# NORTH SUFFOLK COMMUNITY SERVICES, INC.
## Policy and Procedure

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|---|---|
| **Policy Name: Sliding Fee Schedule** | **Original Date: 1/19/2007** |
| **Policy #: FIN 17** | **Current Review: 06/08/2023** |
| **Prepared By: Judi Lemoine, Senior Vice President, Clinical Operations & Systems Integration Malia Wiley, AR Billing Manager, Sandra Heath, Director of Continuous Quality Management** | **Revision #: 7** |
| **Approved By Damien Cabezas, President & Chief Executive Officer** | **Effective Date: 2/1/ 2013** |

### A. STATEMENT AND PURPOSE OF POLICY:

North Suffolk Community Services (NSCS) does not discriminate upon an individual's ability or inability to pay; whether payment for services would be made under Medicare, Medicaid, or CHIP; or the individual's race, color, sex, national origin, disability, religion, age, sexual orientation or gender identity. Federal requirements prescribe that a locally determined discounted/sliding fee schedule be used for all clients seeking services and that services be provided either at no fee or a nominal fee. Such a fee schedule addresses how to equitably charge clients for services rendered. Discounted/sliding fees are made available to clients meeting family size and income guidelines. If needed clients will be assisted with the application process. Sliding Scale fees are based on current federal poverty guidelines; and eligibility is determined by annual income and family size. As such, these schedules are set to ensure that a non-discriminatory, uniform and reasonable charge is evenly and consistently applied. This is done by discounting the Usual and Customary rate for services based on income and family size using the MassHealth Income Standards and Federal Poverty Level Guidelines. No client will be turned away due to inability to provide proof of residency. Clients are not required to maintain a fixed address.
All billing regardless of payer is set at the usual and customary full charge.
Client fees are defined as:

- fees charged for services for clients who have no insurance (including no Medicaid or Medicare or access to other State-funded payer-of-last-resort funds);
- co-pays and deductibles required by Medicare or private insurance;
- Fees due to insurance benefit exhaustion that have been set and agreed to be paid by the client or responsible party according to the Agency's fee scale.

In order to ensure that the Agency plans and conducts all client financial assessments properly and fairly, NSCS will comply with all pertinent laws and regulations, including:

- Department of Public Health (DPH)/Bureau of Substance Abuse Services (BSAS) Payer of Last Resort Policy (effective 7/1/10)
- Chapter 58 of the Acts of 2006 – "An Act Providing Access to Affordable, Quality, Accountable Health Care"
- Massachusetts Regulation 114.3 CMR 46.00 Rates for Certain Substance Abuse Programs

### B. SCOPE:

This policy applies to all Ambulatory Care service programs and service departments (Records, Reception, and Accounts Receivable) of the Agency, to all individuals and communities served by those programs, and to all staff, contract employees and volunteers working in those programs.

## C. ADMINISTRATION:

All staff and management under the supervision of the Executive Leadership team implement this policy, and accompanying procedures. Reviews of implementation are conducted as part of ongoing continuous quality management processes implemented by the Executive Leadership team, Continuous Quality Management department, and management, under the direction of the President & Chief Executive Officer.

## D. PROCEDURE:

This Client Financial Assessment Policy is designed for all clients including clients with no insurance (no Medicaid or Medicare or access to other State-funded payer-of-last-resort funds); co-pays and/or deductibles required by Medicare or private insurance; any fees due to insurance benefit exhaustion that have been set and agreed to be paid by the client or responsible party according to the Agency's private payment schedule. Where another adult is defined as the "responsible party" for financial obligations, this policy and procedure refers to the responsible party where it indicates "client".

Insurance coverage, method of payment and party responsible for payment of deductibles, co-pays, and/or private fees and the amounts of payments are determined prior to every client's initial evaluation visit. This information is gathered by Central Intake. If the client is seeking substance use, abuse or addiction treatment and is a Massachusetts resident, the intake staff in collaboration with Accounts Receivable staff will conduct an Agency Client Financial Assessment Attachment (1) and the DPH/BSAS contract is utilized, a copay is assessed based on family size and income using the Masshealth Income Standards and Federal Poverty Guidelines which assess income based on family size as outlined below.

**2023 MassHealth Income Standards and Federal Poverty Guidelines**

| Family Size | MassHealth Income Standards | | 100% Federal Poverty Level | | 133% Federal Poverty Level | | 150% Federal Poverty Level | | 190% Federal Poverty Level | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Monthly | Yearly | Monthly | Yearly | Monthly | Yearly | Monthly | Yearly | Monthly | Yearly |
| 1 | $522 | $6,264 | $1,215 | $14,580 | $1,616 | $19,392 | $1,823 | $21,876 | $2,309 | $27,708 |
| 2 | $650 | $7,800 | $1,644 | $19,728 | $2,186 | $26,232 | $2,466 | $29,580 | $3,123 | $37,476 |
| 3 | $775 | $9,300 | $2,072 | $24,864 | $2,756 | $33,072 | $3,108 | $37,296 | | |
| 4 | $891 | $10,692 | $2,500 | $30,000 | $3,325 | $39,900 | $3,750 | $45,000 | | |
| 5 | $1,016 | $12,192 | $2,929 | $35,148 | $3,895 | $46,740 | $4,393 | $52,716 | | |
| 6 | $1,141 | $13,692 | $3,357 | $40,284 | $4,465 | $53,580 | $5,035 | $60,420 | | |
| 7 | $1,266 | $15,192 | $3,785 | $45,420 | $5,035 | $60,420 | $5,678 | $68,136 | | |
| 8 | $1,383 | $16,596 | $4,214 | $50,568 | $5,604 | $67,248 | $6,320 | $75,840 | | |
| For each additional person add | $133 | $1,596 | $429 | $5,148 | $570 | $6,840 | $643 | $7,716 | | |

These figures are rounded and may not reflect the figures used in program determination. Institutional Income Standard is $72.80.

| Family Size | 200% Federal Poverty Level | | 225% Federal Poverty Level | | 250% Federal Poverty Level | | 300% Federal Poverty Level | | 400% Federal Poverty Level | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Monthly | Yearly | Monthly | Yearly | Monthly | Yearly | Monthly | Yearly | Monthly | Yearly |
| 1 | $2,430 | $29,160 | $2,734 | $32,808 | $3,038 | $36,456 | $3,645 | $43,740 | $4,860 | $58,320 |
| 2 | $3,287 | $39,444 | $3,698 | $44,376 | $4,109 | $49,308 | $4,930 | $59,160 | $6,574 | $78,888 |
| 3 | $4,144 | $49,728 | | | $5,180 | $62,160 | $6,215 | $74,580 | $8,287 | $99,444 |
| 4 | $5,000 | $60,000 | | | $6,250 | $75,000 | $7,500 | $90,000 | $10,000 | $120,000 |
| 5 | $5,857 | $70,264 | | | $7,321 | $87,852 | $8,785 | $105,420 | $11,714 | $140,568 |
| 6 | $6,714 | $80,568 | | | $8,392 | $100,704 | $10,070 | $120,840 | $13,427 | $161,124 |
| 7 | $7,570 | $90,840 | | | $9,463 | $113,556 | $11,355 | $136,260 | $15,140 | $181,680 |
| 8 | $8,427 | $101,124 | | | $10,534 | $126,408 | $12,640 | $151,680 | $16,854 | $202,248 |
| For each additional person add | $857 | $10,284 | | | $1,071 | $12,852 | $1,285 | $15,420 | $1,714 | $20,568 |

These figures are rounded and may not reflect the figures used in program determination. Institutional Income Standard is $72.80.

If a client is determined eligible for services provided under the DPH/BSAS contract the fee scale below is used to assess the fee for these services: The Usual and Customary rates charged under this contract for an individual receiving these services is 74.84 per clinical hours and 33.66 per group session.

## Sliding Fee Scale for DPH/BSAS Contract Clients

Please note that the difference between the fee scale and the rate scale setting commission rates for individual and group counseling are billed to the Department of Public Health Contracts as indicated by the Payor of Last Resort Policy. The DPH rate for individual is $74.84 per clinical hour and $33.66 per group session. DPH WILL NOT be billed at NSMHA's customary rate, only up to Rate Setting Commission rates. Clients whose income places them at/above the rate setting commission rate are not eligible for DPH subsidy.

| Fees Based on Masshealth Income Standards and Federal Poverty Guidelines | SUBSIDIZED EVALUATION AND INDIVIDUAL TREATMENT (Per Clinical Hour) | SUBSIDIZED GROUP TREATMENT (Charge if per Group Unit: 1.5 hour) |
|---|---|---|
| Less than 100% of Poverty Level | $5.00 | $2.50 |
| 100% of Poverty Level | $10.00 | $5.00 |
| 100-200% of Poverty Level | $25.00 | $12.50 |
| 200-300% of Poverty Level | $40.00 | $20.00 |
| 300-400% of Poverty Level | 60 | 30 |
| Over 400% of Poverty Level | 74.84 | 33.66 |

The client must provide family income documentation to intake or front desk staff. Acceptable sources of family income documentation are but are not limited to the following: 1 month of salary wage stubs, 1 month of unemployment check stubs, 1-month social security check stub, and 1-month disability check stub, copy of bankruptcy notice or a letter (signed by client & preferably notarized) citing client & spouse have no income. A copy of income tax statement cannot be used exclusively, as it represents income earned in the prior year and not current information; however, it can be used to provide proof of the number of dependents. The client must provide proof of address with a copy of recent (within last 2 months) utility bill. The client's Financial Assessment is reviewed every 90 days to determine changes in fiscal or income status in conjunction with updated individual treatment/recovery plans.

If the client has a mental health diagnosis and no insurance, the client will complete the Client Financial Assessment Form Attachment (1) with intake or front desk staff to determine financial eligibility for the discounted fee. Clients are charged based on income using the Masshealth Income Standards and Federal Poverty Guidelines noted above and corresponding fees listed in the Private Pay Fee Scale Grid below. Fees are charged at the Usual and Customary rate for these services and the discounted/sliding fee is applied equally, consistently, on a continuous basis to all recipients of each service location without regard to the particular practitioner that treats them. All potential clients are seen and/or screened regardless of ability to pay, and no client is refused services due to the inability to pay. Eligibility is determined for every clinic client regardless of site/location. Eligibility notice/information will be appropriately displayed at each clinic site. All clients that fall between 100 and 200% of the fee Masshealth Federal poverty guidelines are charged a nominal fee as noted in attachment 3. Clients that fall below 100% of the Masshealth Income Standards may be eligible for services through additional contracts or grant funding.

**Private Pay Sliding Fee Scale**

**Private Pay Fee Payment Plan for Services Listed. Eligibility Requires Financial Assessment be completed**

**Clients that fall below 100% of the Masshealth Income Standards may be eligible for services through additional contracts or grant funding.**

| Internal Paysource # | | | | 8004 | 8005 | 8006 | 8007 | 8008 |
|---|---|---|---|---|---|---|---|---|
| Service Type | Service Code | Description | Usual & Customary Rate | At or lower than 100% of Masshealth Poverty Level Guidelines | Nominal Fee 100-200% of Masshealth Fed Poverty Level Guidelines | 200-300% of Masshealth Federal Poverty Level Guidelines U&C Rate Discount 50% | 300%-400% of Masshealth Federal Poverty Level Guidelines U&C Rate Discount 40% | Over 400% of Masshealth Poverty Level Private Pay Fee U&C Rate Discount 30% |
| Diagnostic Services | | | | | | | | |
| | DE | Interview (age 21 and over) | $210.00 | No Fee | $ 52.50 | $ 105.00 | $ 126.00 | $ 147.00 |
| **Therapy Services** | | | | | | | | |
| **Individual Therapy** | IT30 | Individual Therapy Brief **16-37 mins.** | $90.00 | No Fee | $ 22.50 | $ 45.00 | $ 54.00 | $ 63.00 |
| | IT45 | Individual Therapy **38-52 mins.** | $125.00 | No Fee | $ 31.25 | $ 62.50 | $ 75.00 | $ 87.50 |
| | IT60 | Individual Therapy Extended **53-60 mins.** | $165.00 | No Fee | $ 52.50 | $ 82.50 | $ 99.00 | $ 115.50 |
| **Consultation Services** | | | | | | | | |
| | CC | Case Consultation **Per 15 mins** | $75.00 | No Fee | $ 18.75 | $ 37.50 | $ 45.00 | $ 52.50 |
| | FC | Family Consultation -**Per 15 mins** | $47.00 | No Fee | $ 11.75 | $ 23.50 | $ 28.20 | $ 32.90 |
| | CC1 | Collateral Contact- **Per 15 mins** | $27.00 | No Fee | $ 6.75 | $ 13.50 | $ 16.20 | $ 18.90 |
| | BC60 | Inpatient Bridge Consult | $200.00 | No Fee | $ 50.00 | $ 100.00 | $ 120.00 | $ 140.00 |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Family/Group Therapy** | | | | | | | | |
| | FT | Family Therapy (includes couples) | **$150.00** | No Fee | $ 37.50 | $ 75.00 | $ 90.00 | $ 105.00 |
| | FTWO | Client | **$140.00** | No Fee | $ 35.00 | $ 70.00 | $ 84.00 | $ 98.00 |
| | GT | Group Therapy | **$60.00** | No Fee | $ 15.00 | $ 30.00 | $ 36.00 | $ 42.00 |
| | GT90 | Group Therapy | **$75.00** | No Fee | $ 18.75 | $ 37.50 | $ 45.00 | $ 52.50 |
| **Recovery Support Services** | | | | | | | | |
| | RC | Recovery Coach Services **Per 15 Mins** | **$16.97** | No Fee | $ 5.00 | $ 8.49 | $ 10.18 | $ 11.88 |
| | RSN | Recovery Support Navigator Services **Per 15 Mins** | **$13.97** | No Fee | $ 5.00 | $ 6.99 | $ 8.38 | $ 9.78 |
| **Evaluation And Management** | | | | | | | | |
| | M201 | E&M Minimal Complexity 10 Minutes New Client | **$65** | No Fee | $ 16.25 | $ 32.50 | $ 39.00 | $ 45.50 |
| | M202 | E&M Low Complexity 20 Minutes New Client | **$105.00** | No Fee | $ 26.25 | $ 52.50 | $ 63.00 | $ 73.50 |
| | M203 | E&M Minor Complexity 30 Minutes New Client | **$150.00** | | $ 37.50 | $ 75.00 | $ 90.00 | $ 105.00 |
| | M204 | E&M Moderate Complexity 45 Minutes New Client | **$225.00** | No Fee | $ 56.25 | $ 112.50 | $ 135.00 | $ 157.50 |
| | M205 | E&M High Complexity 60 Minutes New Client | **$275.00** | | $ 68.75 | $ 137.50 | $ 165.00 | $ 192.50 |
| | M211 | E&M Minimal Complexity 5 Minutes | **$30.00** | No Fee | $ 7.50 | $ 15.00 | $ 18.00 | $ 21.00 |
| | M212 | E&M Low Complexity 10 Minutes | **$65.00** | No Fee | $ 16.25 | $ 32.50 | $ 39.00 | $ 45.50 |
| | M213 | E&M Minor Complexity15 Minutes | **$110.00** | No Fee | $ 27.50 | $ 55.00 | $ 66.00 | $ 77.00 |
| | M214 | E&M Moderate Complexity 25 Minutes | **$160.00** | No Fee | $ 40.00 | $ 80.00 | $ 96.00 | $ 112.00 |
| | M215 | E&M High Complexity 40 Minutes | **$225.00** | No Fee | $ 56.25 | $ 112.50 | $ 135.00 | $ 157.50 |
| **Medication Services** | | | | | | | | |
| | IMI | Intramuscular Injection | **$30.00** | No Fee | $ 7.50 | $ 15.00 | $ 18.00 | $ 21.00 |
| **Psychiatric Day Treatment** | | | | | | | | |
| | DY60 | Psychiatric Day Treatment **Per hour** | **$20.00** | No Fee | $ 5.00 | $ 10.00 | $ 12.00 | $ 14.00 |
| | SOAP | Adult "Motivational SOAP" **Per 3.5 hours** | **$175.00** | No Fee | $ 43.75 | $ 87.50 | $ 105.00 | $ 122.50 |
| | DYPA | Day Treatement Preadmission Evaluation **Per Hour** | **$40.00** | No Fee | $ 10.00 | $ 20.00 | $ 24.00 | $ 28.00 |
| **Emergency Services** | | | | | | | | |
| | UC | Urgent Outpatient Services/ Psychotherapy for Crisis | **$171.13** | No Fee | $ 42.78 | $ 85.57 | $ 102.68 | $ 119.79 |
| **Telephonic Services** | | | | No Fee | | | | |
| | NPPE | NON PHY TELEPHONE EVAL 5-10 Mins | **$20.00** | No Fee | $ 5.00 | $ 10.00 | $ 12.00 | $ 14.00 |
| | NPP2 | NON PHY TELEPHONE EVAL 11-20 Mins | **$35.00** | No Fee | $ 8.75 | $ 20.00 | $ 24.00 | $ 28.00 |
| | NPP3 | NON PHY TELEPHONE EVAL 21-30 Mins | **$45.00** | No Fee | $ 11.25 | $ 22.50 | $ 27.00 | $ 31.50 |
| | PHPE | PHY/PROF TELEPHONE EVALU 5-10 Mins | **$100.00** | No Fee | $ 25.00 | $ 50.00 | $ 60.00 | $ 70.00 |
| | PPE2 | PHY/PROF TELEPHONE EVALU 11-20 Mins | **$145.00** | No Fee | $ 36.25 | $ 72.50 | $ 87.00 | $ 101.50 |
| | PPE3 | PHY/PROF TELEPHONE EVALU 21-30 Mins | **$180.00** | No Fee | $ 45.00 | $ 90.00 | $ 108.00 | $ 126.00 |
| **Community Support Services** | | | | No Fee | | | | |
| | CSP | Community Support Services per 15 minute Unit | **$20.00** | No Fee | $ 5.00 | $ 10.00 | $ 12.00 | $ 14.00 |

In addition to the Financial Assessment and determination of the client fee the Clinic Staff will provide the client with the necessary information to assist them in completing enrollment in eligible insurance coverage and assistance will be provided with the application process when needed.

If a client begins treatment with an identified insurance payer (or Medicaid, Medicare, private insurance, or a State payer), but the payer discontinues payment for any reason, the Accounts Receivable Department notifies front desk staff who in turn notifies the client and clinician (all communication via email to preserve a record). If the client and clinician agree in collaboration with the Clinical Manager that further treatment is needed, front desk staff are notified by the clinician, the front desk staff review the private pay fee schedule with the client, and the client signs an agreement to pay. If the client indicates that he/she is unable to pay, income documentation needed is forwarded to Accounts receivable staff, an Agency Client Financial Assessment is completed, as indicated above, and a payment plan is established, in which established fees are paid at a rate which the client can afford.

If a client has not paid his/her co-pay, deductible or private pay fee in full for two visits, or his/her private pay fee in full at the first visit, the front desk staff interview the client and determines the reason for the client's non-compliance. The front desk staff inform the clinician if the client fails to provide appropriate income documentation prior to his/her next appointment. The front desk staff also inform the clinician if the client refuses to pay for co-pays, deductibles and approved Private Payment fees for reasons unrelated to financial ability.

A payment plan can be developed to enable the client to continue treatment. The AR Department staff contacts the client and works out a payment plan for deductible and private payment fees. The client must agree to the payment plan and sign the Client Financial Assessment Form.

Should the client refuse to sign a payment plan or be non-compliant in payment of co-pays, deductibles and private pay fees after execution of the payment plan, the front desk staff notifies the treating clinician, Clinical Manager and AR via email.

Any significant changes occurring in the client's clinical or financial status are communicated to appropriate parties, and the fee assessment is amended accordingly using the sliding fee scale.

**E. DISTRIBUTION:**
This Policy Procedure located on the NSCS intranet and is distributed to all Senior Managers, Multi-Site Office Manager / FTC Office Manager and staff who have responsibility for Ambulatory Care Programs.

**F. REVISIONS AND REVIEWS:**
Revisions are conducted annually, as indicated above, under the direction of the CEO and Executive Team.

**G. CROSS-REFERENCE RELEVANT POLICIES**

**H. ATTACHMENTS:**

| NSCS APPROVALS: | SIGNATURE | DATE |
|---|---|---|
| **PERSONNEL** | | |
| 1. **Approved by CEO/Designee** |  | 6-12-23 |
| 2. **Approved by the Board of Directors if applicable** | | |

**Client Financial Assessment Form**

## ATTACHMENT #1

### Client Financial Application/Assessment Form

It is the intention of NSCS to provide essential services regardless of the individual's ability to pay. Fee Schedule are based upon family income and size. Please complete the following information to determine if you or members of your family are eligible for a discount. The discount will apply to all services received at this clinic, but not those services which are purchased from outside, including reference laboratory testing, drugs and other such services. In the hope that your financial situation improves, discounts apply only to current, not future services. This form will be evaluated at a minimum of every 90 days. Please inquire at the front desk if you have questions.

**PREPARED BY OFFICE MANAGER:**

**CLIENT NAME:** _____ **CLIENT #:** _____

**LOCATION:** _____ **PROGRAM:** _____

**INCOME DOCUMENTATION:**
**(Client & spouse, if applicable)**

_____ **One Month-Salary Wage Stubs**
_____ **One Month-Unemployment Check Stubs**
_____ **One Month-Social Security Check Stub**
_____ **One Month-Disability Check Stub**
_____ **Bankruptcy Notice**
_____ **Client Letter**
_____ **Income Tax Statement **Year _____**
**(Only for documentation of dependents)**

**SPOUSE INCOME:** _____ **Yes** _____ **No** **NUMBER OF DEPENDENTS:** _____

**PROOF OF ADDRESS:** _____ **Received**

**CLIENT ADDRESS:** _____ **TELEPHONE:** _____
**(Not a PO Box)**

_____
_____

**COPY TO CLINICIAN (please list clinician name):**

_____

**APPROVED BY:** _____ **PAYMENT PLAN AMOUNT: $** _____
**(Office manager)** **(See payment plan schedule)**

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**COMPLETED BY CLIENT:**

**I, _____, having provided accurate income documentation and address confirmation, accept the approved payment plan that was developed for payment of my co-pays, deductible and approved assessed fees. I agree to pay the payment plan amount of $ _____ at the time of visit. In understand that non-payment of this payment plan amount could result in the termination of treatment by my clinician.**

**CLIENT SIGNATURE:** _____ **DATE:** _____