From Jay Zucker, NYS Office of Mental Health Counsel’s Office, 5/15/09

Beginning in early 2007, CMS issued several regulations that, if implemented, would prove to be troublesome for New York State, and other State Medicaid programs. Four of these proposals are of particular interest to OMH: Clarification of Outpatient Hospital Facility (Including Outpatient Hospital Clinic) Services Definition; Medicaid Payment for Rehabilitation Services; Medicaid Payment for Targeted Case Management Services; and Medicaid Cost Limits to Public Providers. There has been recent administrative action on all of them.

1. Clarification of Outpatient Hospital Facility (Including Outpatient Hospital Clinic) Services Definition

The proposed rule would have limited the outpatient hospital benefit to those services covered under Medicare, and would have required the exclusion of the cost of any services not covered by Medicare from the calculation of the outpatient hospital and clinic upper payment limit. Section 5003(c) of the American Recovery and Investment Act (ARRA) precluded CMS from taking any action to implement the rule with respect to services furnished before June 30, 2009. CMS has announced that it is rescinding this rule in its entirety.

2. Medicaid Payment for Targeted Case Management Services:

CMS proposed regulations that would have shortened the period during which a person may receive case management services while in an institution for an institutional stay of less than 180 days to services provided during the last 14 days of discharge.

The regulations also required states' reimbursement methodologies to be calculated in a manner that employs a unit of service that does not exceed 15 minutes, and would have prohibited federal funding for case management services that are an integral component of another Medicaid service, another non-medical program, or an administrative activity (so-called "bundled" rates).

While the regulation has not been rescinded in full, all of the above requirements have been rescinded.

3. Medicaid Payment for Rehabilitation Services:

CMS issued regulations limiting the kinds of services for which FFP is available as rehabilitative services, under the so-called rehabilitation option. Under the proposed regulations, states could lose federal matching funds for the costs of certain services for which matching funds are currently allowed, either because they were considered to be "habilitative" rather than "rehabilitative" in nature, or because they were provided by in the context of a licensed program, rather than by a licensed provider. The ARRA included a "Sense of Congress" statement that these regulations should not be implemented. OMH currently funds PROS, ACT and Restorative Services under the Rehabilitation Option.

Congress also required CMS to conduct an independent study of the problems addressed by this regulation and Medicaid Cost Limits to Public Providers, and report to Congress by September 1, 2009. CMS has contracted with The Lewin Group to perform the study. Lewin has circulated a proposed questionnaire that they will be requesting States to answer, and will be setting up a schedule for interviewing State Medicaid officials.

4. Medicaid Cost Limits to Public Providers:

CMS has issued proposed regulations limiting the amount that Federal Medicaid will pay public providers to their cost of providing services. These regulations would put approximately $141 million ($70.5 million Federal share) of Medicaid at risk for State and County-operated mental health providers. OMRDD may be subject to a much larger potential disallowance

OMH and the State have taken the position that the proposed regulation is contrary to current Medicaid law. Congress has steadily moved from requiring cost reconciliation to giving states the flexibility to create their own payment methods. Whereas at its inception, Medicaid required that rates be cost-based, reflecting historic costs incurred by providers, this created an incentive to drive up costs as a means of increasing revenue. In recognition of this fact, States were permitted to set rates prospectively, so long as they were consistent with the efficient and effective provision of care. This created an incentive for providers to keep costs down. For public providers in particular, savings could be used to provide services for uninsured or underinsured individuals.

The ARRA included a "Sense of Congress" statement that these regulations should not be implemented. They are included among those to be studied by The Lewin Group.