**Administrative Fee Payments to Health Homes for OMH State-operated Former TCM Programs**

The $12 per member per month administrative fee for state operated former Targeted Case Management programs will be calculated using Health Home (HH) client enrollment data from the DOH Enrollment Download File shown below. Quarterly payments will be made to HHs starting with the second calendar quarter of 2013. Subsequent to the last quarterly payment for each year, a final reconciliation payment will be made for that year.

In order to receive payment, HHs must provide OMH with the Statewide Financial System (SFS) Vendor ID and bank account to which the HH Administrative fee is to be paid. A Provider Contact Form, included below, must be completed and returned to OMH Community Budget and Financial Management. For information about SFS, you may view the SFS site at: http://www.sfs.ny.gov/

Quarterly payments will be based on a snapshot of the DOH Enrollment Download File taken no less than 30 days after the end of a quarter. A count of the OMH clients (Care Management Agency MMIS ID = 01137237) enrolled in a HH for each month in the quarter will be summed and multiplied by $12 to determine the payment amount.

A converting TCM OMH client (Care Management Agency MMIS ID = 01137237) is eligible to be enrolled in a HH the later of the first day of the month in which the HH contract between the HH and the OMH facility commences or April 1, 2013 (the start of the second calendar quarter of 2013).

The final reconciliation payment for the year will be based on a snapshot of the DOH enrollment file taken no less than 90 days after the end of the calendar year. Enrollment segments with an Insert Date greater than the last day of March of the year in which the snapshot was taken will be excluded from the final reconciliation. A count of the OMH clients (Care Management Agency MMIS ID = 01137237) enrolled in a HH for each month in the year will be summed and multiplied by $12 to determine the total reimbursement due for the year. The sum of the quarterly payments for the year will be subtracted from this amount to determine the adjusted amount to be paid.

The administrative fee will be terminated for a given HH when it begins direct billing Medicaid Managed Care for Care Management services rendered by OMH staff.

| DOH Enrollment Download File | | | | | |
|---|---|---|---|---|---|
| **Field #** | **Field** | **Start Pos** | **Length** | **End Pos** | **Format** |
| 1 | Member ID | 1 | 8 | 8 | AA11111A, Alphanumeric |
| 2 | Begin Date | 9 | 8 | 16 | MMDDYYYY, Numeric |
| 3 | End Date | 17 | 8 | 24 | MMDDYYYY, Numeric |
| 4 | Outreach/Enrollment Code | 25 | 1 | 25 | Character (O/E) |
| 5 | Health Home MMIS ID | 26 | 8 | 33 | Numeric |
| 6 | Care Management Agency MMIS ID | 34 | 8 | 41 | Numeric |
| 7 | Direct Biller Indicator | 42 | 1 | 42 | Character (Y/N) |
| 8 | Referral Code | 43 | 1 | 43 | Character |
| 9 | Disenrollment Reason Code | 44 | 2 | 45 | Numeric |
| 10 | Consent Date | 46 | 8 | 53 | MMDDYYYY, Numeric |
| 11 | NYSID | 54 | 9 | 62 | Alphanumeric |
| 12 | Insert Date | 63 | 8 | 70 | MMDDYYYY, Numeric |
| 13 | Latest Modified Date | 71 | 8 | 78 | Alphanumeric |

# PROVIDER CONTACT FORM

**Provider**

Provider Name:

Address
Line 1:
Line 2:
City:
State: Zip:

County:

Phone no.: Ext.:

Fax no:

E-mail Address:

**Executive Director**

Name:

Title: Position:

Degree:

Phone no.: Ext.:

**E-mail Address**:

**Chairperson of the Board**

Name:

Title: Position:

Degree:

Address
Line 1:
Line 2:
City:
State: Zip:

Phone no.: Ext.:

**Contact Information**

Name:

Title: Position

Phone no.: Ext.:

E-mail Address:

**Disaster Preparedness**

Participates: Yes No

If Yes, for Contact:

Name:

Title: Position:

Phone no.: Ext.:

E-mail Address:

**Payment Information**

Name:

Title:

Address (Please enter exactly as entered/supplied to the Office of the State Comptroller)

Line 1:
Line 2:
City:
State: Zip:

**Circle appropriate entry(ies)**

OMRDD **OMH** OASAS SED

Article 28 Article 31

Auspice
County State Voluntary Proprietary

State funded : Yes No

**Additional Information**

Federal ID #:

Date Opened:

Charity Registration #:

MMIS #:

**PLEASE RETURN THIS FORM TO:** New York State Office of Mental Health, Community Budget and Financial Management, 44 Holland Avenue, Albany, New York 12229, **ATTN: Kevin Gerighty**