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HEALTH LAW SECTION

2008-2009 Officers

ROSS P. LANZAFAME

Chair
Harter Secrest Emery LLP
1600 Bausch and Lomb Place
Rochester, NY 14604
585/231-1203
FAX 585/232-2152

EDWARD S. KORNRICH

Chair-Elect
Proskauer Rose LLP
1585 Broadway
19th Floor
New York, NY 10036
212/969-3395
FAX 212/969-2900

ARI J. MARKENSON

Vice-Chair
Cypress Health Care Management, LLC
44 South Broadway, Suite 614
White Plains, NY 10601
914/390-4366
FAX 866/280-2653

FRANCIS J. SERBAROLI

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212/504-6001
FAX 212/504-6666

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518/462-3000
FAX 518/462-4199

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October 20, 2008

By Email/PDF

Kathleen Ceroalo

NYS Department of Health

Corning Tower Bldg. - Room 2438

Albany, NY 12237

Re: Proposed Rule No. HLT-36-08-00033-P

Dear Ms. Ceroalo

In this proposed rulemaking, the Department of Health ("DOH") establishes a new Subpart 86-8 in which it sets forth a new reimbursement methodology based on Ambulatory Patient Groups ("APGs") for ambulatory services provided in the following facilities: general hospital outpatient clinics, diagnostic and treatment centers, and ambulatory surgery centers. We have the following comments on this proposed rule.

Relationship to Existing Subpart 86-4.

The proposed regulations do not include any discussion of the relationship of this new Subpart 86-8 to existing Subpart 86-4, which contains the current reimbursement methodology for free-standing ambulatory care facilities. We recommend that the rulemaking make the relationship between the two Subparts explicit, clarifying which portions remain applicable, to which facilities, and during what time period.

In this connection, it is our understanding that the existing Subpart 86-4 remains applicable to FQHCs that do not elect reimbursement under the new Subpart 86-8. It is also our understand that the existing Subpart 86-4 remains applicable for all other free-standing facilities until the end of the four year transition period for that portion of the blended rate that remains cost-based.

Transition Period for Existing Facilities.

The proposed regulation contains a four-year transition period for new facilities in Section 86-8.6. Under the statute, existing facilities also have a four-year transition period during which there is to be a blend of the old rate methodology and the new rate methodology. It is our understanding that DOH decided it was not necessary to include the transition period for existing facilities in the regulations, since this provision is in the statute.

We believe that failure to address the transition period for existing facilities in the regulations is likely to cause confusion. For example, Sections 86-8.7 through 86-8.9 could be read to mean that the operating component of the rate for an existing facility is to be computed on the basis of APGs alone, without blending the APG determined rate with the facility's existing cost-based rate. Therefore, we recommend that DOH revise the proposed regulations to specify that existing facilities have a four-year transition period, at the very least by cross-referencing the applicable statutory provision. For example, in section 86-8.10(e), DOH cross-references another statutory provision.

Are Physician Professional Services Included in or Excluded from the Rates?

The proposed rule does not explicitly address whether physician services are included in or excluded from the rates payable under this new Subpart. Since the list of excluded services set forth in section 86-8.10 does not list physician services as an excluded service, it is arguable that those services are included in all of the APG based rates. However, DOH has a power-point presentation on its website in which it states that physician costs are to be billed separately for certain categories of outpatient services, such as ER services, while they are to be included for other categories of services. Moreover, in the case of hospital outpatient clinics, the DOH power-point states that each hospital outpatient clinic may continue its existing practice with respect to physician services, which for some hospitals is to include physician services in the rate, and for other hospitals is to exclude physician services from the rate. We recommend that DOH explicitly address whether, and for which facilities, physician services and costs are included in the rate and are excluded from the rate.

Bad Debt.

The existing regulations in 86-4.12 provide that diagnostic and treatment centers are entitled to an allowance to be added to the basic rate for bad debt and charity care. The new Subpart 86-8 currently includes no provision relating bad debt. We recommend that the proposed regulations be revised to specify all adjustments or allowances which are to be added to the basic rate.

Administrative Rate Appeals (Section 86-8.5).

DOH proposes that rate appeals must be filed within 120 days of the date that the rates are "published by DOH to the facility." (*See* proposed 10 NYCRR 86-8.5(a).) It is unclear what is meant by the term "published." If DOH intends this phrase to mean the date that DOH issues the rates, then the proposed regulation sets forth a timeframe that is inconsistent with the existing DOH regulation governing appeals of hospital rates. The existing regulation allows an appeal to be filed within 120 days from the facility's receipt of the rate sheet from DOH. *See* 10 NYCRR § 86-1.17(a)(2).

Similarly, DOH proposes in subsection 86-8.5(b) that after the initial determination on a rate appeal, a facility must file any further appeal within 30 days of “the date DOH issued such written determination.....” This proposed rule is also inconsistent with the existing regulation governing appeals of all hospital rates and of DTC rates. These existing regulations allow a hospital or DTC to file a further appeal 30 days from the facility’s “receipt” of the determination on the initial appeal. *See* 10 NYCRR § 86-1.17(c) and § 86-4.17(a). We are concerned that, given the short time frame for appeal (30 days), proposing to have the time to appeal run from the date DOH issues a decision will leave too short a window for a provider to exercise its appeal rights. Moreover, the new provision is likely to cause confusion, since all other appeal rights run from the date of receipt. Providers used to the rules applicable in all other circumstances may inadvertently miss the deadline for appeal under Subpart 86-8.

Therefore, we recommend that DOH revise the proposed rule so that the time to file both all appeals runs from the date of receipt. To the extent that DOH is concerned that it has no way to track when a facility has received a determination, it could revise the proposed regulation to use the approach CMS has used in Medicare rules, in which a facility is presumed to have received a determination five days after the date it is issued.

Scope and Definitions (Sections 86-8.1 and 86-8.2).

DOH uses the term “diagnostic and treatment centers” in subsection (a)(4) and “free-standing ambulatory surgery centers” in subsection (a)(5) of section 86-8.1. As we understand it, a free-standing ambulatory surgery center is a type of diagnostic and treatment center. Accordingly, DOH may want to consider modifying the terms used for these facilities or adding defined terms to section 86-8.2.

We recommend that DOH clarify what services it means to exclude in section 86-8.1(b)(2). As presently written, this section would exclude: “payments for services which are not provided pursuant to a facility’s licensure under article 28 of the public health law.” It is not clear from this phrase what services DOH means to exclude. Is DOH addressing facilities that, under one corporate entity, operate multiple sites - each under a separate license and only some of which are licensed under Article 28 of the Public Health Law? Or, is DOH seeking to address a facility that has a single site licensed under article 28 which has services dually licensed by one of the “O” agencies? Even in the latter case, if the services are dually licensed by DOH and an “O” agency, they are still licensed under Article 28.

The current definition of “Packaging” in section 86-8.2(k) is too vague. It gives broad discretion to DOH to develop and change the application of this definition, without any

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notice to or comment by providers and their advisors. DOH should specify in what circumstances it believes that routine ancillary services and drugs should be deemed to be included in the APG, and providers should be given an opportunity to comment on the DOH proposal in notice and comment rulemaking. The same comment applies to the DOH definitions of "Consolidation" and "Discounting" set forth in section 86-8.2(e) and (g).

Peer Groups (Section 86-8.8(d)).

Section 86-8.8, in describing the base rates, states that "Additional discrete base rates may be developed by the Department for such peer groups as may be established by regulation in this Subpart." It is our understanding from this statement that if DOH seeks to establish any peer groups, it will do so only after engaging in notice and comment rulemaking.

Sincerely,



Ellen V. Weissman
Chair, Payment & Reimbursement Committee,
Health Law Section