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
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 DEPARTMENT OF MENTAL HEALTH TITLE 9
(Registered 88, No. 3—1-16-88)

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.


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.


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.


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


 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.


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.
**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:

<table>
<thead>
<tr>
<th>MFBU</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1 - $602</td>
<td>3 - $934</td>
<td>6 - $1,417</td>
<td>9 - $1,825</td>
</tr>
<tr>
<td></td>
<td>2 - $750</td>
<td>4 - $1,100</td>
<td>7 - $1,550</td>
<td>10 - $1,959</td>
</tr>
<tr>
<td></td>
<td>2 - $934 (Adults)</td>
<td>5 - $1,259</td>
<td>8 - $1,692</td>
<td></td>
</tr>
</tbody>
</table>

Asset allowances for 1989 are:

<table>
<thead>
<tr>
<th>Persons</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1 - 2000</td>
<td>4 - 3300</td>
<td>7 - 3750</td>
</tr>
<tr>
<td></td>
<td>2 - 3000</td>
<td>5 - 3450</td>
<td>8 - 3900</td>
</tr>
<tr>
<td></td>
<td>3 - 3150</td>
<td>6 - 3600</td>
<td>9 - 4050</td>
</tr>
</tbody>
</table>

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.
# State of California - Health and Welfare Agency

## Department of Developmental Services

### CLIENT INFORMATION

1. Name | Date of Birth | File Number

### RESPONSIBLE PARTY INFORMATION

2. Name | Relationship to Client | Date of Birth | Marital Status | Telephone Number
3. Address | | | | Social Security Number:
4. Veteran | | | | Telephone Number:
5. Employer | Position | If not employed, date last worked | | Telephone Number:
6. Employer's Address | | | | Telephone Number:
7. Spouse | Address | | | Telephone Number:
8. Spouse's Employer | Position | If not employed, date last worked | | Telephone Number:
9. Spouse's Employer's Address | | | | Telephone Number:
10. Nearest Relative | Telephone/Address | | | Telephone Number:

### 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 ____________________________

**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 8% 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 stated on line 34.

   Signature of Patient or Responsible Person ____________________________
   
   Date ____________________________

40. An explanation of the UMOAP liability was provided.

   Signature: ____________________________
   
   Date ____________________________

   Interviewer ____________________________
   
   Date ____________________________
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<td>$934</td>
<td>$1,100</td>
<td>$1,417</td>
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</tr>
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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.
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:

<table>
<thead>
<tr>
<th>Income</th>
<th>$1,075</th>
</tr>
</thead>
<tbody>
<tr>
<td>MFBU level</td>
<td>$ 934</td>
</tr>
<tr>
<td>UMDAP Deductible</td>
<td>$ 101</td>
</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>Costs of Services</th>
<th>Date of Service</th>
<th>Cumulative Amount of Costs</th>
<th>Cumulative UMDAP Used</th>
<th>Monthly UMDAP To Pay</th>
<th>Amount Paid</th>
<th>Balance Payable</th>
</tr>
</thead>
<tbody>
<tr>
<td>$ 87.50</td>
<td>1/4/97</td>
<td>$ 87.50</td>
<td>$ 87.50</td>
<td>$ 11.00</td>
<td>$ 11.00</td>
<td>$ 11.00</td>
</tr>
<tr>
<td>$ 90.00</td>
<td>2/12/97</td>
<td>$ 177.50</td>
<td>$101.00</td>
<td>$ 10.00</td>
<td>&lt;$11.00&gt;</td>
<td>$ 10.00</td>
</tr>
<tr>
<td>$ 85.00</td>
<td>3/1/97</td>
<td>$ 262.50</td>
<td>$101.00</td>
<td>$ 10.00</td>
<td>&lt;$10.00&gt;</td>
<td>$ 10.00</td>
</tr>
<tr>
<td>$ 82.50</td>
<td>4/3/97</td>
<td>$ 345.00</td>
<td>$101.00</td>
<td>$ 10.00</td>
<td>&lt;$ 0.00&gt;</td>
<td>$ 20.00</td>
</tr>
<tr>
<td>$ 90.00</td>
<td>5/8/97</td>
<td>$ 435.00</td>
<td>$101.00</td>
<td>$ 10.00</td>
<td>&lt;$ 10.00&gt;</td>
<td>$ 20.00</td>
</tr>
<tr>
<td>$ 87.50</td>
<td>6/5/97</td>
<td>$ 522.50</td>
<td>$101.00</td>
<td>$ 10.00</td>
<td>&lt;$ 15.00&gt;</td>
<td>$ 15.00</td>
</tr>
<tr>
<td>$ 82.50</td>
<td>7/8/97</td>
<td>$ 695.00</td>
<td>$101.00</td>
<td>$ 10.00</td>
<td>&lt;$ 15.00&gt;</td>
<td>$ 10.00</td>
</tr>
<tr>
<td>$ 90.00</td>
<td>7/31/97</td>
<td>$ 780.00</td>
<td>$101.00</td>
<td>$ 10.00</td>
<td>&lt;$ 15.00&gt;</td>
<td>$ 10.00</td>
</tr>
<tr>
<td>$ 85.00</td>
<td>8/15/97 Services terminated due to marked improvement</td>
<td></td>
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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