



State of New York
David A. Paterson
Governor

omh Office of Mental Health
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July 29, 2009

Dear Clinic Provider

As you may know, New York State has submitted a federal Medicaid waiver request to establish an indigent care funding pool for mental health clinics that is jointly funded by the state and federal government. Assuming the waiver is approved, the pool would offset a portion of losses from indigent care experienced by:

- a. Diagnostic and Treatment Centers licensed by DOH; and
- b. Mental health clinics licensed by OMH that are not affiliated with hospitals or directly operated by OMH.

For participation in the 2010 pool, 2009 site specific data from Article 31 agencies must be provided by March 31st 2010. The attached overview of indigent care funding for mental health clinics is designed help you understand the rules for the uncompensated care pool and the data that needs to be provided to OMH. It also contains a sample data collection chart. An online data submission form is being developed by OMH. If you have any questions, please feel free to contact us at clinicrestructuring@omh.state.ny.us.

Sincerely,

Norman Brier
Director, Bureau of Financial Planning

Overview of Indigent Care Funding for Mental Health Clinics

July 29, 2009

New York State has submitted a federal Medicaid waiver request to establish an indigent care funding pool for mental health clinics that is jointly funded by the state and federal government. Assuming the waiver is approved, the pool would offset a portion of losses from indigent care experienced by:

- a. Diagnostic and Treatment Centers licensed by DOH; and
- b. Mental health clinics licensed by OMH that are not affiliated with hospitals or directly operated by OMH.

Payments from the indigent care pool will be made in accordance with payment rules established by the OMH and DOH. **For participation in the 2010 pool, 2009 site specific data from Article 31 agencies must be provided by March 31st 2010. In subsequent years, agencies that do not submit annual data for each of their clinic locations by dates to be established by OMH will be excluded from the pool for that year. OMH will be preparing a spreadsheet to facilitate submission of the information as well as a transmittal letter to be submitted which certifies the data. The letter must be signed by the Chief Executive Officer or Executive Director of the agency.**

Periodic partial payments from the pool will be made by the Department of Health. After a transition period for mental health clinics (described below), payments from the pool will be based on annual data from two years prior.

The percent of indigent care paid by the pool is dependent on the total funds in the pool and the total volume of allowable indigent care visits. To be eligible for an allocation of funds from the pool, a mental health clinic must demonstrate that a minimum of five percent of total clinic visits during the applicable period were for visits covered by the indigent care pool.

Mental health clinics qualifying for a distribution from the fund will need to provide OMH with assurances that it undertook reasonable efforts to maintain financial support from community and public funding sources and made reasonable efforts to collect payments for services from third-party insurance payers, governmental payers and self-paying patients. This is subject to audit.

OMH anticipates that visits can be counted toward indigent care volume if they meet the following conditions:

1. Self pay, including partial pay or no pay visits (does not include partial payment associated with co-pays or deductibles). Clinic Plus revenues and visits for comprehensive assessments for non Medicaid populations should be recorded as self pay.

2. Required or optional mental health clinic procedures (as defined in OMH regulations) provided but NOT covered under a clinic's agreement with an insurer. The service must be provided by a practitioner qualified to deliver the service under state regulations.
3. Unreimbursed clinic visits/procedures appropriately provided to an insured recipient by a clinic staff member not approved for payment by a third party payor in contract with the clinic. The provider must document that the clinic or recipient received a denial of payment.
4. Unreimbursed clinic visits/procedures appropriately provided to an insured recipient by a clinic staff member when the procedure is not reimbursed by a third party payer NOT in contract with the clinic. Only visits for which the clinic received a denial of payment from the insurer or an attestation from the client/insured that the insurer made no payment will be considered uncompensated. This documentation must be retained by the clinic and will be subject to an audit by the New York State Office of the Medicaid Inspector General or other party empowered to conduct such audits.

Visits **will not be counted** if they meet the following conditions:

1. Visits paid in whole or part by a third party payer (including Medicaid Managed Care).
2. Visits not authorized (considered not medically necessary) by an insurer/managed care plan.
3. Visits provided to a recipient who has coverage from a third party payer not in contract with the clinic when an insurer **does** reimburse the insured for the visit.
4. Visits delivered by persons unqualified to deliver the services under state regulations.

Transition - Visit Value and Data Collection

The method of pricing indigent care visits and calculating indigent care volume will transition over time as follows:

Indigent Care Value:

1. In 2010, OMH will base indigent care reimbursement on the appropriate peer group Medicaid rate for a 45 minute psychotherapy procedure delivered by an LCSW.
2. In 2011, the indigent care pool rate will be based on the peer group average value of mental health clinic Medicaid APG payments (no blend)¹ for at least the first six months of 2010.
3. In 2012 and after, payments will be based on the current peer group average value of total Medicaid APG payments (no blend).

¹During a transition period, OMH will "blend" a portion of the old Medicaid payment system (COPS and clinic base rates) with a portion of the new Medicaid APG payment. This blend payment will decline each year until it is gone in the 4th year. Indigent care payments will not receive the Medicaid blend payment.

Indigent Care Volume:

1. Indigent Care payments to Art 31 clinics during calendar year 2010 will be based on annualized indigent care visit volume and total care visit volume delivered July 1, 2009 through December 31, 2009.
2. Indigent Care payments to Art 31 clinics during calendar year 2011 will be based on indigent care visit volume and total care visit volume for the period July, 2009 through June, 2010.
3. Indigent Care payments to Art 31 clinics during calendar year 2012 will be based on data as follows:
 - a. Payments to clinics in NYC will be based on data from July, 09 through June, 2010.
 - b. Payments to clinics in the rest of the state will be based on data from calendar year 2010.

Reimbursement Calculation

Clinics must provide eligible indigent care visits equal to 5% of their visit volume to qualify for reimbursement from the pool. Reimbursement is then calculated according to the following schedule. Assuming sufficient funds in the pool, the first 15% of clinic visits (assuming they are uncompensated and qualify for reimbursement) are reimbursed at 50% of their Medicaid value minus self pay revenues received. The second 15% are reimbursed at 75% of their Medicaid value minus self pay revenues received. Eligible visits exceeding 30% are reimbursed at 100% of their Medicaid value minus self pay revenues received. A hypothetical example follows on the next page.

It is important to note, that if the amount of eligible indigent care visits in the pool (D&TC and Article 31) exceeds the funding available in the pool, payments to providers are proportionately reduced.

Supplemental Funding

Should money be made available to OMH, OMH may supplement the distribution providers receive from the joint DOH-OMH indigent care pool.

Hypothetical D&TC/Article 31 Indigent Care Pool Revenue Example

Total Clinic Visits	30,625
Uncompensated Visits	4,900
Uncompensated %	16%

If Uncompensated % is >5%, agency is eligible for Indigent Care Revenue. If Uncompensated is <5%, agency not eligible for participation.

Eligible Costs

Uncompensated Visits	4,900
Medicaid Average Payment ²	\$ 115.00
Uncompensated Cost Base	\$ 563,500

Less: Self-Pay Revenues

Uncompensated Visits	4,900
Self-Pay Revenue Per Visit	\$ 30.00
Self-Pay Revenues	\$ (147,000)
Eligible Uncompensated Cost Base	\$ 416,500

Indigent Care Revenue Projection

Distribution %s	Uncomp %	% Total	Payment %	Indig Care Revenue
1st 15%	15%	93.75%	50%	\$ 195,234
2nd 15%	1%	6.25%	75%	\$ 19,523
>30%	0%	0.00%	100%	\$ -
Total	16%	100.00%	xxx	\$ 214,758

² The peer group Medicaid average payment is the average amount paid for a 45 minute psychotherapy excluding modifiers and MD/NPP supplements

Sample Data Collection Chart

OMH is developing an interim indigent care reporting tool to facilitate the collection of indigent care data. Ultimately, this will be incorporated into the CFR. The following chart contains the fields of information that will likely be requested.

	Agency Name		
	Agency Code		
	Operating Certificate Number		
			Total Visits
			Revenue Earned By Payor
1	Totals from most recent CFR reporting period filed		
	Payors:		
2	Medicaid		
3	Medicaid Managed Care		
4	Child and Family Health Plus		
5	Medicare		
6	Other Private Insurance		
7	Participant Fees- Co-pays and Deductibles		
8	Participant Fees and Accompanying Visits - Not Co-pays		
9	Third Party non-covered services		
10	Third Party - Non-Eligible Licensed Staff		
11	Total Visits and Service Revenue (Sum of lines 2-10)*		
12	Visits eligible for Uncompensated Care Reimbursement (Sum lines 8-10)		
13	Uncompensated Care Visits (Line 12) as Percent of Total Visits(Line 11)		

* Line 11 Visits and Weighted Visits should equal Line 1 Visits and Weighted Visits.

Draft Instructions for the Data Collection Chart

Mental health clinics licensed by OMH that are not affiliated with hospitals or directly operated by OMH must complete and submit this schedule in order to participate in the uncompensated care pool in 2010.

Data in the schedule must be based on date of service rendered and only for services provided during the reporting period. For the purposes of this schedule, a visit is defined as including all procedures provided to a patient on the same day.

In cases where there are multiple payors related to a single service, the data should be provided only for the payor responsible for the largest share of the billed amount.

If there is no reimbursement through insurance or personal ability to pay, the data should be entered on line 8 (Participant fees- not including copays).

Agency Name: The name of the organization (service provider).

Agency Code: The five-digit code assigned to the organization (service provider).

Operating Certificate Number: NYS OMH Outpatient Clinic License #

1. The total visits will be carried forward from CFR Schedule OMH-1, if completed.
2. Enter total visits and revenue for all visits where Medicaid is the major payor.
3. Enter total visits and revenue for all visits where Medicaid Managed Care is the major payor.
4. Enter total visits and revenue for all visits where Child and Family Health Plus is the major payor.
5. Enter total visits and revenue for all visits where Medicare is the major payor.
6. Enter total visits and revenue for all visits where other private health insurance is the major payor.
7. Enter the revenue earned from participant fees related to copays and deductibles. Do not enter visit information on this line.
8. Enter total visits and revenue for all visits where participant fees, not including copays and deductibles, are the major source of reimbursement. This would include partial payments based on personal ability to pay according to a sliding fee schedule and visits and payments associated with Clinic Plus comprehensive assessments for non Medicaid children. Also enter visits for those services where no reimbursement through insurance or personal ability to pay is received.
9. Enter total visits for all visits where you have a contract with the insurance carrier but where insurance will not provide payment due to services not being covered by the policy.
10. Enter total visits for all visits where insurance will not provide payment due to services being provided by licensed staff determined to not be eligible to provide services under the policy.

11. Total visits and service revenues: Sum lines 2-10. The visit figure must match the entries on line 1 when Schedule OMH-1 is completed.
12. Visits eligible for Uncompensated Care Reimbursement: Sum lines 8-10 for visits and weighted visits.
13. Uncompensated Care Visits as percent of Total Visits: (Line 12 divided by line 11) times 100.