January 21, 2004

Dear Outpatient Provider:

During the past decade or more, a number of trends have emerged for mental health providers that are evident nationwide. At the programmatic level, there has been an increased emphasis on accountability, as well as an increased emphasis on quality and performance outcomes. At the financial level, an emphasis on a claims-based system (e.g., Medicaid) has surpassed the reliance on a deficit-based system (e.g., State Aid). The expansion of managed care into the behavioral health field represents an additional factor.

The confluence of the above trends has placed mental health providers in a position of scrutiny and reliance on traditional business practices that many have heretofore not experienced. While increased accountability and quality have been broadly embraced by the mental health community, many providers have been unprepared for the shift to a greater reliance on service revenue. To that end, the enclosed resource documents have been prepared. These documents provide advice and information regarding approaches to moderating expenses, maximizing revenue opportunities, and creating structures, practices and processes that support these goals.

The first document, "Administrative Practices: Advice for Mental Health Programs," provides advice regarding: the creation and use of an effective governance structure; the creation and use of an effective and efficient billing and accounting system; compliance with Medicaid requirements; the establishment of sufficient fee schedules; productivity standards for clinicians; and oversight and control of expenditures.

The second document, "Medicaid Requirements for OMH-Licensed Outpatient Programs," provides a summary of the requirements, applicable to all outpatient providers, that pertain to receipt of Medicaid payments. As described in the first document, providers should ensure compliance with Medicaid requirements to avoid vulnerability to audit adjustments. It is further noted that the majority of Medicaid disallowances result from very concrete problems (e.g., *lack* of documentation rather than *improper* documentation). The purpose of the more detailed document is to assist providers in adopting documentation and business practices that will support them in obtaining sufficient and appropriate revenue, as well as protect them from vulnerability to disallowances.

In late 2002 through mid-2003, OMH convened a Medicaid Audit/Best Practices Workgroup which included provider, local government and NYS Department of Health representatives. Many of the recommendations issued by that group have been included in the above documents.

Any questions regarding the attached resources may be directed to Dawn Lannon, Director, Bureau of Adult Services, at 518-473-6655, or dlannon@omh.state.ny.us.

Sincerely,

Linda Rosenberg, CSW
Senior Deputy Commissioner and Director,
Division of Community Care Systems Management