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November 13, 2009

Erin C. Morigerato, Esq.

Senior Attorney

Office of the Medicaid Inspector General

800 N. Pearl Street

Albany, New York 12204

Dear Ms. Morigerato:

Re: MED-39-09-00007-P and MED-39-09-00008-P

I am submitting these comments on behalf of the Payment & Reimbursement Committee of the Health Law Section of the New York State Bar Association regarding the proposed regulations published in the New York State Register on September 30, 2009 relating to Provider Hearings (MED-39-09-00007-P and MED-39-09-00008-P).

You have proposed amending several regulations to deprive Medicaid providers of their existing hearing rights before an administrative law judge ("ALJ") under 18 N.Y.C.R.R. Part 519 in cases where Medicaid seeks to recoup overpayments resulting from a determination that the provider failed to take reasonable efforts to determine whether third party liability exists. The NY Court of Appeals, in the case of Visiting Nurse Service of New York Home Care v. New York State Department of Health, 5 N.Y. 3d 499, 840 N.E.2d 577, 806 N.Y.S.2d 465 (Nov. 17, 2005), held that Medicaid providers currently have the right to a hearing before an ALJ to contest such third party liability determinations under existing New York regulations. You are proposing to revise the regulations to eliminate these hearing rights, and have proposed substituting, in place of hearing rights before an ALJ under Part 519, a new section 540.6(e)(8) providing an undefined administrative appeal mechanism before the same agency that originally made the decision with a short time frame for filing the entire appeal (30 days) and extremely limited grounds for review ("mistake of fact").

1. Medicare Regulations Do Not Justify the Proposed Amendments.

The proposed rulemaking (MED-39-09-00007-P) asserts that one reason for the proposed change is that otherwise Medicaid would be "inconsistent with current federal regulations." Footnote No. 1 cites to the following federal Medicare regulations, 42 C.F.R. § 433.139 and 42 C.F.R. § 433.310 – 433.320, as supporting this proposition. We have examined the cited federal regulations and find no support for the proposition that Medicaid is inconsistent with current federal regulations. To the contrary, the federal definition of an "overpayment" (in 42 C.F.R. § 433.304) is

consistent with the current Medicaid definition.¹ Instead, your proposed rule (18 N.Y.C.R.R. § 518.1(c)), which seeks to narrow the Medicaid definition of an “overpayment” to eliminate cases involving third party liability, is inconsistent with existing Medicare regulations defining an “overpayment.”

2. The Proposed Rule’s Appeal Rights do not satisfy Due Process.

The Court of Appeals decision in the VNS case, cited above, did not reach the question of whether existing state regulations satisfied due process since the court determined that the existing regulations require that providers be afforded hearing rights before an ALJ. If the state amends the regulations to remove these hearing rights, the state must consider whether the mechanism it is proposing in its place satisfies due process under the federal and state constitutions.

We believe that the appeal mechanism the state is proposing in place of hearing rights before an ALJ does not satisfy due process. Our reasons follow.

a. *Current Regulations.*

Currently, providers have 60 days to appeal an overpayment, and they are only required to file the equivalent of a notice of appeal within this 60 day period (18 N.Y.C.R.R. § 519.7).² The regulations do not limit the grounds a provider may assert in appealing the overpayment determination. The provider is entitled to a hearing before an ALJ, with the opportunity to present and cross-examine witnesses. The ALJ must issue a decision within 120 days of the date of the hearing.

b. *Proposed Regulations.*

i. Time In Which to File Appeal. The proposed rule would allow providers only 30 days to file an appeal, instead of 60 days. The 30 days is to run from the date of “the notice.” However, the proposed regulations inadvertently eliminate the requirement for the department to provide notice. (*See* discussion in section 3, below.) As currently written, it would appear that the provider must submit all material in support of the appeal within this 30 day time frame (supporting documents and written arguments). We believe that there is no justification for shortening the time frame in which to file an “appeal.” This is particularly the case since the proposed appeal mechanism is not designed as one in which there is an expedited review. It includes no timeframe on when the agency must issue its decision after an “appeal” has been filed. We further believe that shortening the time frame to 30 days is

¹ The existing Medicare definition of an “overpayment” states that it “means the amount paid by a Medicaid agency to a provider which is in excess of the amount that is allowable for services furnished under section 1902 of the Act and which is required to be refunded under section 1903 of the Act.” The existing definition under NY Medicaid regulations is: “An overpayment includes any amount not authorized to be paid under the medical assistance program, whether paid as the result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse or mistake.” 18 N.Y.C.R.R. § 518.1(c).

² The current regulations provide: “Request for a hearing. (a) Any clear, written communication to the department by or on behalf of a person requesting review of a department’s final determination is a request for a hearing if made within 60 days of the date of the department’s written determination.” 18 N.Y.C.R.R. § 519.7

tantamount to denying providers any right to appeal, since most providers will require more time than 30 days to pursue even the minimal appeal rights contemplated by the proposed regulation: collecting additional documents and presenting written arguments to contest the initial determination. Since there will be no prejudice to the state of providing at least 60 days to appeal (the current timeframe for simply filing a notice of appeal), we strongly recommend that the timeframe for filing an appeal be no less than 60 days.

ii. Grounds for Appeal. The proposed rule would limit the grounds for appeal to “mistake of fact.” The proposed rule fails to allow a provider to challenge the agency’s determination on other grounds, including whether the determination is contrary to law, arbitrary and capricious, an abuse of discretion, or otherwise erroneous due to matters such as flaws in the statistical sampling or extrapolation methodology. The agency has not proposed any justification for limiting the grounds for appeal, and we cannot imagine any justification that would be sustained under due process principles.³ For the foregoing reasons, we recommend that there be no limitation on the grounds a provider may raise in an appeal. In the alternative, we recommend that the grounds for appeal include, at a minimum, whether the determination is contrary to law, arbitrary and capricious, an abuse of discretion, or is otherwise erroneous (due to matters such as mistake of fact or flaws in the statistical sampling or extrapolation methodology).

iii. Right to a Hearing Before an ALJ. The proposed rule would eliminate the right to a hearing before an independent hearing officer. Instead, the provider would be entitled to provide “written arguments and documentation.” These arguments and documentation are apparently to be submitted to the same agency which made the decision in the first place, with no provision for someone other than the initial decision-maker to review the documents or arguments. Although the proposed rule calls the substitute created by section 540.6(e)(8) an “appeal,” it is really in the nature of a reopening or reargument before the same agency, and indeed potentially the same decision-maker at the agency.

The issues to be decided in third party liability cases are whether the provider “produces acceptable documentation to the department that the provider reasonably attempted to ascertain and satisfy any conditions of approval or other claiming requirements of liable third-party payors.” *See VNS Decision*, 5 N.Y.3d 499 at 507, quoting 18 N.Y.C.R.R. § 540.6(e)(6). These questions are of a type best resolved in a hearing. Indeed, the current regulations already provide for a decision without a hearing where there are no material issues of fact in dispute. 18 N.Y.C.R.R. § 519.23.

iv. Time Limit on Agency Action. The proposed rule fails to require the agency to issue a determination on an “appeal” within any time limit. In contrast, under 18 N.Y.C.R.R. § 519.22, an ALJ must issue a decision within 120 days of the conclusion of the hearing. If you are going to shorten the time to file an appeal (discussed above), the only justification for doing so would be to provide an expedited review mechanism, in which case you should add a time limit (shorter than 120 days) in which the agency must issue a final determination.

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In this connection, we understand that currently Medicaid and Medicare frequently differ on the basic legal issue as to whether, under existing Medicare regulations and guidelines, a given service provided to a dual eligible patient for which Medicaid would pay as the payor of last resort is properly billable to Medicare.

v. Exhaustion of Administrative Remedies and Standard of Review. In the case of an ALJ hearing, once a decision is issued, a provider has a right to sue in court under Article 78 of the CPLR. The standard of review in such cases is whether there is substantial evidence to support the decision of the ALJ. If the ALJ hearing is eliminated, the question will arise as to whether a provider must exhaust administrative remedies at all. If the administrative remedy is, as has been proposed, simply in the nature of a reargument before the same decision-maker (i.e. a reconsideration), we believe it is likely that providers will not be required to exhaust administrative remedies before filing a lawsuit in court. Moreover, the standard of review in court will not be whether the agency determination was based on “substantial evidence,” since there will be no hearing record. This could lead to a situation in which providers have an incentive to sue, even though pursuing a lawsuit is likely to be more costly for both providers and for the agency. We doubt that the courts will welcome this result. Moreover, we believe the existing system, which uses the expertise of ALJs who regularly hear similar cases, is a more cost-effective and wiser use of resources.

For the foregoing reasons, we believe that the proposed rule’s substitute for the hearing rights does not satisfy due process. If the agency believes that there is a benefit of adding a provision requiring reconsideration before allowing a hearing before an ALJ (instead of as a substitute for a hearing), we would be willing to consider such a proposal, provided that the reconsideration process is altered to address the issues set forth above.

3. The Proposed Amendments Have Inadvertent Consequences.

a. Proposed Amendments. The proposed amendments to the DSS regulations include three separate amendments designed to eliminate provider’s hearing rights.

i. First, in proposed rulemaking MED-39-09-00007-P, the state proposes to amend 18 N.Y.C.R.R. § 519.4(b) to expand the list of actions for which there is no right to a hearing by adding a new subsection (4) relating to cases involving third party liability.

ii. Second, in proposed rulemaking MED-39-09-00008-P, the state proposes to amend 18 N.Y.C.R.R. § 518.1(c), which is the definition of an “overpayment,” to add a sentence which eliminates from the definition of an overpayment: “amounts related to cases involving third party liability established under Parts 540.6(e) and 542 of this Title.”

iii. Third, in proposed rulemaking MED-39-09-00008-P, the state proposes to amend 18 N.Y.C.R.R. § 518.5(b) – which applies only “when a determination is made that an overpayment has been made” - to expand the situations in which the procedures set forth in § 518.5(a) do not apply so that they will no longer apply “To cases involving third party liability under Parts 540.6 and 542 of this Title.” These procedures, which would no longer apply, include “notice of the overpayment and an opportunity to be heard in accordance with the procedures under Part 519 of this Title.”

b. Inadvertent Consequences. As a technical matter, amending the definition of an “overpayment” to remove all cases relating to third party liability has a number of consequences which the drafters may not have realized. For example, if an “overpayment” no longer includes third party liability cases, the state will be under no obligation to give “notice” to providers pursuant to 18 N.Y.C.R.R. § 518.5(a) in third party liability cases. For the state to satisfy due process – and for the appeal rights the state proposes to work – the state will have to give notice to providers so that they can

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appeal within the time frame adopted in any final rule. In addition, if the proposed regulation is adopted as currently written, the state will have no right to collect interest on third party liability cases under 18 N.Y.C.R.R. § 518.4, since the right to collect interest accrues only in cases involving an "overpayment." We have not examined all of the contexts in which state regulations and guidance use the term "overpayment" to see whether there are other, unintended consequences of the proposed regulation. We believe that the current Medicaid definition of an "overpayment," which is consistent with the Medicare definition, is appropriate. Indeed, even if you plan – despite our objections – to eliminate provider's hearing rights in third party liability cases, you do not need to amend that definition.

4. Conclusion. In sum, for the foregoing reasons, we recommend that you:

- a. not eliminate a provider's right to a hearing before an ALJ, and
- b. if you seek to add a requirement or an option that a provider may seek reconsideration before appealing to an ALJ, you should
 - i. increase the time for filing from 30 to at least 60 days,
 - ii. not limit the grounds to be considered, and
 - iii. add a time limit in which the agency must render its decision.

Very truly yours,



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