



Hospital Pricing Transparency June 1, 2022

OMH Mission

Our mission is to promote the mental health of all New Yorkers, with a particular focus on providing hope and recovery for adults with serious mental illness and children with serious emotional disturbances.

Understanding the Costs Associated with Your Care

While there are costs associated with your care, it's important to understand that no person will be denied care because they are unable to pay. Mental health is a serious matter and we're committed to providing you with the care you need.

To help you understand the costs associated with care at our facilities, we're providing a list of our standard charges and shoppable services. (See Frequently Used Terms for the definitions for some of the terms found on this page)

Standard Charges

Standard charges are provided for informational purposes only. They are not an accurate picture of the final out-of-pocket costs or the actual amount that will be paid by an insurance plan. Final out-of-pocket expenses depend on the actual services provided as well as your insurance company's determination of your eligibility and benefits when they process our claim.

Paying for Your Care

Navigating insurance, benefits and payment options can be difficult. This is why we have an entire department dedicated to guiding you through the process.

Shortly after admission, your assigned Patient Resource Office (PRO) will contact you to gather information so that they can identify ways to reduce your out-of-pocket costs. Your PRO will:

- confirm if you have any insurance coverage.
- determine if you may qualify for any benefit programs.
- review your eligibility for any financial aid.

Understanding Insurance

If you have health insurance coverage, it's important to understand the details of your insurance policy. This includes:

- what is covered.

- whether you must receive services from available providers in your plan's network.
- what costs you may be financially responsible for, such as: deductibles, coinsurance, or co-payments.

OMH facilities may not be in your plan's network. This means your plan may pay a reduced amount or will not cover any services you receive at any of our state-run facilities. If you're unsure about your plan details, we encourage you to reach out to your insurance company directly.

Medicare

If you have Medicare, your coverage may pay for some of your care provided by an OMH facility. In general, Medicare Part A will pay for up to 190 days of inpatient psychiatric hospital services during your lifetime. For each benefit period, Medicare will cover:

- Days 1-60 less a deductible, which may change annually.
- Days 61-90 less a coinsurance per day.
- Day 91 and beyond is covered less the Lifetime Reserve coinsurance per day (up to a maximum of 60 reserve days over your lifetime).

Medicare Part B (Medical Insurance) may also cover a portion of the cost of services provided to you as an inpatient or an outpatient. To determine your specific available Medicare benefits, contact Medicare directly.

Medicaid

Your Medicaid coverage may pay for some OMH services. However, due to restrictions in federal law known as the Institutions for Mental Diseases (IMD) exclusion, Medicaid coverage is not available for services provided to individuals aged 21 to 64 who are inpatients of OMH psychiatric centers or residents of certain OMH-operated community residences. For more information about the IMD exclusion, please refer to section [1905\(a\)\(30\)\(B\) of the Social Security Act](#).

Individuals under age 21 or over age 64 admitted to an OMH Psychiatric Center or community residence, may be eligible for Medicaid coverage issued by OMH. If eligible, OMH Medicaid coverage will pay for certain inpatient and outpatient services you may receive while admitted to an OMH facility.

To determine if a patient qualifies for Medicaid through the Office of Mental Health, a separate Medicaid application must be submitted to OMH. Shortly after admission, your assigned PRO will send you a financial questionnaire form. Please complete this form as best you can and return it promptly so that the application can be completed. The PRO will confirm your Medicaid eligibility and will use the information to determine if you qualify for financial aid.

Financial Aid

If you still have out-of-pocket expenses, after using all other sources of reimbursement, you may qualify for financial aid. Your PRO will review the completed financial questionnaire to determine if you qualify for need-based financial aid.

Any financial information you provide is confidential and used only to complete a Medicaid application or to determine your eligibility for financial help.

Patient Resource Office Contact List

Patient Resource Office	Phone Number	Facilities Served
Capital District	518-474-7986	New York Psychiatric Institute Rockland Psychiatric Center Capital District Psychiatric Center South Beach Psychiatric Center Mid-Hudson Forensic Psychiatric Center
Creedmoor	718-264-3840	Creedmoor Psychiatric Center Manhattan Psychiatric Center Bronx Psychiatric Center Kirby Forensic Psychiatric Center New York City Children's Center
Pilgrim	631-761-3690	Kingsboro Psychiatric Center Pilgrim Psychiatric Center Sagamore Children's Psychiatric Center
Syracuse	315-426-3910 800-881-5439	Buffalo Psychiatric Center Hutchings Psychiatric Center Western New York Children's Psychiatric Center
Utica	315-793-2378 800-875-2043	Greater Binghamton Health Center Rochester Psychiatric Center St. Lawrence Psychiatric Center Rockland Children's Psychiatric Center Elmira Psychiatric Center Central New York Psychiatric Center Mohawk Valley Psychiatric Center Secure Treatment and Rehabilitation Center (STARC)

Frequently Used Terms

Standard Charges	The regular rate established by the hospital for an item or service provided to a specific group of paying patients.
Gross Charge	The top rate billed to any patient or insurer when a fee scale or contract is not in place.
Payer-specific negotiated charges	The charge that the hospital has negotiated with a third-party payer for an item or service.
De-identified minimum contracted rate	The lowest charges that a hospital has negotiated with all third-party payers for an item or service.
De-identified maximum contracted rate	The highest charges that a hospital has negotiated with all third-party payers for an item or service.
Discounted cash price	The charge that applies to an individual who pays cash for a hospital item or service.

Shoppable Services	A hospital service that can be scheduled in advance by a patient.
Out-of-Pocket	The total amount the patient is required to pay for covered services from a source other than the patient's insurance.
In-Network	When a doctor, physician, or hospital has a contract with a patient's health insurance plan provider.
Out-of-Network	When a doctor, physician, or hospital does not have a contract with a patient's health insurance plan provider.
Deductible	The amount a patient is required to pay for covered services before their health insurance plan starts to pay, determined in accordance with their policy.
Copay	A fixed amount a patient is required to pay for covered services, determined in accordance with their health insurance policy.
Coinsurance	The amount a patient is required to pay for covered services, usually expressed as a share or percentage of the amount the plan pays, determined in accordance with their health insurance policy.

The information on this page is for informational purposes only. While OMH strives to make the program information on this page as accurate as possible, the information we have provided is generalized and does not provide a comprehensive overview of each program's rules and regulations. For the most accurate and updated program information, please contact the program directly.

Mental Hygiene (MHY) CHAPTER 27, TITLE E, ARTICLE 43

§ 43.01 Fees and rates for department services.

- (a) The department shall charge fees for its services to patients and residents, provided, however, that no person shall be denied services because of inability or failure to pay a fee.*
- (b) The commissioner may establish, at least annually, schedules of rates for inpatient services that reflect the costs of services, care, treatment, maintenance, overhead, and administration which assure maximum recovery of such costs.*
- In addition, the commissioner may establish, at least annually, schedules of fees for noninpatient services which need not reflect the costs of services, care, treatment, maintenance, overhead, and administration.*
- (c) The executive budget, as recommended, shall reflect, by individual facility, the costs of services, care, treatment, maintenance, overhead, and administration.*
- (d) All schedules of fees and rates which are established by the commissioner, shall be subject to the approval of the director of the division of the budget. Immediately upon their approval, copies of all schedules of fees and rates established pursuant to this section shall be forwarded to the chairman of the assembly ways and means committee and the chairman of the senate finance committee.*

§ 43.03 Liability for fees.

- (a) The patient, his estate, his spouse, his parents or his legal guardian if he is under twenty-one years of age, and his committee and any fiduciary or representative payee holding assets for him or on his behalf are jointly and severally liable for the fees for services rendered to the patient. Parents or spouses of parents are not liable for the fees for services rendered to a disabled child under twenty-one years of age, who does not share the common household even if the child returns to the common household for periodic visits. For purposes of this section a child is considered disabled if she/he meets the definition of a blind or disabled child under regulations prescribed by the social security act for medical assistance.*

(b) The commissioner may reduce or waive fees in cases of inability to pay or other reason. If the commissioner discovers that assets existing at the time of determination were not disclosed because of fraud or negligence, the department may collect the difference between the amount paid and the actual cost of services. The acceptance of less than the full fee or the waiver of a fee or any part thereof shall not be construed to release a patient, his estate, committee or guardian, the trustee of a fund established for his support, or any fiduciary or payee of funds for or on behalf of a patient from liability for payment of the full fee.

(c) Patients receiving services while being held pursuant to order of a criminal court, other than patients committed to the department pursuant to section 330.20 of the criminal procedure law, or for examination pursuant to an order of the family court shall not be liable to the department for such services. Fees due the department for such services shall be paid by the county in which such court is located except that counties shall not be responsible for the cost of services rendered patients committed to the department pursuant to section 330.20 of the criminal procedure law or patients committed to the department pursuant to article ten of this chapter.

(d) The trustee of a supplemental needs trust for the benefit of a patient, which trust conforms to the provisions of section 7-1.12 of the estates, powers and trusts law, shall not be deemed to be holding assets for the patient or on his or her behalf, as described in such section 7-1.12. As such, neither the trust nor the trustee shall be liable for the fees for services rendered to the patient.

(e) Notwithstanding any other provision of this section, the commissioner shall not collect any fees for services from any monies paid to or to be paid to or on behalf of a patient, his estate or a representative of a patient or his estate, as a result of or in return for a release of liability or a court ordered settlement or judgment against the state arising from an act or omission of the state, the office or any employee or agent thereof, if such act or omission occurred during the course of confinement of or during the provision of care to such patient. Such monies shall not be offset or otherwise encumbered for the purpose of paying such fees.

§ 43.05 Securing financial information.

(a) A person who applies for the reduction or waiver of fees on the ground of inability to pay shall disclose all assets and shall file a release to permit the department to investigate resources and assets and to verify statements made in the application.

(b) The commissioner or his authorized representatives may develop sufficient financial information through investigations and shall have the power to initiate proceedings in a court of competent jurisdiction to discover property, including the examination and inventory of safe deposit boxes leased by a patient, and to otherwise secure payment from all patients or persons liable for them.

(c) Banking organizations, insurance companies, brokers, fiduciaries, business managers, guardians, trustees, representative payees of resources and assets of a patient, or any relative or person having knowledge of any resources and assets of a patient, upon request of the commissioner or his authorized representative, shall furnish full information on the resources and assets of a patient or of any person legally responsible for the support of a patient.