,000 per year or less, the Ability to Pay is zero.
3. If the CMH contracted person has taxable income in addition to Medicaid, the Ability to Pay for such person is deemed to be zero, except for inpatient psychiatric stays of less than 61 days where there is a patient pay amount determined by the Department of Human Services (DHS).
4. For individuals being served under CMH contracts, the Ability to Pay method utilized will be the Monthly Ability to Pay. This consists of the annual Ability to Pay divided by twelve, which will be applied on a monthly basis to the cost of services used during a month, except for Respite, which will utilize a Daily Ability to Pay (annual Ability to Pay divided by 365).
5. Persons served at ESM are provided with a written explanation of policy concerning collection of Ability to Pay or Sliding Fee Discount Program amounts and service suspension or termination (for CMH individuals only) at time of Ability to Pay determination.
6. Willful failure to provide relevant financial information results in a determination of Ability to Pay of the full cost of services received by the individual.
7. Failure to provide relevant information about insurance benefits which may cover the cost of services, or to apply for health care coverage (Medicaid, Medicare, etc.), results in the Ability to Pay or Sliding Fee Discount Program determined to be the full cost of services received.
8. Failure to coordinate health care benefits with primary insurance results in the Ability to Pay or Sliding Fee Discount Program determined to be the full cost of services received.
9. Persons served at ESM or their families are only obligated to pay when the initial bill for services is presented within two years from the date the services were provided.
10. CMH contract served persons served at ESM who willfully fail to provide financial information or pay an overdue balance may have their services suspended or terminated only under the following circumstances:
    a. The person does not appear to pose an imminent danger to self or others.
    b. The clinical and other consequences of the current nonpayment or willful failure to provide financial information have been addressed and discussed with the person and/or appropriate family member or guardian.
    c. ESM will make a reasonable effort such as, but not limited to, developing a payment plan, discussion of impact of non-payment on service delivery and other collection options. Those efforts and the outcomes of those efforts will be documented and maintained in the individual's file.

d. ESM will inform their fiscal coordinator at the appropriate contracted CMH of any pending situations where a person served has refused to supply the required information or has refused to pay overdue balances and they have taken all reasonable efforts to obtain information or payment. Any service suspension or termination will be brought to the attention of the fiscal coordinator at least three weeks prior to the suspension or termination of services. It is the fiscal coordinator's responsibility to work with the contracted CMH's Customer Service and Due Process Departments to assist ESM in making certain reasonable efforts have been made prior to service termination.
e. The person served at ESM will be notified at least twelve working days in advance prior to any suspension or termination of services.
f. ESM may refer individuals receiving services to a collection agency for the purpose of recouping monies for payment of services and in extreme cases may file a claim in court. Prior to sending the individual to a collection agency or court, ESM will make reasonable efforts to work with the individual receiving services to resolve the issue.

11. Once the CMH contracted services individual has been deemed to owe funds or has had services at ESM suspended or terminated, the individual may not transfer to another Core Provider Agency (CPA) until the outstanding balance is paid.

Undue Financial Burden

1. No determination of Ability to Pay or Sliding Fee Discount Program will impose an undue financial burden on the person served or their family members.
2. No person will be denied services because of the inability of responsible parties to pay for the services.

Determining Sliding Fee Discount Program

This program is designed to provide free or discounted care to those who have no means, or limited means, to pay for their behavioral health services (Uninsured or Underinsured).
ESM will offer a Sliding Fee Discount Program to all who are unable to pay for their services. ESM will base program eligibility on a person's ability to pay and will not discriminate on the basis of age, gender, race, sexual orientation, creed, religion, disability, or national origin. The Federal Poverty Guidelines, http://aspe.hhs.gov/poverty, are used in creating and annually updating the sliding fee schedule (SFS) to determine eligibility.

All individuals seeking behavioral services at ESM are assured that they will be served regardless of ability to pay. **No one is refused service because of lack of financial means to pay**.

Notification

ESM will notify patients of the Sliding Fee Discount Program by:

- Financial Agreement Brochure will be available to all individuals at the time of service.
- Notification of the Sliding Fee Discount Program will be offered to each individual upon admission.
- An explanation of our Sliding Fee Discount Program and our application form are available on ESM's website.
- ESM places notification of Sliding Fee Discount Program in the clinic waiting area.
- In addition, information about the Sliding Fee Discount Program will be made available in appropriate languages and literacy levels for ESM's service area.

1. **Request for discount:** Requests for discounted services may be made by individual, family members, staff or others who are aware of existing financial hardship. The Sliding Fee Discount Program will only be made available for clinic visits. Information and forms can be obtained from the Front Desk Support Staff.

2. **Administration:** The Sliding Fee Discount Program procedure will be administered through the ESM Program Directors and/or his/her designee(s). Information about the Sliding Fee Discount Program policy and procedure will be provided and assistance offered for completion of the application. Dignity and confidentiality will be respected for all who seek and/or are provided services.

3. **Alternative payment sources:** All alternative payment resources must be exhausted, including all third-party payment from insurance(s), Federal and State programs.

4. **Completion of Application**: The individual/responsible party must complete the Sliding Fee Discount Program application in its entirety. By signing the Sliding Fee Discount Program application, individuals authorize ESM access in confirming income as disclosed on the application form. Providing false information on a Sliding Fee Discount Program application will result in all Sliding Fee Discount Program discounts being revoked and the full balance of the account(s) restored and payable immediately.

    a. If an application is unable to be processed due to the need for additional information, the applicant has two weeks from the date of notification to supply the necessary information without having the date on their application adjusted. If an individual does not provide the requested information within the two week time period, their application will be re-dated to the date on which they supply the requested information. Any accounts turned over for collection as a result of the patient's delay in providing information will not be considered for the Sliding Fee Discount Program.

5. **Eligibility**: Discounts will be based on income and family size only. ESM uses the Census Bureau definitions of each.
    a. **Family is defined as**: a group of two people or more (one of whom is the householder) related by birth, marriage, or adoption and residing together; all such people (including related subfamily members) are considered as members of one family.
    b. **Income includes:** earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources. Noncash benefits (such as food stamps and housing subsidies) do not count.
6. **Income verification:** Applicants must provide one of the following:
    a. Prior year W-2, two most recent pay stubs, letter from employer, or Form 4506-T (if W-2 not filed).

b. **Self-employed** individuals will be required to submit detail of the most recent three months of income and expenses for the business. Adequate information must be made available to determine eligibility for the program.
c. **Self-declaration of Income** may only be used in special circumstances. Specific examples include participants who are homeless. Individuals who are unable to provide written verification must provide a signed statement of income, and why (s)he is unable to provide independent verification. This statement will be presented to ESM's CFO or his/her designee for review and final determination as to the sliding fee percentage. Self-declared individuals will be responsible for 100% of their charges until management determines the appropriate category.

7. **Discounts:** Those with incomes at or below 100% of poverty will receive a full 100% discount. Individuals receiving a full discount will be assessed a $5 nominal charge per visit. Those with incomes above 100% of poverty, but at or below 200% of poverty, will be charged according to the attached sliding fee schedule. The sliding fee schedule will be updated during the first quarter of every calendar year with the latest federal poverty guidelines, http://aspe.hhs.gov/poverty.

8. **Nominal Fee:** Individuals receiving a full discount will be assessed a **$5** nominal charge per visit. However, individuals will not be denied services due to an inability to pay. The nominal fee is not a threshold for receiving care and thus, is not a minimum fee or co-payment.

9. **Waiving of Charges:** In certain situations, patients may not be able to pay the nominal or discount fee. Waiving of charges may only be used in special circumstances and must be approved by ESM's COO, CFO, or their designee. Any waiving of charges should be documented in the individual's file along with an explanation (e.g., ability to pay, good will, etc).

10. **Applicant notification:** The Sliding Fee Discount Program determination will be provided to the applicant(s) in writing, and will include the percentage of Sliding Fee Discount Program write off, or, if applicable, the reason for denial. If the application is approved for less than a 100% discount or denied, the individual and/or responsible party must immediately establish payment arrangements with ESM. Sliding Fee Discount Program applications cover outstanding individual balances for six months prior to application date and any balances incurred within 12 months after the approved date, unless their financial situation changes significantly. The applicant has the option to reapply after the 12 months have expired or anytime there has been a significant change in family income. When the applicant reapplies, the look back period will be the lesser of six months or the expiration of their last Sliding Fee Discount Program application.

11. **Refusal to Pay:** If an individual willfully fails to provide financial information, pay an overdue balance, verbally expresses an unwillingness to pay or vacates the premises without paying for services, the individual will be contacted in writing regarding their payment obligations. If the individual is not on the sliding fee schedule, a copy of the sliding fee discount program application will be sent with the notice. If the individual does not make effort to pay or fails to respond within 60 days, this constitutes refusal to pay. At this point in time, ESM can explore options not limited, but including offering the individual a payment plan, waiving of charges, or referring the individual

to collections efforts in accordance with ESM's collection policies outlined in the Insurance Billing and Collection of Self-Pay Balances/AR Management Policy (All.002).

12. **Record keeping:** Information related to Sliding Fee Discount Program decisions will be maintained and preserved in a centralized confidential file located in the EMR, in an effort to preserve the dignity of those receiving free or discounted care.
    a. a. Applicants that have been approved for the Sliding Fee Discount Program will be maintained in EMR, noting names of applicants, dates of coverage and percentage of coverage. Information will be tracked via reports from the EMR.
    b. The Billing Department will maintain an additional monthly log identifying Sliding Fee Discount Program recipients and dollar amounts. Denials will also be tracked. This information will be generated via reports from the EMR.

13. **Policy and procedure review:** Annually, the amount of Sliding Fee Discount Program provided will be reviewed by the CFO and/or Controller. The SFS will be updated based on the current Federal Poverty Guidelines. Pertinent information comparing amount budgeted and actual community care provided shall serve as a guideline for future planning. This will also serve as a discussion base for reviewing possible changes in our policy and procedures and for examining institutional practices which may serve as barriers preventing eligible individuals from having access to our services.

14. **Budget:** During the annual budget process, an estimated amount of Sliding Fee Discount Program service will be placed into the budget as a deduction from revenue. Board approval for Sliding Fee Discount Program will be sought as an integral part of the annual budget.

15. **Direct Care Organizations (DCO's)** that ESM contracts with are required to comply with the Sliding Fee Discount Program in accordance with the USDHHS FPL. DCO's are responsible for offering the Sliding Fee Discount for every individual served and collecting the balances prior to billing ESM. DCO's are required to provide services to all individuals seeking healthcare services regardless of ability to pay. **No one is refused service because of lack of financial means to pay.**

Determining Financial Liability for Person(s) Receiving CMH Contracted Services: General
The two ways for determining financial liability for services are the use of the **Ability to Pay schedule** (defined in administrative rule R330.8239) (Exhibit A) and / or a **Total Financial Determination (TFD)** (Exhibit B). Either or both methods can be used to determine Ability to Pay, as discussed below. If an individual disagrees with the Ability to Pay determined by the Ability to Pay schedule, they have the right to request that a Total Financial Determination be completed. If, when the Total Financial Determination is completed, the total liability is higher than that determined by the Ability to Pay schedule, liability reverts back to the Ability to Pay schedule determination.

1. The **Ability to Pay schedule**, based on State of Michigan taxable income, per the most recent filed State of Michigan income tax return (line16), is used for:
    a. An adult's Ability to Pay for inpatient psychiatric stays that are less than 61 days
    b. All non-residential services, and
    c. The responsible adult's Ability to Pay for all services to minors.

2. The **Total Financial Determination** is used for:

a. All services to minors when determining the child's Ability to Pay based on the child's circumstances (see "Determining Financial Responsibility for Services Provided to Children", below). The responsible parent's Ability to Pay is determined using the Ability to Pay schedule as described below.
b. Residential services (see "Determining Financial Responsibility for Individuals Receiving Residential Services", below)
c. Inpatient services over 61 days
d. Appeals of the fee determined by the Ability to Pay schedule

- **Assets** considered in the TFD include, but may not be limited to, cash, including checking and savings accounts, investments, retirement plans and accounts, savings bonds, estate and trust funds, inheritance, revocable trusts and real and personal property not otherwise excluded from the determination of Ability to Pay. ESM considers the value of assets above and beyond those counted as necessities as available for inclusion in the TFD. Items considered as assets on the TFD will include those listed on Exhibit E.
- **Income** considered would include, but need not be limited to, salary and wages, commissions, interests and dividends, social security benefits, veterans' and railroad benefits, unemployment and workers' compensation, short term and long term disability payments, pension and retirement income, alimony, child support, rental income and trust income. All income, both taxable and non-taxable is included when determining a responsible parties' Ability to Pay.
- **Allowable Expenses**
  1. Expenses are defined in R330.8005 as "reasonable un-reimbursed expenditures of money, actual and estimated, during a financial year to maintain a standard of living essential for one's self and his or her dependents"**. All of the following are considered necessities:**
     - Food, clothing, personal necessities
     - Shelter (homestead)
     - Utilities and repairs for the upkeep of a homestead
     - Employment or business expenses
     - Medical services
     - Taxes
     - Elementary, secondary and post secondary education
     - Repayment of personal financial obligations contractually established before initiation of services
     - Payments made under a divorce decree or court order
     - Transportation to maintain employment and necessary family activities

  2. Food, clothing and personal necessities: ESM via the contracted CMH allows up to the amount listed on Exhibit C. This is based on information received from the Department of Community Health from a study of the Detroit/Ann Arbor Consumer Price Index. Amounts allowed for other expenses will be as outlined in Exhibit D.
  3. Administrative approval for unique circumstances: Amounts allowed for expenses may be varied, based on the unique needs of the person served, with approval of agency administrator (a persons' core provider or contracted CMH, as applicable).

Determining Financial Responsibility for Individuals Receiving Residential Services Provided Under a CMH Contract

1. Residential services are defined as 24-hour dependent care and treatment services provided by Adult Foster Care facilities under contract to DCH or a Community Mental Health Services Program (CMHSP) or a delegated service agency of a CHMSP or provided directly by a CMHSP.
2. For persons receiving service that meet the above definition, protected income is considered in determining the Ability to Pay. Protected income for the personal needs allowance (identified in R300.8242 (b)(I)(A)) is the current rate in effect at the time of the determination. The current amount is outlined in Exhibit C. Protected assets are also considered in the Ability to Pay determination for residential services. The amount of protected assets allowed is the amounts listed in Exhibit C.
3. If the person is receiving Social Security Income (SSI), even with other income such as Retirement Survivors Disability Income (RSDI) or earned income, they are automatically eligible for Medicaid with a zero spend-down. The personal needs allowance of an SSI benefit is not collectable toward the cost of specialty mental health services.
4. For persons with earned income, a portion of the earnings is also protected (as identified in R330.8242 (b)(I)(B)). The amount of earned income protected is the current rate in effect at the time, as outlined in Exhibit C. This is in addition to the personal needs allowance.
5. Other expenses allowed on the TFD for residential services include only expenses the person is paying for. Items provided by the residential setting, such as food or personal care items, as well as rent, etc. that are part of the residential service, cannot be listed on the person's TFD.

Determining Financial Liability for CMH Services to Children

1. A single person less than 18 years of age is considered a child for the purposes of determining Ability to Pay. Ability to Pay for the child (based on the child's circumstances) is determined using the TFD form for the child receiving services. A minor who is a Medicaid recipient is deemed to have a zero Ability to Pay for nonresidential services.
2. When determining an Ability to Pay for a child, only the child's income, expenses, dependents, assets and liabilities are considered. A child's SSI, (Social Security Disability Income) SSDI and child support amount are included in the child's income.
    a. Protected income does not apply to a child's income, unless the child is receiving services from an adult foster care facility.
    b. Protected assets are required for the child's Ability to Pay determination. The amount of protected assets allowed are the amounts listed on Exhibit C. Assets for a child includes savings accounts, savings bonds, CDs, revocable trusts, etc. that are held in the child's name.

3. If the child's Ability to Pay and non-Medicaid insurance coverage is less than the cost of services, then the Ability to Pay is determined for the parents using the TFD form. The charge to the family is the child's Ability to Pay plus the parent's Ability to Pay, up to the cost of service. In the case of a minor with a non-custodial parent who is obligated to contribute toward medical expenses, an Ability to Pay form is completed for each parent, and a copy of the divorce decree or court order delineating the responsibility of each parent is maintained in the case file. If the service is covered by non-Medicaid insurance, then the person served/parent/guardian is responsible for all co-pays and deductibles, as well as the Ability to Pay.
4. The liability of parents continues until an unmarried child's eighteenth (18) birthday. Only one determination of Ability to Pay for parents is completed regardless of the number of children receiving services; there is no parental liability for minor children who are married or for those who have legally obtained emancipation.

Financial Determination for Children Receiving CMH Services with Adoption and/or Medical Adoption Subsidy

1. The Ability to Pay determination for adoptive parents is waived for a pre-existing condition that has been approved for an adoption or a medical adoption subsidy. When an adoption or medical adoption

subsidy situation is encountered, a request for verification that the child is approved under the Adoption Subsidy program for the mental health services being provided is submitted to the Division of Adoption Services. If the adoption subsidy or medical adoption subsidy coverage is verified, a parental Ability to Pay determination is NOT completed. All available insurance coverage, including Medicaid is billed for the cost of the services provided.

2. Waiver of parental Ability to Pay applies only to adoption subsidy and medical adoption subsidy.
3. The condition(s) being treated must be the same condition(s) for which the subsidy was granted.
4. If income and/or assets exist in the adopted child's name, an Ability to Pay determination for the child is completed, even if the parental Ability to Pay determination has been waived.

Financial Determination for Respite Services Provided Under a CMH Contract

The fee for respite services for a full day or any portion thereof is determined by using the monthly amount determined from the Ability to Pay schedule, dividing by 30 and rounding up to the nearest dollar, but will not be more than the cost of services. A responsible party may request a new determination as in the Appeal Procedure (below). Respite fees charged during a calendar month will not be, in aggregate, more than the monthly Ability to Pay amount determined from the schedule.

Appeal Procedure for Person(s) Receiving CMH Contracted Services

1. If a person served, or the persons financially responsible parent or legal guardian disagrees with the Ability to Pay amount, the following steps are offered to the responsible party:
   a. The responsible party is offered the opportunity to have a TFD completed. The responsible party is only required to pay the lesser of the two amounts, up to the cost of services
   b. If the responsible party still does not agree with the Ability to Pay amount after completion of the TFD, the responsible party may request a Local Appeal through the contracted CMH's Office of Due Process. A review is held and the contracted CMH will make a redetermination of Ability to Pay.
   c. The responsible party may appeal a redetermination made under Section 2 above to the probate court district in which he or she resides.

Annual or Periodic Redetermination

A redetermination of the person receiving services' Ability to Pay or Sliding Fee Schedule is made annually, or at any time that there is a significant change in the persons' financial situation. If the persons re-determined Ability to Pay is higher than the amount under previous determinations, the person will be charged the higher amount only for financial liability that is incurred after the date of the redetermination. A signed, current Ability to Pay or TFD Form will be kept in the persons record at all times. The person will also be provided with a copy of the current determination.

IV. DEFINITIONS

None

V. EXHIBIT

A. Ability to Pay Chart
B. Total Financial Determination Worksheet
C. Amounts used for Total Financial Determination
D. Total Financial Determination Allowable Expenses
E. Determination of Assets for Total Financial Determination
F. Sliding Fee Discount Application
G. Sliding Fee Schedule (for the Sliding Fee Discount Program)

VI. REFERENCES

- Michigan Mental Health Code, Chapter 8, Financial Liability for Mental Health Services. Section 330.1800 – 330.1844
- DCH Administrative Rules R 330.8005 – 330.8284
- R 330.8215 Explanation of financial liability process
- Former CMH Policy VI B 2
- OCCMHA Policy CM 5.1: Ability to Pay Determination
- GHS Policy 05-010-97: Ability to Pay
- MCCMH-MCO Policy 7-001: Determination of Financial Liability
- Network 180 Policy: Financial Intake and Ability to Pay
- NHSC Sliding Fee Discount Schedule Information Package 3-2016
- USDHHS Federal Poverty Guidelines (https://aspe.hhs.gov/poverty-guidelines)

VII. REVISION HISTORY

Easter Seals Reviewed	09/15/15
Easter Seals Revised	04/29/14
Easter Seals Reviewed	09/19/12
OCCMHA Reviewed	02/10/12
Easter Seals Revised	07/05/11
OCCMHA Revised	12/31/10
Easter Seals Revised	08/27/10
OCCMHA Revised	10/01/09
Easter Seals Reviewed	05/14/09

*For additional revision history please refer to the retention policies

Insurance Billing and Collection of Self-Pay Balances

I. PURPOSE

To outline the policy and protocol for billing insurance companies and individuals receiving services for services rendered by Easter Seals Michigan (ESM). ESM will adhere to legal, non-fraudulent billing practices to bill all individuals and insurance companies for services rendered.

II. POLICY

This policy provides the general workflow protocols to follow and supplements the detailed procedures located in the program operations manual for insurance billing and include insurance verification first visit process, obtaining authorizations for services through 3rd party insurance, collecting self-pay balances and accounts receivable for billing activities.

III. PROTOCOL/PROCEDURE

Pre-Billing

1. Insurance information will be obtained and verified for every individual receiving service for every visit by support staff prior to every visit. (Please see Operations Manual for Insurance Verification Procedure).
2. Pre-authorization is obtained prior to individual being seen for services by support staff (Please see insurance verification procedure).This will occur prior to the start of services and every service thereafter. Primary clinical staff is responsible for tracking and obtaining authorizations for ongoing services.
3. Services will not be provided that are not prior-authorized by payer.
4. Financial information is obtained and reviewed:
    a. The initial point of service for all Specialty Medicaid individuals (Refer to the ATP procedure in the Operations Manual) to determine ATP
        i. All Specialty Medicaid individuals receiving services will have an ATP determined.
        ii. This will be reviewed and re-determined on an annual basis by primary clinicians.
        iii. Specialty Medicaid individuals are provided the ATP amount in writing.
    b. The initial point of service for all 3rd party/self-pay, Med Rehab Programs, etc. individuals (Refer to the financial assistance procedure in the Operations Manual)
        i. Sliding Fee Discount Program will be offered to all individuals in accordance with the USDHHS Federal Poverty Guidelines
        ii. This is re-determined annually or with the significant change in financial circumstances.

iii. Individuals are provided the Sliding Fee Discount Amount, if eligible, in writing
iv. All individuals are provided the financial agreement. The Sliding Fee Discount Program application will be offered to all individuals not receiving specialty Medicaid services.

5. All financial and demographic information will be entered and scanned into the EMR within 48 hours of receiving the information by program support staff.
   a. Insurance information will be reviewed at every visit to ensure correct information is on file for **ALL** individuals by primary clinical staff.
6. Diagnosis information is loaded into the EMR for all individuals within 48 hours of being received by designated program staff
   a. For Specialty Medicaid individuals, the support staff enters the diagnosis information into the EMR.
   b. For 3rd party/self-pay individuals, the primary clinician enters the diagnosis information into the EMR.

7. Service is recorded accurately in the EMR via SAL entry within 48 hours of the service being performed by program staff.
8. All staff will be trained on the insurance verification, insurance authorization, ATP and financial assistance policies and procedures on an annual basis.
9. Internal spot auditing function will be completed on a quarterly basis by the QI/UM and billing department to ensure ESM is submitting accurate, clean claims on a regular, timely basis and verifying documentation is sufficient to support the services billed.

Billing Claims

1. ESM will submit claims directly to insurance companies that it is paneled with.
   a. Paneling activities are determined by the Grants and Contracts Department in association with the Senior Leadership (SL).
   b. ESM billing department will assist individuals submitting charges to an unpaneled insurance company by providing a receipt with a detail of service and diagnosis codes.

2. All services provided are billed at the same rate regardless of payer. Rates are determined annually by the grants and contracts department in association with ESM SL
3. All charges being submitted are as legitimate and accurate to the best of the biller's knowledge.
4. Any approved correction(s) to the core data (SALs) must be made prior to the billing department submits any changes or corrections. The billing department will not change any CPT or diagnosis codes.
5. All billable services will be submitted electronically to insurance payers on a weekly basis by the billing department.
6. Insurance claims are submitted to the primary, secondary, and tertiary insurance carriers as necessary. Medicaid is always deemed the payer of last resort. If there is more than one commercial insurance policy on record, the primary insurance will be determined by the subscriber whose birthday falls first in the calendar year.
7. All individuals will be billed on a monthly basis by the billing department for all existing balance including but not limited to: co-pays, co-insurances, deductibles, ATPs or any other non-covered service by insurance.
   a. Specialty Medicaid individuals will be billed in accordance with the ATP policy.

8. The billing department will submit reverse COFR and other contract billings monthly no later than the 10th of the following month from when services originally occurred unless it is otherwise specified by the contract.

9. Individual's balance and co-payment will be reviewed at every visit by support staff for all individuals receiving service. If there is a balance due, individual(s) will be asked to supply payment at the time of services being rendered.
    a. If balance becomes greater than $100.00 the individual will need to contact the billing department to setup a payment plan and the arrangement documented in the EMR.
    g. The Individual will be contacted in writing regarding their payment obligations. If the individual is not on the sliding fee schedule, a copy of the sliding fee discount program application will be sent with the notice. If the individual does not make effort to pay or fails to respond within 60 days, this constitutes refusal to pay. At this point in time, ESM will make a reasonable effort such as, but not limited to, developing a payment plan, discussion of impact of non-payment or referring the patient collections efforts.
    h. Those efforts and the outcomes of those efforts will be documented and maintained in the individual's file in the EMR.
    c. Balances that reach $500.00 and are over 120 days old may be sent to a collections agency after approval by billing and finance department.

Post-Billing Claims

1. Individual payments will be accepted in accordance with ESM Policy A7.033 Accounting Practices: Cash, Check, and Credit Card Receipts.
    a. Payments made by individuals will be applied to the oldest open existing balance on the account unless it is otherwise specified.
2. Insurance payments are applied to exact date of service and procedure as specified by the Explanation of Benefits (EOB).
3. Explanation of Benefits, remittance advices and payments are processed by the billing department within the month they are received, no later than the 10th of the following month.
4. Accounts Receivable reports will be reviewed on a monthly basis by the billing department. When charges become past due by 60+ days, the billing department will institute the follow up process by communicating with insurance company, individual and or resubmitting claims as necessary.
5. Items not covered by payer will be billed to the individual as necessary.
6. In certain situations, individuals may not be able to pay the nominal or discount fee. Waiving of charges may only be used in special circumstances and must be approved by ESM's COO, CFO, or their designee. Any waiving of charges should be documented in the individual's chart in the EMR along with an explanation (e.g., ability to pay, good will, etc.)
7. All individuals seeking healthcare services at ESM are assured that they will be served regardless of ability to pay. No one is refused service because of lack of financial means to pay.
8. Internal spot auditing function will be completed on a quarterly basis by the QI/UM and billing department to ensure ESM is submitting accurate, clean claims on a regular, timely basis and verifying documentation is sufficient to support the services billed.

IV. DEFINITIONS

Explanation of Benefits (EOB) / Remittance Advice: Payment received from insurance or managed care company contains a document called the explanation of benefits (EOB). This statement explains what was paid and what services were not covered and is sent to the provider and the patient. A service may not be covered if a patient has not met his or her yearly deductible. In this case, ESM bills the individual for his or her fee up to the calculated Ability to Pay amount.

Fraudulent Billing Practices: Billing for services that were not performed and/or inaccurately coding a service to receive a higher level of payment.

Specialty Medicaid: Behavioral Health and Developmental Disability services in Michigan are delivered through a county-based community mental health services programs (CMHSPs). MDCH, along with 46 regional Community Mental Health Services Programs(CMHSPs), contracts public funds for behavioral health, and developmental disability services. Medicaid funds, which are paid on a per Medicaid- eligible capitated basis, are contracted with CMHSPs, or affiliations of CMHSPs, as Prepaid Inpatient Health Plans (PIHPs).

V. EXHIBIT

None

VI. REFERENCES

Program Operations Manuals for the following procedures:
- Insurance Verification
- Ability to Pay
- Sliding Fee Discount Program
- Sliding Fee Discount Program Application
- Insurance Authorizations

USDHHS Federal Poverty Guidelines: https://aspe.hhs.gov/poverty-guidelines
ESM Policy A7.001
ESM Policy A7.003: Insurance Billing (Rescinded)
ESM Policy A7.008: Collecting Self-Pay Balances (Rescinded)

VII. REVISION HISTORY

Easter Seals Reviewed	09/15/15
Easter Seals Revised	02/27/14
Easter Seals Revised	10/29/13
Easter Seals Revised	05/02/12
Easter Seals Reviewed	07/05/11
Easter Seals Reviewed	05/19/10
Easter Seals Revised	05/13/09
Easter Seals Reviewed	07/16/08
Easter Seals Reviewed	05/22/07
Easter Seals Reviewed	06/28/06
Easter Seals Review	08/02/05
Easter Seals Initial	01/23/04

Easter Seals Michigan

Financial Agreement

(Effective August 16, 2016)

Thank you for choosing Easter Seals Michigan (hereafter "ESM") as your provider. ESM is committed to building a successful relationship with you and your family. Your clear understanding of our Financial Agreement is important to our professional relationship. Please understand that payment for services is a part of that relationship. Please ask if you have any questions about our fees, our policies, or your responsibilities.

ESM is committed to assisting you and your family to understand and maximize the insurance or government program benefits to which you may be entitled. In accordance with Federal Poverty Guidelines, ESM offers a Sliding Fee Discount Program to all individuals. Please fill out a Sliding Fee Discount Application to see if you qualify.

Please review the information provided in this Financial Agreement, outlining:

- our procedure concerning **insurance claims**
- your requirements for insurance **referrals and pre-authorization**
- your responsibilities for insurance **co-payments and deductibles**.
- payment requirements with a **self-pay accounts**
- our procedure concerning **returned checks**
- payment responsibilities with:
    - **minors accompanied by an adult**
    - **unaccompanied minors**
    - **separated/divorced families**
- our practices concerning **outstanding account balance**
- our assistance available under our Sliding Fee Discount Program
- your responsibilities to notify ESM of changes (**change notice)**
- our fees for **copies of medical records**

Insurance Claims

Insurance is a contract between you and your insurance company, below are the duties and responsibilities that prevail:

- **You are required to inform ESM of any and all insurance coverage you have for ESM services provided to you.**
- In order to properly bill your insurance company ESM requires that you disclose all insurance information including primary and secondary insurance, as well as, any change of insurance information.
- Failure to provide complete insurance information may result in your responsibility for the entire bill.
- For all covered services please understand that ESM is **not** a party to your insurance contract. Your insurance coverage is a contract between you and your insurance provider.
- ESM will bill your primary insurance company as a courtesy to you.
- Although ESM may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits.
- ESM will not become involved in disputes between you and your insurance company regarding deductibles, co-pays, covered procedures, secondary insurances, usual and customary charges, etc., other than to supply factual information as necessary.
- If your insurance company is not contracted with us, therefore you agree to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance under your coverage.
- If ESM is out of network for your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately.
- Any services that ESM files with your insurance that do not have a response after 90 days from the date of service may be transferred to your account balance. This balance will remain the responsibility of the individual/family until payment is received or written correspondence is received by the insurance company verifying that payment is forthcoming from them.

Ultimately, you are responsible for the timely payment on your account with ESM.

Referrals and Pre-authorizations

If an insurance company requires a referral and/or pre-authorization, it must be obtained before the services are provided. Before services are performed please be certain that you have obtained all the necessary authorizations; our support staff can provide you with assistance in this effort upon your request.

Failure to obtain the referral and/or pre-authorization may result in a lower or no payment from the insurance company and may become your responsibility.

Co-payments and Deductibles

You are expected to present an insurance card at each visit. All co-payments, deductibles, and past due balances are due at the time of service unless previous arrangements have been made with the billing department.. Co-payments and deductibles are not eligible for ESM's Sliding Fee Discount Program (outlined below).

ESM accepts cash, check or credit cards. No post-dated checks will be accepted.

Self-pay Accounts

Self-pay accounts are for individuals:

- without insurance coverage,
- covered by insurance plans in which the office does not participate,
- without an insurance card on file with us, or
- those who prefer to pay cash (or equivalence) in lieu of insurance.

It is always the individual or family's responsibility to know if our office is participating with their plan. If there is a discrepancy with our information, the consumer will be considered self-pay unless otherwise proven.

Payment in full is expected at the time services are rendered.

Returned Checks

The charge for a returned check is $20 payable by cash or money order. This will be applied to your account in addition to the insufficient funds amount. It is the practice of ESM to place an account on a cash only basis following a returned check.

Payment Responsibility: Accompanied Minors by an Adult

The adult accompanying a minor (parent and/or guardian) is responsible for full payment (non-covered office visits, co-pays, etc.) at the time of service.

Payment Responsibility: Unaccompanied Minors

The parent(s) or guardian(s) is responsible for full payment (non-covered office visits, co-pays, etc.) and will receive the billing statements. A signed release to provide service may be required for unaccompanied minors. *Pursuant to the Michigan Mental Health Code, under certain circumstances a minor 14 years may not be subject to these requirements.*

Payment Responsibility: Separated/Divorced Families

- For those families where parents are separated or divorced, the parent authorizing treatment and bringing the child to be seen is responsible to us for payment. All payments are due when services are rendered.
- In the case of contracted insurance only, co-pay is due at the time services are rendered. Subsequently all charges deemed parent responsibility by the contracted insurer are due to ESM by the parent who authorized treatment.
- If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent. ESM will not act as a mediator in collecting payments.
- A copy of the bill with appropriate insurance coding will be given to the authorizing parent.
- If the account is not resolved in a timely manner, the authorizing parent's information will be submitted to our collection agency.
- Non-compliance with this policy may result in discharge from services.

Outstanding Account Balance

A statement will be sent to you monthly, detailing unpaid charges. If you have questions regarding items which have not been paid by your insurance, ESM asks that you contact your insurance company or employer as benefit packages vary by employer.

Any balance due is expected at the time of service.. Extended payment arrangements are available if needed. Please ask to speak with a billing coordinator to discuss a mutually agreeable payment plan. If no resolution can be made, and adequate payment has lapsed for 120 days, the account may be sent to a collection agency. All individuals seeking behavioral healthcare services at ESM are assured that they will be served regardless of ability to pay. **No one is refused service because of lack of financial means to pay.**

In the event an account is turned over to for collections, the person financially responsible for the account will be responsible for all collections costs including attorney fees and court costs.

Sliding Fee Discount Program ESM does provide for discounts on service rates under strict conditions of qualification, process, and award. This program is outlined below.

1. The Sliding Fee Discount Program is not intended for anyone covered under public funded programs such as community mental health organizations, substance abuse programs, etc.

2. You will be considered eligible for this assistance if you meet ALL of the following criteria:

    a. Adjusted Gross Income (AGI) at or below 200% Federal Poverty Guidelines(FPG)

    b. Able to provide documented proof of denial issued from Medicaid

    c. You meet and can demonstrate the income and dependent criteria outlined below.

3. If you are deemed a candidate for financial assistance, you can obtain an application and follow the process of the application:

4. Along with the completed Sliding Fee Discount Program Application you must provide one of the following:

    - Prior year W-2, two most recent pay stubs, a copy of the latest year Federal Form 1040 (as filed with the IRS) tax letter from employer, or Form 4506-T (if W-2 not filed).

    - Self-employed individuals will be required to submit detail of the most recent three months of income and expenses for the business. Adequate information must be made available to determine eligibility for the program.

    - Self-declaration of Income may only be used in special circumstances. Specific examples include participants who are homeless. Individuals who are unable to provide written verification must provide a signed statement of income, and why (s)he is unable to provide independent verification. This statement will be presented to ESM's CFO or his/her designee for review and final determination as to the sliding fee percentage.

    - Self-declared individuals will be responsible for 100% of their charges until management determines the appropriate category.

The following financial evaluation table will be utilized to determine the amount of **discount you will be provided against the ESM standard rates.**

Annual Income Thresholds by Sliding Fee Discount Pay Class and Percent Poverty						
Poverty Level*	At or Below 100%	125%	150%	175%	200%	Above 200%
	Charge					
Family Size	Nominal Fee ($5)	20% pay	40% pay	60% pay	80% pay	100% pay
1	0-$11,880	$11,881-$14,850	$14,851-$17,820	$17,821-$20,790	$20,791-$23,760	$23,761+
2	0-$16,020	$16,021-$20,025	$20,026-$24,030	$24,031-$28,035	$28,036-$32,040	$32,041+
3	0-$20,160	$20,161-$25,200	$25,201-$30,240	$30,241-$35,280	$35,281-$40,320	$40,321+
4	0-$24,300	$24,301-$30,375	$30,376-$36,450	$36,451-$42,525	$42,526-$48,600	$48,601+
5	0-$28,440	$28,441-$35,500	$35,501-$42,660	$42,661-$49,770	$49,771-$56,880	$56,881+
6	0-$32,580	$32,581-$40,625	$40,626-$48,870	$48,871-$57,015	$57,016-$65,160	$65,161+
7	0-$36,730	$36,731-$45,913	$45,914-$55,095	$55,096-$64,278	$64,279-$73,460	$73,461+
8	0-$40,890	$40,891-$51,113	$51,114-$61,335	$61,336-$71,558	$71,559-$81,780	$81,781+
For each additional person, add	$4,160	$5,200	$6,240	$7,280	$8,320	$8,320

* Based on 2016 Federal Poverty Guidelines (http://aspe.hhs.gov/poverty)

5. You will be given two weeks to return the completed forms to ESM. The application will be evaluated for approval by ESM's Accounting Department, and written notice will be provided to you and your Clinical and support staff.

6. Consideration for financial support will not be made without all required documentation made available, including a signed copy of this Policy and the Sliding Fee Discount Program Application

7. The individual/responsible party must complete the Sliding Fee Discount Program application in its entirety. By signing the Sliding Fee Discount Program application, persons authorize ESM access in confirming income as disclosed on the application form. Providing false information on a Sliding Fee Discount Program application will result in all Sliding Fee Discount Program discounts being revoked and the full balance of the account(s) restored and payable immediately.

8. If an application is unable to be processed due to the need for additional information, the applicant has two weeks from the date of notification to supply the necessary information without having the

date on their application adjusted. If an individual does not provide the requested information within the two week time period, their application will be re-dated to the date on which they supply the requested information. Any accounts turned over for collection as a result of the individual's delay in providing information will not be considered for the Sliding Fee Discount Program.

9. Services may begin while the application is in process, but you will be required to pay the full cost at time of service for all services rendered during that time. If approved for the Sliding Fee Discount Program, the discount will be made effective the date a completed application and documentation was received in its entirety

10. Sliding Fee Discount Program may be redetermined on an annual basis or at the time of a significant change in financial status.

Medical Record Copies

Requests for copies of medical records will be charged as follows:

- Copy Fee: $23.34
- Pages 1-20: $ 1.17 per page
- Pages 21-50: $ .58 per page
- Pages 51+ : $ .23 per page

Copies will be sent immediately after payment has been received.

***Rates are based on the State of Michigan Department of Community Health Consumer Price Index Increase of Medical Records Access Act Fees, Effective January 1, 2016.*

CONFIRMATION & AGREEMENT

I am aware that ESM offers a Sliding Fee Discount Program to all individuals that are unable to afford or pay for their services. I am also aware that my services will not be refused due to a lack of financial means to pay.

I understand and agree that (regardless of my insurance status) I am responsible for the balance of my account.

I authorize the release of information to any insurance company involved in this case.

I will notify ESM of any changes in (my) or (my child's) health status.

I understand that this is a direct assignment of my rights and benefits under my insurance policy for payment made directly to ESM.

I understand my responsibilities to perform under this Financial Policy, anything unclear to me I have inquired on for clarification, and therefore I accept the responsibility for payment for the individual being served and listed below

Responsible Party/Guarantor:

_____ _____

Signature Date of Signature

_____ _____

Print Name of Person Signing Above Print Name of Person Being Served

Note: If person signing is other than Person being Served, Parent, or Guardian, and are hereby accepting responsibility for payment, please indicate relationship below: