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Behavioral Health Services

Information Sharing

Drug Medi-Cal Organized Delivery System
Process for Share of Cost (SOC)– BHS 2019-001

February 1, 2019

Drug Medi-Cal Organized Delivery System (DMC-ODS) Providers:

Share of Cost (SOC) is the client financial obligation to pay the provider up to a predetermined amount before a service can be billed to Drug Medi-Cal. Where applicable, Medi-Cal beneficiaries must meet a specified monthly SOC for medical expenses before Medi-Cal will pay claims for services provided. A beneficiary's SOC is usually determined by the County Eligibility Operations Department and is based upon the beneficiary's or family's income and living arrangement. Members of the family may have the same or different SOC amounts. The monthly SOC may change at any time if the individual's or family's income increases or decreases, or the family's living arrangement changes.

In order to meet the SOC requirement for Medi-Cal beneficiaries, the County has developed process flowcharts and forms to assist with the workflow and documentation. Units of service applied in clearing the SOC on the California Department of Health Care Services (DHCS) website should be entered in *SanWITS* as *County billable.* Programs should use the County of San Diego Interim Rate Cap in the calculation of *DMC billable* services in *SanWITS* to clear the SOC. The County of San Diego Interim Rate Cap was distributed to all Providers and can be found on the DMC-ODS SharePoint: (https://cwc.sdcounty.ca.gov/sites/BHS/DMC-ODS/Shared Documents/DMC ODS Approved Interim Rate Caps.pdf) . Payments received from clients should be reported on the invoice to the County as other revenues.

Please refer to the attached documents as reference on how the SOC should be tracked and monitored by providers. They are as follows:

- Flowcharts
  - Drug Medi-Cal Share of Cost Verification Process
  - Drug Medi-Cal Client Obligation Share of Cost Clearance Process

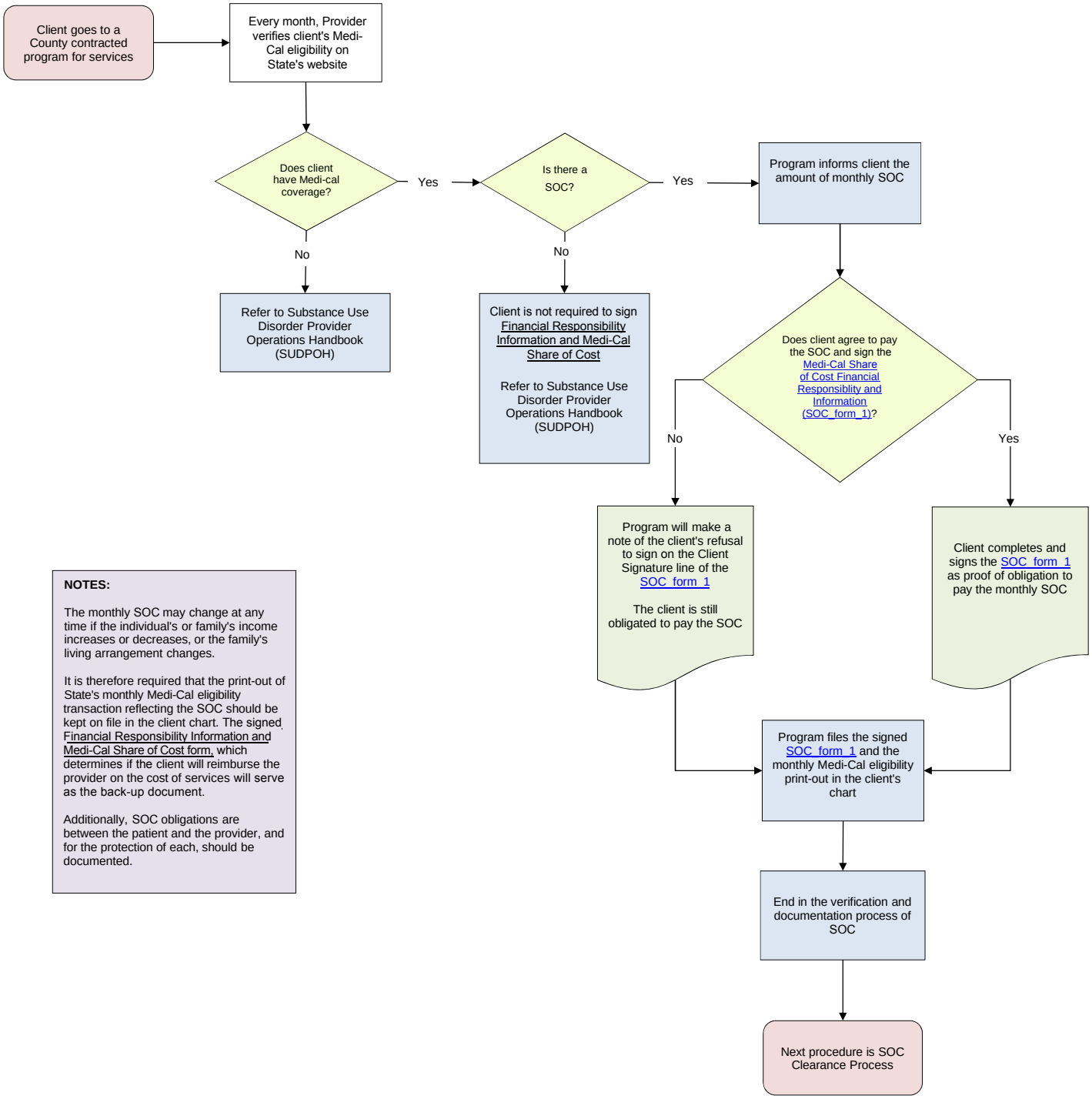
- Forms
  - Medi-Cal Share of Cost Financial Responsibility and Information
  - Services to Meet the Monthly Share of Cost
  - Share of Cost Payment

The implementation date of this new SOC process is February 1, 2019. The County Billing Manual will be updated to include the instructions, flowcharts and forms for the SOC.

Please email ADSBillingUnit.HHSA@sdcounty.ca.gov or fax to (619) 236-1418 if you have questions about this Information Sharing.

For more information about the DMC-ODS, visit our website at www.sandiegocounty.gov/dmc.

Drug Medi-Cal Share of Cost (SOC) Verification Process



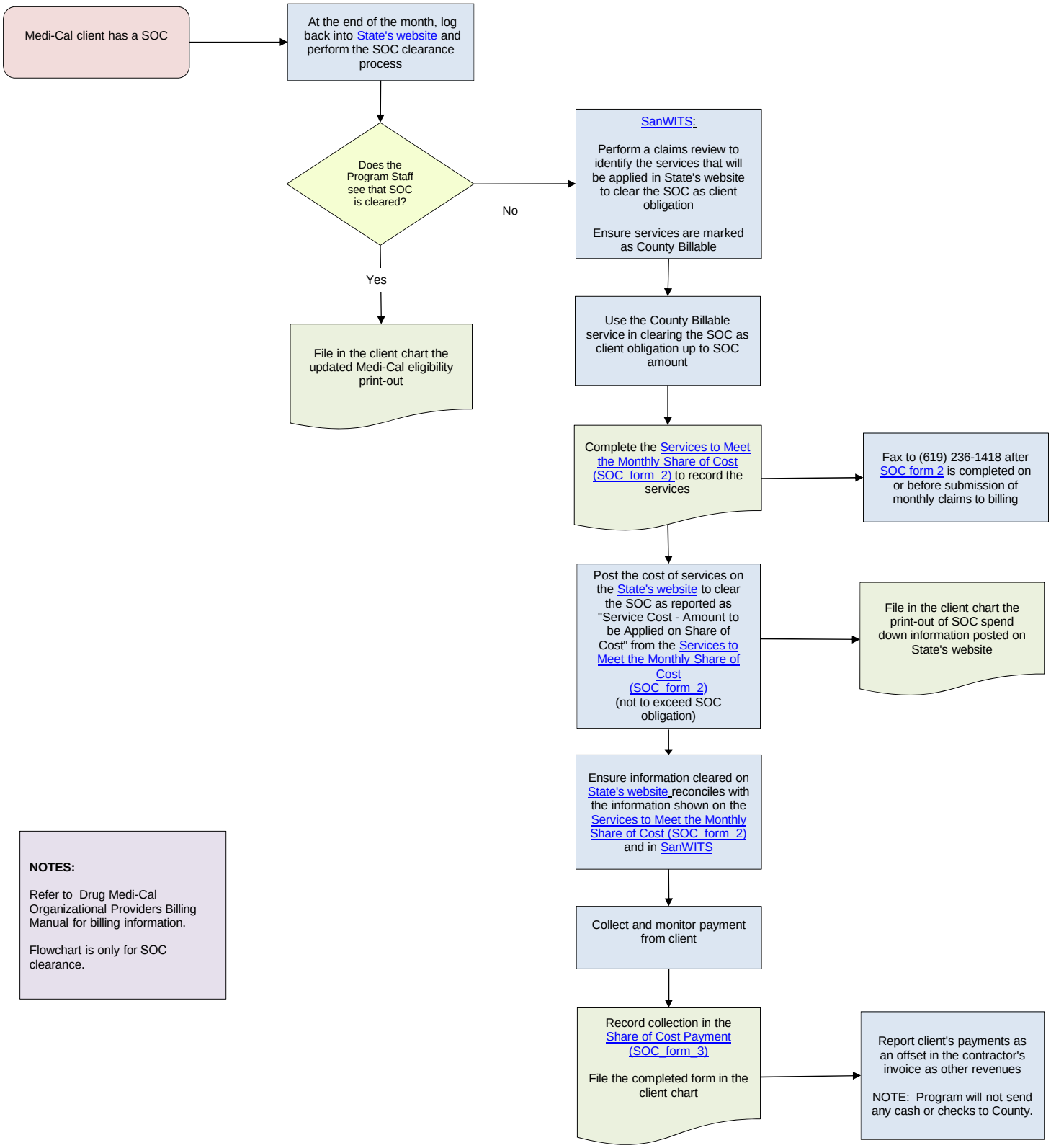
NOTES:

The monthly SOC may change at any time if the individual's or family's income increases or decreases, or the family's living arrangement changes.

It is therefore required that the print-out of State's monthly Medi-Cal eligibility transaction reflecting the SOC should be kept on file in the client chart. The signed Financial Responsibility Information and Medi-Cal Share of Cost form, which determines if the client will reimburse the provider on the cost of services will serve as the back-up document.

Additionally, SOC obligations are between the patient and the provider, and for the protection of each, should be documented.

Drug Medi-Cal Client Obligation Share of Cost (SOC) Clearance Process



FINANCIAL RESPONSIBILITY INFORMATION AND MEDI-CAL SHARE OF COST INSTRUCTIONS

REQUIRED FORM:

This form is a required document in the client file for all San Diego County funded Substance Use Disorder programs.

WHEN:

Completed upon admission for all clients and monthly for clients with a Medi-Cal Share of Cost (SOC). **Reminder:** Programs must verify all clients' Medi-Cal eligibility along with any applicable SOC on a monthly basis. For additional information, refer to the **DMC Eligibility Printout** instructions in Section 1 of the Substance Use Disorder Utilization Review Management (SUDURM).

> ***Note:*** *If a client received DMC services **prior to** becoming Medi-Cal eligible, staff must inform the client to request an evaluation for retroactive Medi-Cal and assist client with applying for retroactive Medi-Cal benefits as needed. Staff should also check Medi-Cal eligibility for the prior month(s) when Drug Medi-Cal service(s) were received to verify if those services may be billed to DMC, now. (For example: Client was admitted into program 10/25/2018 with no health coverage and began receiving services during this time. On 11/15/2018, client receives a letter of approval for Medi-Cal with an effective date of 11/01/2018. Since the client received services prior to 11/01/2018, the counselor and client contact a Medi-Cal Eligibility Worker to request an evaluation for retroactive Medi-Cal for the month of October. The client is later approved for retroactive Medi-Cal for month of October and DMC services received from 10/25/2018 – 10/31/2018 can now be billed to DMC.)*

COMPLETED BY:

Authorized agency representative or client

REQUIRED ELEMENTS:

- **Client's name:** Complete client's first and last name.
- **Parent or authorized representative's name**: If minor, complete name of parent or authorized representative.
- **Do you and/or your family have health coverage:** Circle appropriate yes, no, or N/A answer. If client does not have health coverage, client must be provided a referral to 2-1-1 and Covered California website.
- **If answer is NO, were you provided a referral to 2-1-1 and Medi-Cal or Covered California:** Circle appropriate yes, no, or N/A answer.
- **CalWORKS recipient:** Circle appropriate yes or no answer.
- **Medi-Cal Eligible**: Circle appropriate yes or no answer.
- **Do you currently have Medi-Cal**: Circle appropriate yes or no answer.
    - If answer is YES, complete "For Medi-Cal Recipients" section below
    - If answer is NO, complete "For Non-Medi-Cal Clients" section on page 2

For Medi-Cal Recipients: Complete this section if client answered yes to having Medi-Cal

- **Do you have a Medi-Cal Monthly Share of Cost:** Circle appropriate yes or no answer. If YES, complete the following sections:
    - **Spend Down Amount:** Monthly amount required to meet the Share of Cost
    - **Agreed amount to pay:** Amount client agreed to pay towards the monthly Share of Cost

- **One-time payment due on:** Indicate the amount the client will pay one-time
- **Installment payment plan:** Indicate the amount client will pay and check how often
  - **Daily:** Complete with daily payment amount (if applicable)
  - **Monthly:** Complete with monthly payment amount (if applicable)
  - **Weekly:** Complete with weekly payment amount (if applicable)
  - **Others (please specify):** Complete with other payment amount and specify payment plan (if applicable)
  - **The first payment is due on and the final payment is due on:** Complete with when first and last payments are due

Note: For more information regarding how to handle Share of Cost, please refer to the **BHS Drug Medi-Cal Organizational Providers Billing Manual**.

For Non-Medi-Cal Clients: Complete this section if client answered no to having Medi-Cal

- **Number of dependent(s) on income (including self):** Complete the number of people dependent on the income of the client including self.
- **Gross Family Income (before taxes**): Complete the client's gross family income earned before taxes.
- **Court-ordered revenue and recovery expenses:** Complete total deductions taken for court ordered revenue and recovery expenses. Client may be asked to provide proof of payments.
- **Adjusted Income:** This is gross family income minus court-ordered revenue and recovery expenses.
- **Fee based on sliding scale:** Use the County Sliding Fee Scale to determine the fee. (Located in Appendix E.1 of the Substance Use Disorder Provider Operations Handbook - SUDPOH)
- **Adjusted Fee**: This is the final fee based on client's ability to pay or funding source (e.g., indigent, Medi-Cal eligible, CalWorks, third party pay).
- **Reason for fee adjustment:** This is an explanation of why client's fee was adjusted.
- **Client signature:** Client must sign and date affirming all statements are true and correct.
- **Parent or authorized Representative Signature:** If minor, parent or authorized representative must sign and date.
- **Completed by:** The staff completing or reviewing this form must sign and date.

FINANCIAL RESPONSIBILITY INFORMATION AND MEDI-CAL SHARE OF COST

This form shall be completed upon admission for every client and shall be completed ***monthly*** for clients with a Medi-Cal Share of Cost (SOC).

If the client is seeking treatment without the knowledge or consent of a parent or authorized representative, the information given below should be based only on the client's financial information. If the client is seeking treatment with the knowledge and/or consent of a parent or authorized representative, the information given below should be based on the parent or authorized representative's financial information.

Client's Name: _____

Parent or authorized representative's name: _____

Do you and/or your family have health coverage? ☐YES ☐NO ☐N/A

Were you provided a referral to 2-1-1 and Medi-Cal or Covered California? ☐YES ☐NO

CalWORKS Recipient: ☐YES ☐NO

Medi-Cal Eligible: ☐YES ☐NO

Do you currently have Medi-Cal? ☐YES ☐NO

(If YES, complete "**For Medi-Cal Recipients**" section below. If NO, complete "**For Non-Medi-Cal Clients**" section on page 2.)

For Medi-Cal Recipients

Do you have a Medi-Cal Monthly Share of Cost? ☐YES ☐NO

If YES, complete the following:

Spend Down Amount $_____

Agreed amount to pay $_____

☐ One-time payment due on _____

☐ Installment payment plan

☐ Daily $_____ ☐ Weekly $ _____

☐ Monthly $_____ ☐ Others (please specify) _____ $_____

The first payment is due on _____ and the final payment is due on _____.

NOTE: If it has been determined to require the client to pay a minimum Share of Cost fee, the fee is owed to the program, but no service will be refused due to a client's inability to pay.

For Non-Medi-Cal Clients

Number of dependents on income (*including self*):

_____

Gross Family Income (*before taxes*) $ _____

Court-ordered revenue and recovery expenses $ _____

(Client may be asked to provide proof of payments)

Adjusted income (*gross minus court expenses*) $ _____

Fee based on sliding scale $ _____

Adjusted fee $ _____

Reason for fee adjustment: _____

Indigent Clients

It has been determined to require clients to pay a minimum fee even when indigent, although no service will be refused due to client's inability to pay, the fee is owed to the program.

I affirm that the statements made herein are true and correct to the best of my knowledge:

Client Signature: _____ Date: _____

Authorized Representative Name: _____ Relationship: _____

Signature: _____ Date: _____

Completed by:

Program Staff Name: _____

Signature: _____ Date: _____

Services to Meet the Monthly Share of Cost

Client Name: _____ Client ID: _____

Program: _____ Admit Date: _____

Instructions: Complete this form if you have verified Medi-Cal client has a Share of Cost at the end of the month. Print a copy of the eligibility for your records.

Fax to (619) 236-1418 after completion of this form on or before submission of monthly claims to Behavioral Health Services (BHS) Billing Unit.

A	B	C	D	E	F	G	H
Date	**State's Share of Cost Balance to meet**	**Service Date**	**HCPCS Code**	**SanWITS Total Cost of Service**	**Service Cost - Amount to be applied on Share of Cost**	**Balance (B - F)**	**Program Staff Initials**

Share of Cost Payment Tracking

Client Name: _____ Client ID: _____

Program: _____ Admit Date: _____

Date	Amount Due	Payment Type (Cash, check, money order, etc.)	Amount Paid	Running Balance	Receipt Number	Program Staff Initials