STATE OF CALIFORNIA--HEALTH AND WELFARE AGENCY PETE WILSON, GOVERNOR

DEPARTMENT OF MENTAL HEALTH
1600 - 9TH STREET
SACRAMENTO, CA 95814
(916) 654-2378

August 24, 1998

DMH INFORMATION NOTICE NO.: 98-13

TO: LOCAL MENTAL HEALTH DIRECTORS
LOCAL MENTAL HEALTH PROGRAM CHIEFS
LOCAL MENTAL HEALTH ADMINISTRATORS
COUNTY ADMINISTRATIVE OFFICERS
CHAIRPERSONS, LOCAL MENTAL HEALTH BOARDS

SUBJECT: UNIFORM METHOD OF DETERMINING ABILITY TO PAY (UMDAP) BRIEF

The purpose of this information notice is to remind local programs that, despite many changes in the California public mental health system since 1991, the UMDAP process is still a statutory requirement and is generally unchanged.

Counties, providers and consumers have asked what UMDAP is and how it works in relationship to new programs and program reforms. The enclosure to this notice attempts to answer these questions, specifically how UMDAP relates to Phase II of Medi-Cal Consolidation and the proposed relationship to the imminent Healthy Families Program. In addition, Dr. Mayberg has recently agreed that the UMDAP screening process may be waived for Medi-Cal eligibles with no share-of-cost liability.

The Financial Services Committee of the California Mental Health Directors' Association has asked its UMDAP Work Group to continue to review and recommend changes to simplify the process and make it more flexible.

If you have questions or comments on UMDAP, please contact Alan Nakano by phone at (916) 653-8799 or Fax at (916) 653-9269.

Sincerely,

Linda A. Powell

LINDA A. POWELL
Deputy Director
Administrative Services

Enclosure

THE UNIFORM METHOD OF DETERMINING THE ABILITY TO PAY (UMDAP)

What is UMDAP?

UMDAP is a sliding scale of liabilities based on the client's or responsible party's ability to pay for the costs of mental health services provided. Other required activities inherent in UMDAP include billing, accounts receivable maintenance and reporting, and collections and write off.

Authority

The authorization for the Director of the State Department of Mental Health (DMH) to establish the uniform fee schedule is cited under Welfare and Institutions Code (WIC) Sections 5709 and 5710 (Attachment A) and California Code of Regulations (CCR), Title 9, Division 1, Subchapter 3, Article 3, Section 524 (Attachment B). Both state that fees shall be charged in accordance with a uniform fee schedule adopted by the Director of DMH and that fees shall be charged in accordance with the ability to pay, but not in excess of actual costs.

History

The UMDAP System was developed and implemented in State Fiscal Year (SFY) 1972/73 for use by Short-Doyle (SD) funded local mental health and contract providers.

Originally, UMDAP had four fee schedules for different geographic parts of the state. These fee schedules were based on income tax rates and the Federal Bureau of Labor Statistics family budget data which was discontinued in 1982. From 1982-1985, the Consumer Price Index was used to update the regional fee schedules.

Effective July 1, 1985, the fee schedules were revised into a single statewide fee schedule. The single schedule was based on the California Tax Schedule rate and was adjusted for each additional family member's consumption. The DMH developed the fee schedule after obtaining input from county mental health administrators and clinicians.

The last Uniform Fee Schedule (Attachment C) was issued as part of DMH Information Notice No. 89-52 on September 20, 1989. The fee schedule went into effect October 1, 1989 and remains applicable.

During 1993 and 1994, DMH obtained input on the fee schedule through the Financial Services Committee of the California Mental Health Director's Association (CMHDA). No change in the fee schedule resulted.

In 1996, CMHDA established a work group under the Financial Services Committee to recommend UMDAP changes. The UMDAP work group is currently in the midst of identifying and getting concurrence on their suggested changes.

How is UMDAP Applied?

The system is based on an annual sliding scale liability determined by an adjusted gross family income. increases are made for excess liquid assets above an established ceiling while reductions are made for specific extraordinary monthly expenditures. On the reverse of the Payor Financial Information form (PFI) DS 1239 (3/83) (Attachment D) is the calculation format which is the following formula:

Gross Family Income+Excess Net Liquid Assets-Extraordinary Expenses= Monthly Adjusted Gross Family Income

or

GFI+ENLA-EE=MAGFI

The system utilizes a standard financial screening format and a uniform payment schedule. The payment schedule is adjusted for variations in SSI payment standards and changes in the Medi-Cal family budget unit schedules (Attachment E). The last schedule change occurred on October 1, 1989.

Attachment F is an example of a family of three with adjusted gross family income of $1,075. The annual liability is determined to be $101. The client may be billed monthly for 12 months or for the projected period of services. In this example 10 months of service is determined appropriate for this client. The client is to be billed $11 the first month and $10 a month for the remaining 9 months. Or if payments are not made, each $10 may be accumulated and billed unless collections are made or disposition is made of the billing.

What Are Some of the Major UMDAP Policies?

UMDAP policy provides that clients/responsible persons are responsible for payment of the actual cost of care, inclusive of all other resources such as MC and third party payors, up to their annual liability. This policy has successfully withstood the challenge of insurance carriers who have attempted to limit reimbursement to not more than client's share. It also satisfies the MC criteria for the "Nominal Fee Provider" (NFP) exemption to the "Lower of Cost or Charges" (LCC) rule of the Health Care Financing Administration's Provider Reimbursement Manual (HCFA 15-1).

Medicaid laws supersede UMDAP for clients on MC. UMDAP follow the tenet that a client and a family unit may access any or a combination of mental health services for a single predetermined maximum annual liability.

The Federal cost reimbursement principle of LCC would jeopardize much of the state and federal reimbursement that counties now get; however, in DMH Letter 91-20 (Attachment G) it was established that if a provider uses the UMDAP sliding scale charge structure, they would be exempt from this rule as a NFP. The NFP is a provider who charges less than 60% of reasonable cost. Originally, only public providers could qualify but in 1991-92 non-public providers were deemed eligible to qualify as nominal fee providers to be exempt from LCC.

What Methodology is Used to Develop The Uniform Patient Fee Schedule?

The current fee schedule is based on the California Tax Schedule of 11% (effective July 1, 1985) and is reduced by 10% for each additional family member. The Monthly Adjusted Gross Family Income (MAGFI) starts at the public assistance level and generally increases in $50 increments. At the $2,500 level, MAGFI increases in $100 increments. The shaded areas are the UMDAP charges reflected at maintenance need levels for those who are MC eligible but do not apply for MC.

The UMDAP system requires counties/providers to complete the heading information of the financial screening document and when a client is identified as MC eligible allows the providers to then stop the UMDAP process and then, complete the SD/MC financial screening process. If a client is identified as being SD/MC eligible only after meeting their MC Share of Cost, technically they are not SD/MC eligible and must interface with the UMDAP process. The Director has recently determined that the UMDAP process may be waived for those MC eligibles who have no Share of Cost.

What Are the Current Issues?

CMHDA is currently reviewing UMDAP to make changes to the system. The UMDAP work group has focused on flexibility for the counties within an overall state policy framework. The work group is currently modifying the Fee schedule and how it is to be applied: 1/12th annual liability or allow both?

Our understanding is that HCFA 15-1 has been adopted by the Health Care Financing Administration to apply to public health in general as a control on overall health care expenditures. Only when there are specific exceptions that exempt a particular program do they not apply. The original application came from Medicare laws but since has been widely adopted by Federal and State programs including Medicaid.

Phase II Consolidation- Unless future state legislation specifically exempts new (former fee-for-service MC) clients from UMDAP, the process must be applied. This is to assure compliance with HCFA 15-1 and to allow counties and providers to recoup their actual costs, regardless of the level of their published charges. Otherwise, UMDAP applies up to the time the person is determined MC eligible. Thereafter, the SD/MC financial screening process and the MC billing take precedence.

Healthy Families (Recommendation)- The Healthy Families Program (HFP) will likely be billed through the SD/MC system using a separate and distinct aid code. UMDAP is to apply until the person is determined to be HFP eligible and has enrolled. At this point, the HFP sliding scale enrollment fee structure and the policies and procedures developed for that program, including the co-payments, will apply. Those families that are eligible but do not enroll must follow the UMDAP guidelines and procedures.

services allowable under the Medi-Cal program and rendered to Medi-Cal beneficiaries. Providers under this subdivision shall report to the local mental health program and the local mental health program shall report to the State Department of Mental Health any information required by the department in accordance with procedures established by the Director of Mental Health.

(c) Notwithstanding any other provision of this division or Division 9 (commencing with Section 10000), absent a finding of fraud, abuse, or failure to achieve contract objectives, no restrictions, other than any contained in the contract, shall be placed upon a provider's expenditure or retention of funds received pursuant to this section.

(Amended by Stats. 1991, Ch. 611, Sec. 59. Effective October 7, 1991.)

5706. Notwithstanding any other provision of law, the portions of the county mental health services performance contract which become a contractual arrangement between the county and the department shall be exempt from the requirements contained in the Public Contract Code and the State Administrative Manual, and shall be exempt from approval by the Department of General Services.

(Added by Stats. 1991, Ch. 89, Sec. 174. Effective June 30, 1991.)

5707. Funds appropriated to the department which are designated for local mental health services and funds which the department is responsible for allocating or administering, including, but not limited to, federal block grants funds, shall be expended in accordance with this section and Sections 5708 to 5717, inclusive, except when there are conflicting federal requirements, in which case the federal requirements shall be controlling.

(Repealed and added by Stats. 1991, Ch. 89, Sec. 174. Effective June 30, 1991.)

5708. (a) To maintain stability during the transition, counties that contracted with the department during the 1990–91 fiscal year on a negotiated net amount basis may continue to use the same funding mechanism.

(b) For those counties that contracted with the department pursuant to subdivision (a) with respect to the 1990–91 fiscal year, the negotiated rate mechanism for Short-Doyle Medi-Cal services for those counties shall be continued until a new ratesetting methodology is developed pursuant to Section 5724.

(Amended by Stats. 1992, Ch. 1374, Sec. 35. Effective October 28, 1992.)

5709. Regardless of the funding source involved, fees shall be charged in accordance with the ability to pay for mental health services rendered but not in excess of actual costs in accordance with Section 5720.

(Repealed and added by Stats. 1991, Ch. 89, Sec. 174. Effective June 30, 1991.)

5710. (a) Charges for the care and treatment of each patient receiving service from a county mental health program shall not exceed the actual or negotiated cost thereof as determined or approved by the Director of Mental Health in accordance with standard accounting practices. The director may include the amount of expenditures for capital outlay or the

interest thereon, or both, in his or her determination of actual cost. The responsibility of a patient, his or her estate, or his or her responsible relatives to pay the charges and the powers of the director with respect thereto shall be determined in accordance with Article 4 (commencing with Section 7275) of Chapter 3 of Division 7.

(b) The director may delegate to each county all or part of the responsibility for determining the liability of patients rendered services under a county mental health program other than in a state hospital, and the liability of their estates or responsible relatives to pay the charges, and all or part of the responsibility for collecting the charges. If this responsibility is delegated by the director, the director shall establish and maintain the policies and procedures for making the determinations and collections, and each county to which the responsibility is developed shall comply with the policy and procedures.

(c) The director shall prepare and adopt a uniform sliding scale patient fee schedule to be used in all mental health agencies for services rendered to each patient. In preparing the uniform patient fee schedule, the director shall take into account the existing charges for state hospital services and those for community mental health program services. If the director determines that it is not practicable to devise a single uniform patient fee schedule applicable to both state hospital services and services of other mental health agencies, the director may adopt a separate fee schedule for the state hospital services which differs from the uniform patient fee schedule applicable to other mental health agencies.

(Repealed and added by Stats. 1991, Ch. 89, Sec. 174. Effective June 30, 1991.)

5711. (a) In the case of federal audit exceptions, federal audit appeal processes shall be followed unless the State Department of Mental Health, in consultation with the California Conference of Local Mental Health Directors, determines that those appeals are not cost beneficial.

(b) Whenever there is a final federal audit exception against the state resulting from expenditure of federal funds by individual counties, the State Department of Mental Health or the State Department of Health Services may request the Controller's office to offset the county's allocation from the Mental Health Subaccount of the Sales Tax Account of the Local Revenue Fund by the amount of the exception. The Controller shall be provided evidence that the county has been notified of the amount of the audit exception no less than 30 days before the offset is to occur. The State Department of Mental Health and the State Department of Health Services shall involve the appropriate counties in developing responses to any draft federal audit reports which may directly impact the counties.

(Amended by Stats. 1991, Ch. 611, Sec. 60. Effective October 7, 1991.)

5712. The department shall contract with counties for the funds appropriated to, and allocated by, the department pursuant to paragraph (2) of subdivision (a) of Section 5700 in accordance with the following:

(a) The net cost of all services specified in the contract between the counties and the department shall be financed on a basis of 90 percent state

524. Fee Schedules.

Fees for service to an individual shall be charged in accordance with the ability of the patient or responsible relative to pay, but not in excess of actual costs. Fees shall be charged in accordance with a uniform fee schedule adopted by the Director of the State Department of Mental Health pursuant to this Act.

NOTE: Authority cited: Section 5750, Welfare and Institutions Code. Reference: Sections 5717 and 5718, Welfare and Institutions Code.

HISTORY:

1. Change without regulatory effect (Register 88, No. 3).

525. Auxiliary Personnel.

Each Local Mental Health Service should have sufficient clerical personnel, and such accounting and statistical assistance as may be necessary to maintain adequate records.

NOTE: Authority cited: Section 5751, Welfare and Institutions Code. Reference: Section 5751, Welfare and Institutions Code.

HISTORY:

1. Editorial correction adding NOTE filed 10-26-82 (Register 82, No. 44).

526. Admission Policies.

Each Local Mental Health Service shall have admission policies which shall be in writing and available to the public. Such policies shall include a provision that patients will be accepted for care without unlawful discrimination on the basis of ethnic group identification, color, religion, age, sex, physical or mental disability. This section shall apply to services provided by contract as well as those provided directly by the Local Mental Health Service.

NOTE: Authority cited: Section 11138, Government Code; and Section 5750, Welfare and Institutions Code. Reference: Section 11135, Government Code; and Section 5325.1, Welfare and Institutions Code.

HISTORY:

1. Change without regulatory effect (Register 88, No. 3).

527. Discriminatory Practices.

The Local Mental Health Service shall not employ unlawful discriminatory practices in the admission of patients, assignment of accommodations, employment of personnel, or in any other respect on the basis of ethnic group identification, color, religion, age, sex, or physical or mental disability. This section shall apply to services provided by contract as well as those provided directly by the Local Mental Health Service.

NOTE: Authority cited: Section 11138, Government Code; and Section 5750, Welfare and Institutions Code. Reference: Section 11135, Government Code; and Section 5325.1, Welfare and Institutions Code.

HISTORY:

1. Change without regulatory effect (Register 88, No. 3).

529. Mental Health Advisory Board Composition.

(a) The composition of the Mental Health Advisory Board shall reflect the minority populations found in the county.

(b) Each county shall indicate in the county mental health plan the minority group affiliations of current board members.

(c) Each county shall describe in the plan efforts being made to place presently unrepresented and under-represented minority group members on the Board, including a timetable to achieve equitable representation.

ATTACHMENT C

UNIFORM PATIENT FEE SCHEDULE
COMMUNITY MENTAL HEALTH SERVICES
Effective October 1, 1989

MONTHLY ADJUSTED GROSS INCOME*	PERSONS DEPENDENT ON INCOME ANNUAL DEDUCTIBLES				
	1	2	3	4	5 or more
	MEDI-CAL ELIGIBLE AREA				
0- 569	27	33	30	27	
570- 599	48	36	32	29	
600- 649	45	40	36	32	
650- 699	50	45	41	37	
700- 749	56				
750- 799	63				
800- 849	71	64			
850- 899	79	71	64	58	
900- 949	89	80	72	65	
950- 999	99	90	80	72	
1000-1049	111	100	90	81	
1050-1099	125	112	101	91	
1100-1149	140	126	113	102	
1150-1199	156	140	126	113	
1200-1249	177	159	143	129	
1250-1299	200	180	162	146	
1300-1349	226	203	183	165	149
1350-1399	255	230	207	186	167
1400-1449	288	259	233	210	189
1450-1499	326	293	264	238	214
1500-1549	368	331	298	268	241
1550-1599	416	374	337	303	273
1600-1649	470	423	381	343	309
1650-1699	531	478	430	387	348
1700-1749	600	540	486	437	393
1750-1799	678	610	549	494	445
1800-1849	752	677	609	548	493
1850-1899	835	752	677	609	548
1900-1949	927	834	751	676	608

MONTHLY ADJUSTED GROSS INCOME*	PERSONS DEPENDENT ON INCOME ANNUAL DEDUCTIBLES				
	1	2	3	4	5 or more
1950-1999	1029	926	833	750	675
2000-2049	1142	1028	925	833	750
2050-2099	1268	1141	1027	924	832
2100-2149	1407	1266	1139	1025	923
2150-2199	1562	1406	1265	1139	1025
2200-2249	1734	1561	1405	1265	1139
2250-2299	1925	1733	1560	1404	1264
2300-2349	2136	1922	1730	1557	1401
2350-2399	2371	2134	1921	1729	1556
2400-2449	2632	2369	2132	1919	1727
2450-2499	2922	2630	2367	2130	1917
2500-2599	3275	2948	2653	2388	2149
2600-2699	3482	3134	2821	2359	2285
2700-2799	3695	3326	2993	2694	2425
2800-2899	3915	3524	3172	2855	2570
2900-2999	4139	3725	3353	3018	2716
3000-3099	4370	3933	3540	3186	2867
3100-3199	4607	4146	3731	3358	3022
3200-3299	4850	4365	3929	3536	3182
3300-3399	5099	4589	4130	3717	3345
3400-3499	5458	4912	4421	3979	3581
3500-3599	5830	5247	4722	4250	3825
3600-3699	6214	5593	5036	4532	4079
3700-3799	6610	5949	5354	4819	4337
3800-3899	7018	6316	5684	5116	4604
3900-3999	7438	6694	6025	5423	4881
4000-4099	7870	7083	6375	5738	5164
4100-4199	8314	7483	6735	6062	5456

Above $4200 Add $400 for each $100 additional income.

*Monthly Gross Income after adjustment for allowable expenses and asset determination from computation made on the financial intake form.

**Medi-Cal eligible. The shaded Medi-Cal eligible area identifies income levels presumed eligible if client meets Medi-Cal eligibility requirements. (See back page).

Prepared and published by the California Department of Mental Health in accordance with Sections 5717 and 5718 of the Welfare and Institutions Code.

QUICK REFERENCE

MEDI-CAL ELIGIBILITY

All clients with monthly income at or below the Medi-Cal Family Budget Unit (MFBU) and have assets at or below the asset allowance area are presumed eligible if they meet aid eligibility requirements.

Maintenance need levels by Medi-Cal Family Budget Unit (MFBU) are:

MFBU			
1 - $602	3 - $934	6 - $1,417	9 - $1,825
2 - $750	4 - $1,100	7 - $1,550	10 - $1,959
2 - $934 (Adults)	5 - $1,259	8 - $1,692	

Asset allowances for 1989 are:

Persons		
1 - 2000	4 - 3300	7 - 3750
2 - 3000	5 - 3450	8 - 3900
3 - 3150	6 - 3600	9 - 4050

Aid categories commonly found in community mental health are:

REFUGEE - First 18 months in the U.S.	DISABLED - Meeting federal definition of disability.
AGED - 65 years of age and over.	AFDC - Aid to Family with Dependent Children.

MEDI-CAL SHARE-OF-COST

Persons with an extended treatment prognosis who are within a few hundred dollars of asset allowance and maintenance need levels may be eligible for Medi-Cal with a share-of-cost and/or real or personal property spend down.

For Example: A single 70-year old man would be eligible for Medi-Cal except that his income is too high. He has a $1,000 medical bill. He meets the low asset levels, but his income from retirement is $1,000 per month. His income is $1,000 minus the standard $20 disregard and the $24.90 payment for the Medicare Part B, leaving a "net" of $955.10. His "share-of-cost" for Medi-Cal is $955.10 minus $602 ("need level") or $353.10. Medi-Cal will pay the remainder of the $1,000 medical bill for that month and other months when he obligates the share of cost. He has to submit a Medi-Cal form MC-177 each month he obligates a share of cost above $353.10. His eligibility will be redetermined by Social Services each year.

All persons with property and income within a few hundred dollars of the Medi-Cal limits and are expected to have substantial treatment cost must be referred to Social Services for eligibility determination. Persons on Medi-Cal, SSI or have incomes in the shaded area do not have an annual deductible.

CLIENT INFORMATION

1. Name	Date of Birth	File Number

RESPONSIBLE PARTY INFORMATION

2. Name	Relationship to Client	Date of Birth	Marital Status

3. Address	Telephone Number

4. Veteran	Social Security Number

5. Employer	Position	If not employed, date last worked

6. Employer's Address	Telephone Number

7. Spouse	Address

8. Spouse's Employer	Position	If not employed, date last worked

9. Spouse's Employer's Address	Telephone Number

10. Nearest Relative	Telephone/Address

THIRD PARTY INFORMATION

11. Insurance Company	Address

12. Policy/Group/ID Number	Assignment/Release of Information obtained

13. V.A. Claim Number	Medicare Claim Number

14. Medi-Cal Claim Number	Date referred for Eligibility Determination

PRIOR SHORT/DOYLE TREATMENT

15. Prior Short/Doyle Treatment: Where:	From:	To:

16. Present Short/Doyle Balance	Monthly Payment

PAYOR FINANCIAL INFORMATION

Confidential
Client Information
See W&I Code, Section 5328

FINANCIAL LIABILITY

17. Gross monthly family income: Responsible person _____

Spouse _____

Other _____

18. TOTAL _____

19. Number dependent on income _____

Schedule of Asset Allowances

Persons			
1	$1500	6	$2600
2	$2250	7	$2700
3	$2300	8	$2800
4	$2400	9	$2900
5	$2500	10 or more	$3000

ASSET DETERMINATION

20. List all liquid assets (savings, bank balances, market value of stocks, bonds and mutual savings):

Source _____ Amount: $_____

_____ $_____

_____ $_____

21. Total of liquid assets . . . . . $_____

22. Insert amount from schedule of Asset Allowances . . . . . $_____

23. Total net liquid assets (Deduct line 22 from line 21) . . . . . $_____

24. Divide line 23 by 12 months . . . . . $_____

25. Add lines 18 and 24 . . . . . $_____

ALLOWABLE EXPENSES

26. Court ordered obligations paid monthly . . . . . $_____

27. Monthly child care (necessary for employment) . . . . . $_____

28. Monthly dependent support payments . . . . . $_____

29. Monthly medical expense payments in excess of 3% of gross income . . . . . $_____

30. Monthly mandated deductions from gross income for retirement plans (not Social Security – Allowance made in payment schedule) . . . . . $_____

31. Total allowable expenses (add lines 26 through 30) . . . . . $_____

32. Deduct line 31 from line 25 (adjusted gross income) . . . . . $_____

33. Use line 19 and line 32 to determine the annual liability from Fee Schedule . . . . . $_____

34. Agreed upon payment plan to satisfy the above liability . . . . . $_____

35. Annual liability and service period: From _____ To _____

36. Provider of Financial Information (if other than patient or responsible person)

Name _____ Address _____

37. Adjusted by _____ Reason _____

38. Approved by _____ Date _____

39. *I affirm that the statements made herein are true and correct to the best of my knowledge and I agree to the payment plan as state on line 34.*

▶ _____ _____

Signature of Patient or Responsible Person — Date

40. An explanation of the UMDAP liability was provided.

▶ _____ _____

Signature of Interviewer — Date

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All persons with property and income within a few hundred dollars of the Medi-Cal limits and are expected to have substantial treatment cost must be referred to Social Services for eligibility determination. Persons on Medi-Cal, SSI or have incomes in the shaded area do not have an annual deductible.

EXAMPLE OF UMDAP

The Uniform Fee Schedule (Attachment C) is based on the client's ability to pay and has ascending scale on income above the Medi-Cal Family Budget Unit (MFBU) maintenance need level. The MFBU level is established at the SSI/SSP rate level.

In a family unit of three with an income of $1,075 per month, the client's financial status for UMDAP purposes is established as follows:

Income	$1,075
MFBU level	$ 934
UMDAP Deductible	$ 101

This family unit's obligation to pay the UMDAP deductible is based on adjusted income and ability to pay. Since the family's $101 is an annual deductible, the county/provider may bill the total amount of the bill until collected. However, based on its service plan expectations the family is projected to have services for 10 months and therefore, may pay on a plan of $11 the first month and $10 for the remaining 9 months. If the family has outpatient service units, the billing and payment schedule will look like the following:

Costs of Services	Date of Service	Cumulative Amount of Costs	Cumulative UMDAP Used	Monthly UMDAP To Pay	Amount Paid	Balance Payable
$ 87.50	1/4/97	$ 87.50	$ 87.50	**$ 11.00**		**$ 11.00**
$ 90.00	2/12/97	$ 177.50	$101.00	**$ 10.00**	**< $11.00>**	**$ 10.00**
$ 85.00	3/1/97	$ 262.50	$101.00	**$ 10.00**	**< $10.00>**	**$ 10.00**
$ 82.50	4/3/97	$ 345.00	$ 101.00	**$ 10.00**	**< $ 0.00>**	**$ 20.00**
$ 90.00	5/8/97	$ 435.00	$ 101.00	**$ 10.00**	**<$ 10.00>**	**$ 20.00**
$ 87.50	6/5/97	$ 522.50	$ 101.00	**$ 10.00**	**<$ 15.00>**	**$ 15.00**
$ 82.50 $ 90.00	7/8/97 7/31/97	$ 695.00	$ 101.00	**$ 10.00**	**<$ 15.00>**	**$ 10.00**
$ 85.00	8/15/97	$ 780.00	$ 101.00	**$ 10.00**	**<$ 10.00>**	**$ 10.00**
	8/15/97	Services terminated due to marked improvement				
	9/1/97	$ 780.00	$ 101.00	**$ 10.00**	**<$ 10.00>**	**$ 10.00**
	10/1/97	$ 780.00	$ 101.00	**$ 10.00**	**<$ 10.00>**	**$ 10.00**
	11/1/97	$ 780.00	$ 101.00		**<$ 10.00>**	**$ 0.00**

ATTACHMENT G

STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY PETE WILSON, Governo

DEPARTMENT OF MENTAL HEALTH
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December 20, 1991

DMH LETTER NO.: 91-20

TO: LOCAL MENTAL HEALTH DIRECTORS
LOCAL MENTAL HEALTH ADMINISTRATORS
LOCAL MENTAL HEALTH PROGRAM CHIEFS
COUNTY ADMINISTRATIVE OFFICERS
CHAIRPERSONS, MENTAL HEALTH ADVISORY BOARDS

SUBJECT: Clarification of DMH Letter No. 90-05 and the Federal "Lower of Costs or Charges" (LCC) Reimbursement Principle

REFERENCE: Code of Federal Regulations at 42 CFR 413; Welfare and Institutions Code, Sections 5717 and 5718; Medicare Provider Reimbursement Manual (HCFA 15-1, Chapter 26)

SUPERSEDES: DMH Letter 90-05

EXPIRES: Retain until superseded

The purpose of this letter is to provide additional information regarding the application of the Federal "Lower of Costs or Charges" (LCC) principle to Short-Doyle/Medi-Cal reimbursement as discussed in DMH Letter 90-05. This policy results from careful review of applicable Federal regulations and guidelines by legal counsel in the Department of Mental Health (DMH) and the Department of Health Services (DHS).

I. Sliding Scale Charge Structure

DHS has determined that the Uniform Method of Determining Ability to Pay (UMDAP) is a sliding scale charge structure in accordance with Federal definitions. This determination will likely result in most counties and providers qualifying as "nominal fee" providers and thus probably exempt from LCC in most fiscal years. The Medicare Provider Reimbursement Manual (HCFA 15-1), Chapter 26, Section 2616, reads, in pertinent part, as follows:

> "A public provider . . . with a . . . nominal charge structure will receive payment for items or services furnished Medicare beneficiaries based on reasonable cost. Only a public provider with a . . . nominal charge structure, as defined . . ., is exempted from the lower of costs or charges application . . .. (W)hen a public provider imposes nominal charges for services furnished, a comparison of the provider's aggregate customary charges and aggregate reasonable costs . . . shall be performed to determine the basis for payment. If the comparison substantiates the charges as being nominal, i.e. less than fifty" (now sixty) "percent of reasonable cost, the public provider will be entitled to payment of the reasonable cost for such services. . . . (I)f the aggregate charges are determined to be other than nominal, the provider will receive payment based on the lower of its customary charges or reasonable cost. . . ."
>
> (Note: Public Law 98-369 amended the Social Security Act to change the percentage used for determining nominal charges from 50 percent of costs to 60 percent of costs. The same amendment, and regulations at 42 CFR 413, also allows non-public providers using a nominal charge structure and serving a significant portion of low income patients to request an exemption from LCC).

Please note that "nominal fee" status alone does not guarantee an exemption from LCC. The county/provider must apply for an exemption and must demonstrate that its aggregate customary charges are less than 60 percent of its aggregate reasonable cost using the procedures and conditions contained in HCFA 15-1, Sections 2606.2 D and E.

DHS has made a special point of emphasizing the need for all providers hoping to qualify as nominal fee providers to apply UMDAP consistently to all patients and to actually make an attempt to collect fees due from patients. It is critical that there is evidence that UMDAP has been used as required, and that, if it is determined that some amount should be paid by the patient, an attempt was made to collect. Even though fees may rarely be collected, the attempt to collect is required, or the provider will not qualify as a nominal fee provider.

II. COUNTY-OPERATED PROGRAMS

A. "SB 900" Contract Counties

Prior to Fiscal Year (FY) 1991-92, counties that contracted with this department on a negotiated net amount (NNA) basis under Section 5705.2 of the Welfare and Institution Code (commonly referred to as "SB 900") are, by definition, automatically deemed to be nominal fee providers. The reason is that "SB 900" contracts between counties and the state are "all inclusive" contracts.

The county agreed to serve all persons who need mental health services and who come to the attention of the county. The contract specifies that the county is required to provide mental health services to each and every person within the county needing mental health services, regardless of whether state funding has been exhausted.

This means that, by definition, all persons served by the county mental health program are "contractual" patients, even though some may be full-paying from their own funds or may have third party insurance coverage. Therefore, there are no "noncontractual" patients, and the county is exempt from LCC, since (in accordance with DHS instructions) only "noncontractual" patients may be used in the formula for computing the applicability of LCC.

Beginning in FY 1991-92, former "SB 900" counties must approach LCC in the same way as counties that have been operating under a Short-Doyle Plan, as discussed below. The new "performance contracts" established in AB 1288 (Chapter 89, Statutes of 1991) will be used by all counties, and since a majority of the funding formerly provided by the state has been transferred to the counties and become a local funding source, the "performance contracts" cannot be considered to be "all inclusive" contracts like "SB 900" contracts were.

B. Short-Doyle Plan Counties

County operated programs in counties which operate under a Short-Doyle Plan are not automatically deemed to be nominal fee providers. However, as public providers, such county operated programs can be nominal fee providers if the necessary conditions exist.

Basically, if none of the patients served are either full-paying from their own funds or have any third party insurance coverage, the county operated program will most likely qualify as a nominal fee provider. However, the computation to compare costs and charges will usually have to be done to verify that federal criteria are met, especially if any patients are found to have been full-paying from their own funds or covered for the full amount by third party insurance coverage. The finding of a full-paying or fully insurance-covered patient does not preclude nominal fee provider status, but does indicate that the status must be documented by performing the computations and comparisons in accordance with the provisions of Chapter 26 of HCFA 15-1.

These provisions will remain unchanged for FY 1991-92 and subsequent years and will apply to all counties.

III. CONTRACT PROVIDERS

Contract providers which provide mental health services to patients pursuant to a contract with county mental health services can be nominal fee providers if all necessary conditions are met. A contract provider must either be a "public provider" or a "provider with a significant portion of low income patients" as defined in Section 413.13 of Title 42 of the Code of Federal Regulations.

If a contract provider qualifies under the provisions of 42 CFR 413.13, then the same requirements and analyses apply that are used to determine the status of county operated programs as delineated in II. B. above.

This policy will be applied to all audit findings and appeals for fiscal years prior to 1991-92. Counties should request exemption from LCC, if necessary, at the time of audit or appeal. In FY 1991-92 and subsequent years, the LCC exemption calculations are included in the new automated Short-Doyle/Medi-Cal Cost Report package.

If you have any questions regarding this policy, please contact your Community Program Operations Liaison.

CARL E. RAUSER
Chief Deputy Director
Local Program Operations

cc: California Council on Mental Health
Chief, Community Program Operations Branch
Program Operations Chiefs