October 29, 2007

Center for Medicare and & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Room 445-G
Washington, DC 20201

Re: CMS-2213-P; Medicaid Program; Clarification of Outpatient Clinic and Hospital Facility Services Definition and Upper Payment Limit (Federal Register, Vol. 72, No. 188, September 28, 2007)

The Coalition of Behavioral Health Agencies is submitting its comments on behalf of the more than 100 community based agency members who provide mental health and chemical dependence services to more than 350, 000 adults and children in a very diverse New York City and environs.

CMS is proposing the above changes as an emergency regulation, requiring merely 30 days of comment. The Coalition disagrees that this proposed change is minor and that 30 days is sufficient for adequate analysis and comment on its likely impact to the already fragile health and behavioral health service system.

Furthermore, this rule promulgation in a 30 day period is a direct violation of the Congressional moratorium barring CMS from regulating on matters relating to how states finance their Medicaid programs. Contrary to the statement on regulatory impact, the changes are, in fact, a major change in current practice with significant economic effects.

Many Medicaid financed programs, serving needy and vulnerable consumers, are fragile and at fiscal risk. Changes in finance methodologies require enough time to consider and make certain that any changes are reasonable and that such changes would be fully understood and calculated in their effect. Also such changes require time enough to involve input from all stakeholders. The 30 day period is grossly inadequate. While our agencies would not be directly affected by Graduate Medical Education payments, changes in the GME provision are also subject to the congressional moratorium and therefore not a fit subject for emergency rule making. Violation of congressional moratoria is bad precedent and should not be permitted.

The Coalition seeks the withdrawal of this rule by CMS. We are opposed to the changes proposed.

Proposal is Arbitrary

The proposed regulatory changes seem arbitrary, not developed with care and not fulfilling CMS's own purposes. CMS posits its purpose as to improve functionality of the Upper Payment Limit (UPL), provide more transparency in determining coverage and clarify the scope of services for which federal participation is available. To the contrary, the impact of the regulation would be to remove from the current scope of services some previously reimbursable services and fail to identify services that are and are not allowable under the new methodology. Consequently, such a rule is neither transparent nor clarifying. Moreover an entire new system for determining the Upper Payment Limit (UPL) is to be implemented.

Impact is Uncalculated

Within the text of the proposed regulatory changes, CMS admits that "(d)ue to a lack of available data, we cannot determine the fiscal impact of this proposed rule." The changes, therefore, could impact negatively on providers of clinic services, and in turn on the consumers who rely on these clinics for psychiatric treatment. The risk of disruption of clinical treatment is much too high given how little is known about the fiscal impact of this proposal.

Major vs. Minor Change and Related Costs

Assertions in the Regulatory Impact Statement about the limited nature of the change (an assertion contested by The Coalition), would allow HHS to implement these changes in a short time. <u>If these changes are finalized, it would lead to a fundamental overhaul of current New York State billing practices.</u> This will require computer system changes, retraining of staff and changes in forms and submissions to billing intermediaries. All of these changes would take significant time and entail significant costs to providers. Moreover, providers would be at risk for disallowances for charges made in good faith under current rules if they are found to exceed the UPL or other requirements of this new regulation.

Exclusion of Previously Authorized Costs and Valuable Services

The proposed regulations will allow Medicaid billing only for services authorized for reimbursement under Medicare. This will disallow a number of valuable services, such as day treatment, continuing day treatment and intensive psychiatric rehabilitation which are not covered by Medicare. States would then be left with the difficult choice of paying in full for the cost of these programs, or eliminating these services altogether, leaving thousands of New Yorkers with profound psychiatric disabilities without care.

Furthermore, the proposed rule would terminate the federal share of funding for the federally-mandated Early and Periodic Screening and Diagnosis Treatment (EPSDT) services for children.

Reductions in Quality of Care

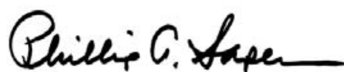
By limiting the locations where services may be provided and requiring separation of professional and other charges, the proposed regulation will result in the reduction of the quality of care provided to consumers. The introduction on page 55159 of the Federal Register acknowledges the requirement that Medicaid reimburse quality care. Many aspects of care for

behavioral health clients require services in settings outside the walls of the clinic and require professional and non-professional efforts which address aspects of behavioral health problems that are not directly treatment of the client. These services and out-side clinic service locations are time honored ways of providing continuous, comprehensive and high quality care and positively affect treatment.

Creation of Liability for Every Provider
The Federal Register filing (p. 55160) reports that the current regulations limit outpatient hospital and rural health clinic payments in privately operated facilities to a "reasonable estimate of the amount that would be paid for the services furnished by the group of facilities under Medicare payment principles." This requirement has been met in the past by comparing the overall costs for all providers to the estimated cost for such services under Medicare. In the explanation of the newly prescribed methodologies for determining the UPL, the regulation is described as being applied "for each provider as reported by MMIS." This provision seems to be designed to require cost comparisons on a provider by provider basis. All differences in location, populations served or of other differentiating parameters would be removed from consideration and the leveling benefits of considering the system as a whole would be lost. This provision would put individual providers at potential risk, despite their real world differences, if their charges differ from those calculated to be allowable under Medicare.

In summary, the proposed regulations violate the moratorium secured by P.L. 110-28 wherein Congress explicitly instructed CMS not to implement the May 28 final rule. The proposed changes are sufficiently complex and problematic that they can hardly be considered "non-major." They are likely to negatively affect many providers, and by extension many consumers of service, and should not be allowed to take effect without major scrutiny and widespread opportunity for analysis, stakeholder comment and possible modification. **In the strongest possible terms, we urge CMS to withdraw this rule.**

Sincerely,



Phillip A. Saperia
Executive Director