





BEHAVIORAL HEALTH SERVICES

UMDAP (Uniform Method of Determining Ability to Pay) Guide
September 2022

Presented by
Patient Accounts Unit
Behavioral Health Services Billing
1380 Howard Street
San Francisco, CA 94103



BACKGROUND AND PURPOSE

UMDAP = Uniform Method for Determining Ability to Pay

The UMDAP Fee Schedule was designed by the stakeholders, who anticipated a larger role for government spending, especially in terms of Mental Health. It was written to accommodate inflationary economic growth, increase in cost-of-living including monthly Share Of Cost (SOC) for Medi-Cal recipients that would tie into various other factors. That is why, the fee is based on income and the number of people who depend on that income.

The UMDAP Fee Schedule is based on the California Tax Schedule Rate; despite many changes in California public mental health system since 1991, the UMDAP process is still a valid statutory requirement and remains unchanged. It is also known as Sliding Fee Scale and is aligned with the Federal Poverty Level (FPL) Guidelines.

The determining process requires Client's Income, Assets, Allowable Expenses and Household Size. Note that is how the logic is incorporated in Avatar CalPM >> Family Registration Form to have the system auto-calculate the UMDAP amount.



UMDAP VS. SHARE OF COST

Clients are normally charged the cost of services. An UMDAP Sliding Fee amount is determined if they are unable to pay their Service Cost amounts. Note that the County can only charge the Client the cost of services received or their UMDAP amount, **whichever is less**. In other words, Clients are charged up to their annual UMDAP amount. Once UMDAP is determined, the counties are not authorized to bill the Client for their monthly SOC. For example, if the client has a \$200 SOC per month and an annual UMDAP of \$100, we are only authorized to bill them \$100 for the year because UMDAP is the lesser amount.

It is against Federal laws, State regulations, and the BHS (formerly known as CBHS) Code of Conduct to automatically waive or reduce Patient Fees payable.

Being able to pay 'something' often gives the client a sense of being a valued member of the society. Also, it helps make the program viable by offsetting County Fund.



MEDI-CAL SHARE-OF-COST (SOC)

“Share of Cost” is the amount you agree to pay for health care before Medi-Cal starts to pay. This is called “meeting your share of cost.” Your Share of Cost is a set amount based on how much money you make. The more money you make, the higher your Share of Cost is. You only need to meet your Share of Cost in the months that you get health care services. After you meet your share of cost, Medi-Cal pays for your care the rest of that month. It is like a monthly deductible.

Monthly Cost	Yearly Service Cost	Monthly SOC	Yearly SOC	UMDAP
\$ 1,200.00	\$ 14,400.00	\$ 500.00	\$ 6,000.00	\$ 120.00



WHY MEDI-CAL SOC IS SO IMPORTANT?

UMDAP is not the same as the Medi-Cal Share-of-Cost. The Billing Staff clear or spend down their Clients' SOC amounts by using the actual Services received by the Client. The cost of these services is what the Client is required or, is obligated to pay to the Provider. For this reason, SDMC requires the SOC amounts cleared to be reported as the "Patient Paid" amount on SDMC claims. The remaining balance amount (Total Service Cost less "Patient Paid" amount) is what Medi-Cal will cover. The Service amounts used for clearing the Client's SOC is compared to the Client's UMDAP. The Client is charged the lesser of these two amounts; usually their UMDAP.

Under State Regulations, BHS Providers still have the option to adjust their Clients' UMDAP to whatever amount they determine the Client can pay and with the approval from their Program Director/ Manager.



DEPARTMENT OF HEALTH CARE SERVICES GUIDELINES

The CA Department of Health Care Services (DHCS) and the Welfare & Institutions (W&I) Code requires an annual PFI (Patient Financial Information)/UMDAP to be completed for all Mental Health Clients in order to continue to receive services from Behavioral Health Services (BHS), formerly known as CBHS Providers. Note the EGI (Episode Guarantor Information) form in Avatar CalPM system is equivalent to PFI.

According to Title 9, Section 5750 and 5718, and under the W&I Code, it is the responsibility of all Mental Health and Substance Abuse Disorders Programs to determine Clients' eligibility for Medi-Cal benefits and other entitlements so that Providers may assist Clients to obtain these entitlements. If the Client is unable to pay monthly Medi-Cal share of cost amount determined by county welfare department, (i.e.: Human Services Agency of SF, also known as DHS-Department of Human Services), the Clinicians are empowered to offer them Sliding Fee Scale, i.e.: UMDAP, and provide a "Therapeutic Adjustment" so that these Clients are not financially traumatized. But such adjustments must be documented in progress notes in case of an audit.

Authority cited: Section 5750, Welfare and Institutions Code. References: Sections 5717 and 5718, Welfare and Institutions code.



FINANCIAL ASSESSMENT FACTORS

1. Gross Monthly Income (Include all in the Household):	Amount
A) Monthly Income you receive?	\$
B) What is your Parent's/ Spouse or Domestic Partner's Income?	\$
C) What is the income of other people who support you?	\$
2. How many people are in your household? (Number of Family Members Dependent on Income)	
3. Asset Amount (List all liquid assets)	
A) How much Money do you have in the Bank?	\$
B) Do you have other Assets that you can convert to Cash? If yes, what is the value?	\$
4. Allowable Expenses (To be deducted)	
A) Do you have any monthly Court Ordered payments?	\$
B) Monthly Child Care Payments (Only if needed for employment)	\$
C) Monthly Dependent Support Payments	\$
D) Monthly Medical Expense Payments (In excess of 3% gross income)	\$
E) Monthly Mandated Deductions for Retirement Plan (Social Security not included)	\$
5. Annual UMDAP Amount per DMH Sliding Fee Schedule	\$
6. Total Monthly UMDAP Amount	Therapeutic Adjustment Made
NOTE: Patient Fee Adjustment Amount and Reason(s) must be documented in Client's Progress Note. The adjusted UMDAP amount must be approved by the Clinic Program Director/ Manager.	
	\$



FAMILY REGISTRATION FORM

The screenshot shows a web-based form for family registration. On the left, there is a navigation menu with 'Family Registration' selected, and a 'Submit' button. Below the menu are several icons for actions like adding, deleting, and favoriting. The main form area contains several input fields: 'Family Name' (with a red label and a yellow location pin icon), 'Family's Address - Street', 'Family's Address - Street 2', 'Family's Address - Zipcode', 'Family's Address - City', 'Family's Address - State' (a dropdown menu), 'Family Activation Date' (with a date picker showing '09/01/2012' and 'T'/'Y' buttons), and 'Inhibit Billing By Mail' (with radio buttons for 'Yes' and 'No').

Enter **LASTNAME, FIRSTNAME MI** in the **Family Name** field and complete the address info too.

This would help to look for the Client by LASTNAME, FIRSTNAME in the future.



FAMILY REGISTRATION FORM >> UMDAP Information tab

Financial Liability – This field requires Client’s or Responsible Party’s monthly income amount. The next field labeled as “Gross monthly...” means wages, Social Security OASDI, SSI or SSP, etc. received by each family member. If applicable, income for “Spouse” and/or “Other” family members.

Dependents On Income – Enter family household number (*count all persons, including non-clients, in household*).

Asset Determination - This subsection is about liquid assets (convertible to cash).

Note the data in the grayed fields are system populated. They are not editable fields.

*****Always click **Add New Item** button in order to add a new UMDAP period.** The system would not allow to make retro adjustments if charges are closed. In such cases, please send an email to nanalisa.rasaily@sfdph.org.



FAMILY REGISTRATION FORM >> FAMILY ACTIVATION DATE & UMDAP START DATE

The **Date** field in '**Family Activation Date**' (in the first tab) must match with the '**Start Date of UMDAP Year**' (in the last tab).

Start Date Of Family Membership (in Family Members tab) – The system will only allow you to enter a different year, but not month and day, when you need to add a new member.

The **Client ID #** (in Family Members tab) allows the **Family Account #** to link with the Financial Eligibility record. Thus, when the UMDAP guarantor is added in Financial Eligibility form by the Billing Staff, the annual UMDAP liability will be distributed automatically.

******* If a Client has Medi-Cal Share of Cost benefit and the Family Registration form is not completed with the current UMDAP information, the system will generate monthly Patient Statement with an indication of **Full Pay** on the top right corner of the statement.



FAMILY REGISTRATION FORM >> FAMILY MEMBERS >> END DATE OF FAMILY MEMBERSHIP

The screenshot shows a web interface for family registration. On the left is a sidebar with navigation options: 'Family Registration', 'Family Members' (highlighted), and 'UMDAP Information'. Below these is a 'Submit' button and a set of icons for actions like home, back, forward, refresh, and search. The main area is titled 'Family Membership Information' and contains a table with the following columns: 'Client ID #', 'Family Member Name', '...', 'Date Of ...', 'Age at Time of Data Entry', 'Country Of Or...', and 'Ethnic O...'. Below the table are three buttons: 'Add New Item', 'Edit Selected Item', and 'Delete Selected Item'. At the bottom, there are two input fields: 'Client ID#' and 'End Date of Family Membership'. The 'End Date of Family Membership' field is highlighted with a red box and includes a calendar icon and 'T' and 'Y' buttons.

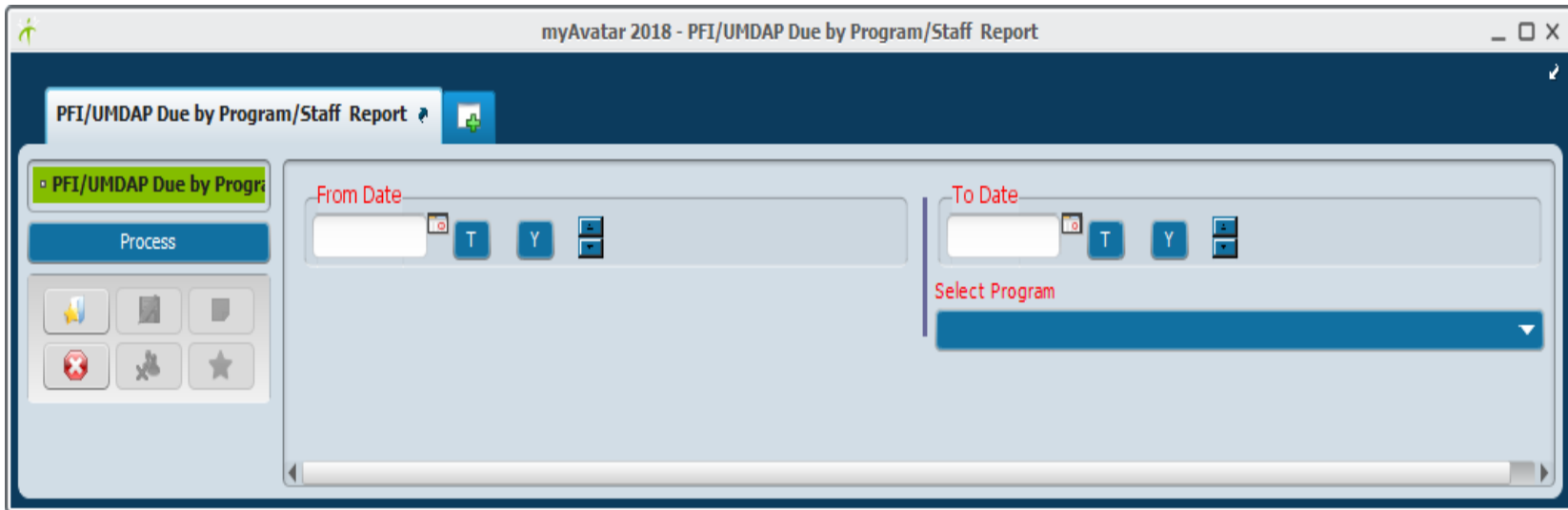
When to enter **'End Date of Family Membership'** and why?

If Clients who have **'Full Scope Medi-Cal'** benefit and are NOT required to complete the financial assessment for **Patient Sliding/UMDAP Fee**.

If you enter **'End Date of UMDAP Year'** as **'End Date of Family Membership'** this would remove the Client's name or PATID from showing up on the **'PFI/UMDAP Due Report by Program'**.



PFI/UMDAP DUE BY PROGRAM/STAFF REPORT



The screenshot shows a web application window titled "myAvatar 2018 - PFI/UMDAP Due by Program/Staff Report". The interface includes a sidebar with a "Process" button and several icons. The main content area has two date selection fields: "From Date" and "To Date", each with a calendar icon and a dropdown menu. Below the "To Date" field is a "Select Program" dropdown menu.

The report is designed to display the client records who's annual UMDAP periods have expired and a new UMDAP period needs to be added in Family Registration form, if the Client is still receiving services at your program. The report should be run a weekly basis to easily track and distribute among the responsible staff.



FULL SCOPE MEDI-CAL AID CODE 6G

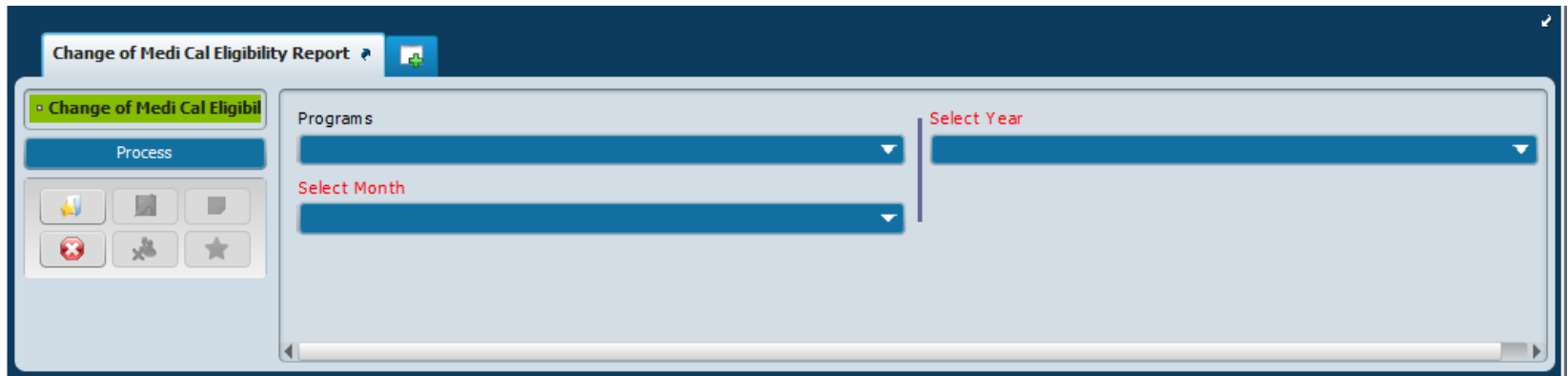
Code	Benefits	SOC	Program/Description
6G	Full Scope	No	250 Percent Program Working Disabled. Provides full-scope Medi-Cal benefits to working disabled recipients who meet the requirements of the 250 Percent Program.

The SOC that shows on client's record is the monthly premium that needs to be paid. This program gives clients who are federally disabled and working the opportunity to be covered by Medi-Cal instead of having a high share of cost as long as they meet the criteria. It is their primary coverage if they don't have Other Health Coverage or Medicare. They are obligated to pay this "premium" monthly unlike share of cost which they don't have to if they did not avail of services in a particular month.

The client is responsible for sending their monthly premium to the State either via US mail or through auto debit (EFT) from their account. Most of the time, such clients have Medicare as their primary and Full Scope Medi-Cal as secondary coverage. The monthly premium amount is usually between \$20-\$250. Thus, do not collect any money from such clients.



CHANGE OF MEDI-CAL ELIGIBILITY REPORT



The screenshot shows a web application interface for generating a "Change of Medi Cal Eligibility Report". The interface includes a title bar, a sidebar with a "Process" button and several icons, and a main content area with three dropdown menus: "Programs", "Select Month", and "Select Year".

The clinic staff needs to run this report on a monthly basis to determine the eligibility status of their clients. If there is a change, a new EGI (Episode Guarantor Information) form needs to be completed in order to notify the Billing Staff.



CHANGE OF MEDI-CAL ELIGIBILITY RESULT



San Francisco Department of Public Health
Community Behavioral Health Services

Change of Medi-Cal Eligibility by Program Report For August 2017

Confidential Patient Information

Epi #	Epi Open Date	Meds ID	Guar	Guar Effective Date	Termination Date	Aid Code	Share of Cost	Other Health Coverage	Elig stat	Elig stat code
65	1/18/2017	[REDACTED]	88	1/1/2017		Before: [REDACTED] Now: 6H		D D	NO ELIG	999
24	6/21/2017	[REDACTED]	88	6/1/2017		Before: M1 Now: M1		A K		1
1	6/14/2017	[REDACTED]	88	6/1/2017		Before: 14 Now: 1H		D D		301
2	12/21/2012	[REDACTED]	88	12/21/2012	4/30/2013	Before: [REDACTED] Now: 37		N N	NO ELIG	999
4	2/27/2015	[REDACTED]	88	2/1/2015	4/30/2015	Before: [REDACTED] Now: 67		D D	NO ELIG	999



HOW TO READ THE CHANGE OF MEDI-CAL ELIGIBILITY RESULT

The **3-digit** status code '**999**', '**791**' and '**691**' in the last column mean that client does not have coverage. The specific letters in the **OHC** (Other Health Coverage) column indicate as follows:

- **A** Applies to any carrier
Note: Services are directly billable to Medi-Cal.
- **D** Medicare Part D Prescription Plan
- **F** Medicare Part C Health Plan
- **H** Multiple Plans Comprehensive
- **K** Kaiser
- **N** No Other Health Coverage
- **P** PPO/PHP/HMO/EPO Private Health Plan



HEALTHY SAN FRANCISCO (HSF)

Healthy San Francisco (HSF) enrollees include working individuals whose Employers chose the City's plan for their employees and SF residents who have signed up for low or no cost healthcare coverage. HSF enrollees have a **Quarterly Participant Fee** depending on their income and FPL (Federal Poverty Level), which is determined at the time of enrollment. Participants who earn less will pay less; Participants who earn more will pay more.

In addition, the enrollees have a **Point-of-Service (POS) Fee** depending on their income that is payable at the time of services are being rendered. HSF enrollees who receive specialty services from BHS providers are assessed a POS fee amount that is different than POS fees charged in Primary Care Clinics because the CA Department of Health Care Services (DHCS) requires BHS to use UMDAP.

Further, DHCS allows SFDPH - BHS to deduct the Clients' HSF Participation Fee (i.e., the annual premium paid for HSF coverage) from their UMDAP annual liability amount. If the HSF participant's FPL is greater than 150%, he/she will be required to set up an UMDAP, and you can deduct the HSF Quarterly Participation Fee from the annual UMDAP liability amount calculated by the family registration form. This adjusted annual UMDAP amount is divided by 12 (months). The resulting amount is the HSF Client's monthly POS fee for BHS services.

Should you have any questions for HSF benefit coverage, please call 415.255.3680.



2022 Uniform Patient Fee Schedule

Annual/Monthly Income Guidelines			MAGI*	Persons Dependent on Income Annual Deductibles				
FPL	Annual	Monthly	Monthly Adjusted Gross Income	1	2	3	4	5 or more
100%	\$ 13,590	\$ 1,133	1100-1149	\$ 140	\$ 126	\$ 113	\$ 102	\$ 92
105%	\$ 14,270	\$ 1,189	1150-1199	\$ 156	\$ 140	\$ 126	\$ 113	\$ 102
110%	\$ 14,949	\$ 1,246	1200-1249	\$ 177	\$ 159	\$ 143	\$ 129	\$ 116
114%	\$ 15,493	\$ 1,291	1250-1299	\$ 200	\$ 180	\$ 162	\$ 146	\$ 131
119%	\$ 16,172	\$ 1,348	1300-1349	\$ 226	\$ 203	\$ 183	\$ 165	\$ 149
123%	\$ 16,716	\$ 1,393	1350-1399	\$ 255	\$ 230	\$ 207	\$ 186	\$ 167
127%	\$ 17,259	\$ 1,438	1400-1449	\$ 288	\$ 259	\$ 233	\$ 210	\$ 189
132%	\$ 17,939	\$ 1,495	1450-1499	\$ 326	\$ 293	\$ 264	\$ 238	\$ 214
138%	\$ 18,754	\$ 1,563	1500-1549	\$ 368	\$ 331	\$ 298	\$ 268	\$ 241
140%	\$ 19,026	\$ 1,586	1550-1599	\$ 416	\$ 374	\$ 337	\$ 303	\$ 173
145%	\$ 19,706	\$ 1,642	1600-1649	\$ 470	\$ 423	\$ 381	\$ 343	\$ 309
150%	\$ 20,385	\$ 1,699	1650-1699	\$ 531	\$ 478	\$ 430	\$ 387	\$ 348



2022 Uniform Patient Fee Schedule

Annual/Monthly Income Guidelines			MAGI*	Persons Dependent on Income Annual Deductibles				
FPL	Annual	Monthly	Monthly Adjusted Gross Income	1	2	3	4	5 or more
154%	\$ 20,929	\$ 1,744	1700-1749	\$ 600	\$ 540	\$ 486	\$ 437	\$ 393
158%	\$ 21,472	\$ 1,789	1750-1799	\$ 678	\$ 610	\$ 549	\$ 494	\$ 445
163%	\$ 22,152	\$ 1,846	1800-1849	\$ 752	\$ 677	\$ 609	\$ 548	\$ 493
167%	\$ 22,695	\$ 1,891	1850-1899	\$ 835	\$ 752	\$ 677	\$ 609	\$ 548
172%	\$ 23,375	\$ 1,948	1900-1949	\$ 927	\$ 834	\$ 751	\$ 676	\$ 608
175%	\$ 23,783	\$ 1,982	1950-1999	\$ 1,029	\$ 926	\$ 833	\$ 750	\$ 675
180%	\$ 24,462	\$ 2,039	2000-2049	\$ 1,142	\$ 1,028	\$ 925	\$ 833	\$ 750
185%	\$ 25,142	\$ 2,095	2050-2099	\$ 1,268	\$ 1,141	\$ 1,027	\$ 924	\$ 832
190%	\$ 25,821	\$ 2,152	2100-2149	\$ 1,407	\$ 1,266	\$ 1,139	\$ 1,025	\$ 923
193%	\$ 26,229	\$ 2,186	2150-2199	\$ 1,562	\$ 1,406	\$ 1,265	\$ 1,139	\$ 1,025
196%	\$ 26,636	\$ 2,220	2200-2249	\$ 1,734	\$ 1,561	\$ 1,405	\$ 1,265	\$ 1,139
200%	\$ 27,180	\$ 2,265	2250-2299	\$ 1,925	\$ 1,733	\$ 1,560	\$ 1,404	\$ 1,264



WHEN IS A NEW EGI, UMDAP/PFI AND/OR CONSENT FOR BILLING REQUIRED?

Authorization to Release Information for Billing and Assignment of Benefits

- PHI requirement, per 42 CFR
- First time
- Annually
- For all Clients across the board (MH and SUD)

Note: The form is signed by the Client or their Responsible Party, to document their consent and authorization to release health information for billing purposes, agreement for coordination of healthcare benefits, and assignment of benefits (i.e., health coverage payments) to the SF Department of Public Health.

EGI (Episode Guarantor Information)/PFI (Payer Financial Information)

- First time
- Annually
- Whenever there is a change of benefit coverage information

Note: Per State Regulations, an EGI must be completed for the Client upon Admission into a MH or SUD treatment program; and, at least annually for Clients who are continuing to receive services from SFDPH - CBHS.

UMDAP/Sliding Fee

- First time and annually (12 months from when it is completed)

Note: If a client has an Out-of-Pocket expense, such as a monthly Medi-Cal Share-of-Cost, Medi-Cal annual deductible and Co-insurance amounts payable, Medi-Medi-SOC, HSF, only Medicare Part B (no Medi-Cal coverage as secondary), Medicare Part C or HMO or Private Insurance coverage, and is unable to pay these amounts, Providers use UMDAP to determine a Sliding Fee amount that the Client or their Responsible Party can pay for services received from CBHS Providers. Mental Health Programs complete the Avatar Family Registration form/screen to enter UMDAP for their Clients.



RESOURCES

Please copy and paste the URLs on your internet browser to view these online documents.

Handling of Patient Payments in BHS Programs

<https://www.sfdph.org/dph/files/CBHSPolProcMnl/2.03-18.pdf>

Uniform Patient Fee Schedule and 2022 FPL Guidelines

https://www.sfdph.org/dph/files/CBHSdocs/BHISdocs/UserDoc/2022_Uniform_Patient_Fee_Schedule.pdf

UMDAP Sliding Fee Scale

<https://www.sfdph.org/dph/files/CBHSdocs/BHISdocs/UserDoc/UMDAPSlidingFeeSchedule.pdf>



QUESTIONS?

Please send your feedback to nanalisa.rasaily@sfdph.org.

Thank you for your participation.

BHS Patient Accounts Billing Unit

