

## **Description CSP Medicaid**

Community Support Program (CSP) Medicaid is a NYS Office of Mental Health initiative for certain community-based mental health programs.

CSP Medicaid is paid to providers by the Medicaid payment system (MMIS) as an add-on to certain outpatient rates (Clinic, Continuing Day Treatment (CDT), or Day Treatment) on a program specific basis. Therefore, each Medicaid visit to an outpatient program may include the base Medicaid payment, plus the CSP Medicaid payment (and some providers may also receive a COPS Medicaid payment or a Level II COPS fee supplement Medicaid payment). OMH maintains the responsibility for CSP Medicaid rate setting, as described in 14 NYCRR Part 588.14.

CSP Medicaid is similar to COPS Medicaid in many respects, the primary difference between the two being that COPS Medicaid pays for outpatient services (e.g., Clinic), while CSP Medicaid pays for community support services (e.g., Psychosocial Clubs), through an add-on to the Medicaid eligible program. A complete list of CSP Medicaid-eligible programs appears later in this document.

### **Historical Context**

The CSP Medicaid program was initiated in 1998 for designated Article 31, D&TC, and certain major public Article 28 hospitals through the creation of a CSP base supplement for certain community support services programs.

The CSP base supplement funding was expanded in: 2000 (to include a 1.5% COLA); 2003 (to include a 3% COLA); in 2003, State funded Shared Staff working under Local auspice were repatriated back to the State Psychiatric Centers and funding for these positions was added to the CSP Medicaid program. Also, from 2003 to 2005, there was further expansion of the CSP Medicaid program, through the inclusion of additional eligible funds. Effective October 1, 2010, due to the implementation of Ambulatory Patient Groups (APGs), there will be a change in how Clinic providers with CSP rates will receive this revenue. Non-Hospital providers will see their CSP revenue split between the blend rate and capital rate codes during the four year APG phase in period, then solely in the capital rate code thereafter. Hospital providers are no longer receiving CSP Medicaid; therefore, their capital rate will reflect capital revenue only.

### **CSP Medicaid Rates**

The CSP Medicaid rate is calculated by OMH, and is equal to the CSP base supplement funding for all CSP programs eligible for CSP Medicaid, divided by the product of (1) the estimated annual number of Medicaid paid claims that will generate CSP payments (this estimate represents the three-year average of the Medicaid paid claims for the specific program that the CSP rate will be added to, for the three most recent fiscal years for which data is available or an approved appeal amount) and (2) the CSP constant of 89%. The constant represents a vacancy factor built into the rate calculation methodology. Effective April 1, 2009 CSP rates attached to Continuing Day Treatment (CDT) programs were recalculated utilizing actual paid claims for service dates April 1, 2009 through March 31, 2010 to reflect the half-day/full-day visit approach methodology. This adjustment will be in effect until such time as the three year average reflects actual billing, thus supporting the actual cost of the program.

Determination of how much of the CSP base supplement funding will be included in the CSP rate calculation takes place in three steps:

1. Determine if the program is eligible for conversion to CSP Medicaid.
2. Determine what percentage of the program's funding is eligible for conversion to CSP Medicaid based on the services provided in these programs and their Medicaid eligibility.
3. Determine what percentage of the services provided by each program is provided to persons who are enrolled in Medicaid, based on the most current Patient Characteristic Survey (PCS) data.

CSP Medicaid rates are subject to a 'cap' or maximum amount, which is adjusted periodically. As of April 1, 2008 the CSP rate cap is \$325.59.

The OMH maintains rate sheets to document CSP Medicaid rate calculations on a provider specific basis. CSP Medicaid rates are recalculated annually based on an updated three-year average of the number of Medicaid paid claims. Changes that occur in any of the CSP calculation components would warrant a change to the specific provider(s) CSP rate.

The calculated CSP Medicaid rate is added to the standard base Medicaid rate that is already in effect for the provider and the program. However, for Article 28 general hospitals, the CSP Medicaid rate is not added to Clinic or CDT collateral or group collateral type visits. Please note that effective July 1, 2010; CSP will no longer be included in a provider's COPS-Only rate codes (4093-4098). To compensate for this rate change, the 3 year average used to calculate all CSP rates attached to Clinics will no longer include any COPS-Only visits. (Data Source: MMIS or prior approved appeal.)

An LGU, or a provider with the support from the LGU, may appeal a CSP Medicaid rate within sixty (60) days of receipt of a rate change notification. Rate appeal due dates are included in the rate sheet cover letter and narrative.

Providers should also be aware that when CSP rates are recalculated retroactively, due to data and timing factors, there will be an effect on their Medicaid checks. When the new rate is lower than the previous rate MMIS will recoup the difference between the two rates for all paid services retroactive to the effective date of the rate change. When the new rate is higher than the previous rate, MMIS will send a check for the difference between the two rates for all paid services retroactive to the effective date of the rate change. **Retroactive rate adjustments are accounted for in the same fiscal year in which the original claim was paid, as outlined in the CSP Revenue Reconciliation section later in this document.**

The maximum amount of CSP Medicaid revenue that a provider can retain on an annual basis is equal to that provider's CSP Medicaid threshold. The CSP Medicaid threshold is equal to the full annual amount of provider's CSP base supplement funding. It is important to note that for Article 31 providers there is a two month lag accounted for when calculating a revised threshold.

The specifics of each provider's CSP funding are contained in their CSP rate sheet which is maintained by the OMH COPS/CSP Rate Setting Unit. When a provider's CSP rate changes, an abbreviated rate sheet which details the changes and elements necessary for rate calculation is sent to the provider, accompanied by a letter explaining the change(s). Providers should

reference their historical rate sheets for any details not provided on the abbreviated rate sheets. It is recommended that any changes provided in the abbreviated rate sheet be incorporated by the provider into a historical document by the provider. Providers may contact the COPS /CSP Rate Setting Unit for electronic copies of their full rate sheet at any time.

### **CSP Revenue Reconciliation**

OMH maintains a Medicaid payment database that reflects payments made to providers by service date, payment date and rate code specific detail. This payment database assumes the most recent rate is in effect at the time of payment and therefore accounts for any retroactive rate adjustments in the same fiscal year as the original claim was paid. **Providers must keep track of CSP revenue receipts. ANY CSP revenue received in excess of the CSP threshold must be kept in a reserve account for future recovery by the OMH.**

CSP received in a local fiscal year in excess of that year's CSP threshold will be recouped by the State through MMIS (see Part 588.14(f)). A CSP payment report will be sent to each provider detailing the amount of CSP that OMH has determined the provider received during the reconciliation process. Providers will have an opportunity to verify the data used to calculate the recovery amount by the OMH before implementation of the recovery by MMIS. Included in any notice of recovery of overpayment will be a description of the recovery process, as well as the date the request for recovery would be sent to MMIS.

When a provider's CSP revenue is less than their threshold for a fiscal year, and a rate amendment will not ensure maintenance of funding, the underachievement amount will be paid to the provider through a State aid payment (see Part 588.14(g)). For Non-Hospital providers, CSP reconciliations will be processed in this manner through September 30, 2010 (the date of APG implementation). Reconciliations subsequent to APG implementation will be processed by a methodology which is still being finalized, and will be published at a later date.

### **CSP Medicaid Rate Setting and Threshold Establishment Example**

The following example is provided for the purpose of illustrating what has been presented directly above.

Agency X, an Article 31 provider, operates a clinic program, and receives CSP state aid payments for two community support services programs; both programs are eligible to be included in CSP Medicaid: an Outreach program, OMH program code 0690; and an Ongoing Integrated Supported Employment program, OMH program code 4340.

In 2010, Agency X received \$100,000 in CSP state aid payments from the OMH for the Outreach program, and \$100,000 in CSP state aid payments for the Ongoing Integrated Supported Employment program.

It has been determined that 100% of the programs expenses associated with the Outreach program are eligible for inclusion in CSP Medicaid, and 60% of the Ongoing Integrated Supported Employment program expenses are eligible for inclusion in CSP Medicaid.

Based on Patient Survey Characteristics (PSC) data, It has been determined that 90% of the services provided by the Outreach program were provided to persons enrolled in Medicaid, and 80% of the services provided by the Ongoing Integrated Supported Employment program were provided to persons enrolled in Medicaid.

Beginning in 2011:

- \$90,000 of the \$100,000 in CSP state aid payments for the Outreach program is to be included in CSP Medicaid Rate -  $\$100,000 * 100\%$  (as 100% of this program is eligible for inclusion) \* 90% (as 90% of the services are provided to persons enrolled in Medicaid), and
- \$48,000 of the \$100,000 in CSP state aid payments for the Ongoing Integrated Supported Employment program is to be included in CSP Medicaid Rate -  $\$100,000 * 60\%$  (as 60% of this program is eligible for inclusion) \* 80% (as 80% of the services are provided to persons enrolled in Medicaid).

The OMH continues to allocate the State aid not converted to CSP Medicaid to the provider, so Agency X will continue to receive \$10,000 of CSP State aid for the Outreach program, and \$52,000 for the Ongoing Integrated Supported Employment program.

The MMIS paid claims database indicates the three-year average of the Medicaid paid claims for the clinic program during years 2008, 2009, and 2010 were 2,000 per year. This then serves as the estimate of the 2011 clinic Medicaid paid claims.

A clinic CSP rate is calculated:  $(\$90,000 + \$48,000) / 2,000 / 89\% = \$77.53$ .

Agency X's 2011 CSP threshold is set at \$138,000 (\$90K from PC 0690 and 48K from PC 4340).

Assuming they are paid for 2,000 clinic services in 2011 (2,000 service provided on or after November 1, 2010), Agency X will receive:  $2,000 * \$77.53 = \$155,060$  of CSP Medicaid revenue.

After the close of 2010, OMH will send Agency X a CSP payment report that will detail the CSP overpayment ( $\$155,060 - \$138,000 = \$17,060$ ), and the OMH will direct the DOH to begin to recover these funds per the directions that are provided in the overpayment report.

If Agency X only was paid for only 1,000 clinic paid claims in 2010, their CSP revenue would have been \$77,530, OMH would either adjust the provider's rate through a rate appeal or make a State aid payment to Agency X for the difference ( $\$138,000 - \$77,530 = \$60,470$ ).

Even though Agency X received this CSP Medicaid revenue as a result of the provision of clinic services, the CSP Medicaid revenue will be budgeted and claimed (on the CBR and CCR) in the program columns of the Outreach program and the Ongoing Integrated Supported Employment program per the directions detailed in Appendix DD of the CBR manual.

### **Medicare/Medicaid Crossover Payment Methodology**

In order to determine the individual Medicaid components (base Medicaid, COPS, CSP and/or Level II COPS) of a Medicaid payment made on a Medicare/Medicaid Crossover paid claim you would need to know the following information:

- The crossover billing logic – Medicaid payment on a crossover paid claim is limited to the difference between either Medicare approved amount and Medicare paid amount, or Medicaid rate and Medicare paid amount, whichever is greater;

- The Medicare approved amount associated with the particular rate code the crossover logic is being applied against – Note: Medicare approved, and Medicare allowed, are synonymous;
- The Medicare paid amount for the particular rate code in question;
- The base Medicaid rate/fee – all Article 28 providers, and some D&TC providers, have base Medicaid rates for clinic, CDT, and day treatment; all Article 31 providers, and some D&TC providers, have base Medicaid fees for clinic, CDT, and day treatment; all providers have base Medicaid fees for partial hospitalization (PH) and intensive psychiatric rehabilitation treatment programs (IPRT) – although for the purpose of this explanation, base rates and base fees will both be referred to as base Medicaid rates;
- The COPS rate, if applicable;
- The CSP rate, if applicable;
- The Level II COPS fee supplement, if applicable;
- The total Medicaid rate for a particular outpatient program; and
- The total amount paid (Medicare plus Medicaid).

## Methodology

For providers who receive COPS and CSP on the same rate code:

1. Determine the Medicaid payment by subtracting Medicare paid from the total amount paid.
2. Determine the base Medicaid component:
  - If the base Medicaid rate is greater than or equal to Medicare approved, then the base Medicaid component is equal to the difference between the base Medicaid rate, and Medicare paid.
  - In all other cases, the base Medicaid component is equal to the difference between Medicare approved, and Medicare paid.
3. Determine the base Medicaid plus COPS component:
  - If the sum of the base Medicaid rate and the COPS rate is greater than or equal to Medicare approved, then the base Medicaid plus COPS component is equal to the difference between the sum of the base Medicaid rate and the COPS rate, and Medicare paid.
  - In all other cases, the base Medicaid plus COPS component is equal to the difference between Medicare approved and Medicare paid.
4. Determine the COPS component by subtracting the base Medicaid component from the base Medicaid plus COPS component.
5. Determine the CSP component by subtracting the base Medicaid plus COPS component from the Medicaid payment.

For providers who receive CSP and Level II COPS on the same rate code, apply the same logic as above, substituting Level II COPS for COPS. For providers who receive just COPS, CSP, or

Level II COPS on a particular rate code, apply the same logic as above, assuming all unused rate components are equal to \$0.00.

Please note:

In no instance can the COPS, CSP, or Level II COPS payment credited through the application of this logic be less than \$0.

### **CSP Medicaid Reporting/Claiming**

CSP Medicaid accounting for Article 31 providers is conducted on a cash basis while CSP Medicaid accounting for Article 28 general hospitals is on an accrual basis. OMH payment reports fully explain the accounting rules supporting both methodologies. Upstate and Long Island providers account for CSP Medicaid on a calendar year basis, while NYC providers utilize a July-June local fiscal year (LFY) basis.

Providers are required to budget and claim CSP Medicaid on the Consolidated Budget Report (CBR), the Consolidated Claiming Report (CCR), and the Consolidated Fiscal Report (CFR) -- consistent with Appendix DD of the CBR and CFR manuals.

### **CSP Eligible Programs**

- 0320 On-Site Rehabilitation (100% eligible)
- 0340 Sheltered Workshop/Satellite SW (60% eligible)
- 0380 Transitional Employment Placement (60% eligible)
- 0510 Pre-admission screening (100% eligible)
- In 2006 replaced by:
  - 0690 Outreach or
  - 1400 SPOA
- 0630 Homemaker (100% eligible)
- In 2006 replaced by:
  - 1760 Advocacy/Support Services
- 0660 Alternative Crisis Support (100% eligible)
- In 2006 replaced by:
  - 1760 Advocacy/Support Services
- 0680 Mobile Treatment Team (100% eligible)
- In 2006 replaced by:
  - 2680 Crisis Intervention
- 0690 Outreach (100% eligible)
- 0700 Non-inpatient Crisis Service (100% eligible)
- In 2006 replaced by:
  - 1760 Advocacy/Support Services or
  - 2680 Crisis Intervention
- 0770 Psychosocial Club (100% eligible)
- 1320 Vocational Services C&F (100% eligible)
- 1380 Assisted Competitive Employment (60% eligible)
- 1400 SPOA (100% eligible)
- 1650 Family Support Services C&F (100% eligible)
- 1760 Advocacy/Support Services (100% eligible)
- 2340 Affirmative Business/Industry (60% eligible)
- 2680 Crisis Intervention (100% eligible)
- 3040 Home-Based Crisis Intervention
- 4340 Ongoing Integrated Supported Employment (60% eligible)

**Resources:**

[Information for Service Providers](#) – references for COPS, CSP and DSH

To reference New York Codes, Rules and Regulations (NYCRR) go to website for [Department of State \(DOS\) web site](#). 

[Appendix DD](#) of the CBR manual (the appendix that addresses fiscal reporting)