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Inside

NYSBA

HEALTH LAW JOURNAL

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THE HEALTH LAW SECTION
NEW YORK STATE BAR ASSOCIATION

in cooperation with

ALBANY LAW SCHOOL

A Message from the Section Chair

It used to be common to wonder about whether one's life was sufficiently "relevant" and whether what one did mattered much. Even asking those questions in this new century sounds a bit dated, but the doubts sometimes linger, particularly when we might be spending inordinate amounts of time on something unlikely to grace the pages of the *New York Law Journal*, let alone be aired on "Court TV."

Nevertheless, we in the Health Law Section have a strong claim to relevance—at least most of the time and in most of what we do in our professional lives. Our practice is, after all, largely devoted to advising patients, practitioners, health care facilities, health plans and an array of other health care clients what the rules are in our highly complex health care system—and, even on our least exciting days, we probably make some modest contribution to making that system work. Because what our clients do is important, what we do is important, particularly when we help ensure that the health care world—and the people who inhabit it—fulfill their various roles and responsibilities in accordance with the rules.

And those of you who devote yourselves to the work of this Section can be particularly confident of the relevance of your work. This Section has played, for example, an important and growing role in the development of health care legislation, regulation and policy in New York State for decades. We have been in the forefront of the effort to enact legislation that would allow family members to make health care decisions for loved ones who have not executed health care proxies and have addressed issues as varied as genetic testing and screening, mental health insurance coverage, professional discipline and telemedicine in legislative testimony and reports.

Our public service mission extends beyond the policy arena. Members of our Section's Committee on AIDS and the Law and the Consumer/Patient Rights Committee organized and presented a program entitled "Returning to Work with HIV, Cancer or Other Chronic Illnesses," aimed at educating caregivers, patients and their advocates about legal issues relating to the rights and challenges faced by persons with chronic illness in the workplace. The Section has participated in Law Day and senior citizen legal clinics, has educated the media about emerging health care issues, and has undertaken first-class CLE programs—most recently in the areas of fraud and abuse, HIPAA and professional discipline and, this spring, on long-term care issues.

Our Annual Program focus speaks to our continued relevance: in the ongoing debate over the future of the American health care system, it is important to ask how the legal system either advances or diminishes the quality of health care. We will be devoting a full day of presentations to this critical cutting-edge topic and expect to make an important contribution to the quality of health care debate in New York State.

"[T]hose of you who devote yourselves to the work of this Section can be particularly confident of the relevance of your work."

This *Journal* continues to provide Section members with articles that are useful, timely and thoughtful. This special edition will enhance our understanding of the complex and critical topic of long term care regulation in New York. I thank and congratulate guest editors Ari Markenson and Sandra C. Maliszewski for assembling this excellent roster of articles.

If you need any further evidence of the relevance of the health care practice, turn no further than your nearest newspaper or news magazine and try to avoid articles addressing issues like the right to refuse or discontinue medical treatment, Internet sales of prescription drugs, genetic medicine's latest breakthroughs, Medicare reform efforts, or the problems of the uninsured. In my view, we're privileged to be part of a field that really does matter—and it remains the mission of the Health Law Section to provide you with an opportunity to maintain this discipline's relevance and importance in the broader world in which we live.

James W. Lytle

In the New York State Courts

By Leonard Rosenberg

Court of Appeals Upholds Department of Health's Interpretation of Nursing Home Regulation to Require Actual Improvement As Condition of Reimbursement for Restorative Therapy

In re Elcor Health Services, Inc. v. Novello, 100 N.Y.2d 273, 763 N.Y.S.2d 232 (2003). In this suit, Elcor Health Services, Inc. ("Elcor") challenged the Department of Health's ("DOH") interpretation of 10 NYCRR 86-2.30(i)(27) so as to require "actual improvement" by a resident before a nursing home can receive reimbursement for restorative therapy.

Upon admission to a nursing home, a resident's needs are assessed in a process that includes completion of a patient review instrument (PRI). Aggregate PRI results affect the nursing home's Medicaid reimbursement rate.

Several PRI questions relate to the patient's need for restorative therapy or maintenance therapy. To satisfy the requirement for restorative therapy, the instructions require medical documentation demonstrating that "[t]here is a positive potential for improved functional status within a short and predictable period of time. Therapy plan of care and progress notes should support that patient has this potential/is improving" [10 NYCRR 86-2.30(i)(27)]. A resident without such potential would qualify only for maintenance therapy.

DOH prepared a clarification sheet that also imposed an "actual improvement standard" with respect to restorative therapy. It states that the documentation must not only show that the resident had a potential for significant improvement in functional status, but also that the resident is actually improving. After

an audit of Elcor's PRI results, the Department concluded that because 29 residents did not actually respond to therapy or improve, they should have been placed in the maintenance therapy category. As a result, Elcor's Medicaid reimbursement was reduced.

Elcor brought an article 78 proceeding to challenging DOH's action. The Supreme Court found that the actual improvement requirement in the clarification sheet was a regulation that had never been properly promulgated or filed by DOH. The court ordered DOH to recalculate Elcor's reimbursement rate without using the actual improvement standard. However, the Appellate Division reversed the Supreme Court, holding that the actual improvement standard was a reasonable interpretation of the restorative therapy requirement, and not an unpromulgated rule. The Appellate Division granted Elcor leave to appeal.

The Court of Appeals first rejected Elcor's contention that the actual improvement standard is an unpromulgated rule, and instead regarded it to be a "reasonable interpretation" of the regulation. The Court then rejected Elcor's argument that the actual improvement standard was arbitrary and capricious, noting that the Second Circuit Court, in *Concourse Rehabilitation & Nursing Center v. Whalen*, 249 F.3d 136 (2d Cir. 2001), held that the actual improvement standard was not arbitrary and capricious because the state considered the costs of furnishing restorative therapy as required by the federal statute.

Finally, the Court considered Elcor's allegation that that the standard resulted in reimbursement rates that violated Public Health Law § 2807(3), which requires that reimbursement rates be reasonable and adequate to meet the costs incurred by efficiently and economically operated facilities. The Court disagreed, finding the Department's interpretation was not inconsistent with reimbursement for "efficiently and economically operated facilities."

Note: The full text of the Elcor *decision appears on page 54.*

Court Lacks Authority to Transfer Patient to Non-secure Facility in Context of Article 9 Retention Proceeding

Consilvio v. Michael B., 764 N.Y.S.2d 12 (1st Dep't 2003). Pursuant to Mental Hygiene Law § 9.33, a hospital sought to retain the respondent as an involuntary psychiatric patient. The judge presiding over that proceeding directed that the respondent be transferred from a secure psychiatric facility to a non-secure one. The Appellate Division reversed that order.

The Appellate Court reasoned that in the context of a Mental Hygiene Law Article 9 retention proceeding, the court lacked the power to mandate the transfer in question, because the only relevant inquiry is the patient's continuing need for involuntary care and treatment in a psychiatric facility. The court's authority to delve into an administrative determination to maintain a patient at a secure facility is limited to one of two instances: 1) a CPLR Article 78 proceeding to contest a decision by the Office of Mental Health (OMH) to transfer a patient to a secure facility; or, 2) a CPLR Article 78 proceeding to contest an

OMH denial of a patient's request for an order of transfer from one facility to another. Article 9 of the Mental Hygiene Law does not endow a court with the power of de novo review of an administrative decision to confine a patient at a secure facility.

The Appellate Division noted that due process constraints are met despite the unavailability of such de novo judicial review under Article 9 of the Mental Hygiene Law. Citing the Court of Appeals' decision in *Mental Hygiene Legal Services on behalf of Aliza K.*, 92 N.Y.2d 500, 683 N.Y.S.2d 150, the court noted that the administrative determination concerning the transfer of a patient from a non-secure to a secure facility "satisfy[ies] the requirements of procedural due process in all respects" in light of the fact that such a decision is one better made by medical professionals than by judges.

Absent "Clear and Imminent Danger" to Petitioner, Court Abused Its Discretion by Ordering Disclosure of Confidential HIV and Hepatitis Test Results

In re Garinger, 759 N.Y.S.2d 550 (2d Dep't 2003). The Public Health Law (PHL) and Mental Hygiene Law (MHL) require health and social service workers to maintain the confidentiality of HIV and other health-related information, except to the extent ordered by a court. PHL § 2782(k); MHL § 33.13. A court may grant an order for disclosure of confidential HIV-related information upon an application showing "a clear and imminent danger to an individual whose life or health may unknowingly be at significant risk as a result of contact with the individual to whom the information pertains." PHL § 2785.

In this case, a proceeding was brought pursuant to PHL §§ 2782(k) and 2785, and MHL § 33.13, in which the petitioner obtained an order directing the release of the respondent's medical and clinical records insofar as those records contained the results of HIV and hepatitis tests taken by the respondent. To the extent that the respondent's clinical records did not contain the results of such tests, the order directed the respondent to take the necessary tests and reveal the results to the petitioner.

The Appellate Division reversed the order directing disclosure of confidential HIV information, holding that the petition failed to allege any material facts to support a finding that the disclosure was warranted by "clear and imminent danger" to the petitioner. The court also held that the petitioner presented no facts to support its argument that the interests of justice significantly outweighed the respondent's need for confidentiality in otherwise protected health information.

With regard to compelling the respondent to take an HIV or hepatitis test, the Appellate Division held that the petition failed to cite any specific statutory authority that would allow the court below to compel the respondent to be tested for HIV. It further held that the court below abused its discretion in ordering the respondent to take a hepatitis test, as there was no evidence that the respondent was ever suspected of having hepatitis.

Physician's Non-Compliance with OPMC Comprehensive Medical Review Order Constitutes Professional Misconduct

Daniels v. Novello, 762 N.Y.S.2d 141 (3d Dep't 2003). In response to a complaint against the petitioner physician, the Office of Professional Medical Conduct (OPMC) ordered a comprehensive medical review (CMR) of the physician's patient and office records pursuant to the Public Health Law. The physician unsuccessfully challenged that order in an Article 78 proceeding. Thereafter, the physician still refused to comply with the CMR order, which refusal served as the basis for a charge of professional misconduct under Education Law § 6530[15].

At the hearing of that misconduct charge, the Administrative Law Judge (ALJ) refused the physician's attempt to submit evidence relating to the merits of the allegations that gave rise to the CMR order. The hearing panel found that the physician's refusal to comply with the CMR order constituted misconduct, and imposed a suspension of the physician's license until 60 days after compliance with the CMR order. That decision was affirmed upon administrative appeal.

The Appellate Division ruled that the ALJ's decision to exclude evidence concerning the merits of the underlying allegations was proper, because the only conduct under review was the physician's refusal to comply with the CMR order, which refusal itself constituted professional misconduct. The factual predicate for the CMR order had no bearing on the petitioner's uncontroverted refusal to comply with the CMR order; thus the refusal was a rational basis for the misconduct finding.

The Appellate Court did, however, annul the penalty as unauthorized by statute, because the Public Health Law does not permit a license suspension to continue until a CMR order is satisfied. Instead, the PHL authorizes either a suspension for a fixed period of time, or a suspension continuing until the completion of a course of retraining, therapy or treatment.

Conviction for Unauthorized Practice of Medicine Upheld for Knowingly Hiring Unlicensed Physician

In *People v. Corines*, 764 N.Y.S.2d 117 (2d Dep't 2003), the Appellate Division, Second Department, upheld the conviction of a physician for unauthorized practice of medi-

cine. The conviction was not premised upon the physicians' own conduct of practicing medicine without a license—he was a duly licensed physician—but rather upon a theory of vicarious liability. The evidence presented at his trial showed that he knowingly employed a suspended physician, who practiced medicine without a license in violation of Education Law § 6512(1) by administering anesthesia to three patients under the care of the licensed physican.

Physician Employee of Hospital-Based P.C. Was Not Entitled to Medical Staff Hearing Upon Loss of Employment with P.C.

Longmore v. Kingston Hospital, 761 N.Y.S.2d 344 (3d Dep't 2003). The Appellate Division held that an emergency room physician employed by a hospital-based professional corporation was not entitled to a hearing under the hospital's bylaws when the hospital began a relationship with a different independent contractor.

The physician worked as an emergency room physician for Kingston Emergency Physicians, P.C. ("P.C."). Prior to 2002, the P.C. provided emergency medical services to Kingston Hospital as an independent contractor. The physician was appointed as a member of the hospital's Emergency Room Department "Courtesy Staff," and was later reappointed for a two-year term ending in December 2002.

In April 2002, Kingston Hospital began a relationship with a new independent contractor. The new entity did not hire the physician, and accordingly he ceased working in the hospital's emergency room. The physician requested a hearing pursuant to the hospital's bylaws. Because the hospital did not employ the physician, it denied his hearing request. The physician then commenced an Article 78 proceeding to compel a hearing, and also sought monetary damages for lost compensation.

The motion court granted the hospital's motion for summary judgment on the ground that the petitioner failed to state a cause of action. In affirming that decision, the Appellate Division held that because the physician was not an employee of the hospital, the hospital did not terminate his employment, and therefore did not take any "adverse action" against the physician that would entitle him to a hearing under the hospital's bylaws.

Likewise, the court found that the physician failed to state a cause of action for damages. Although the physician asserted claims for breach of contract and interference with contractual relations, based on alleged assurances by the hospital's medical director and by the new provider of emergency services that he would be hired, the court held that such allegations were inadequate to demonstrate the existence of any contract.

Court Reaffirms Limited Scope of Judicial Review of Hospital Privilege Determinations

Bhard-waj v. United Health Services, Hospitals, Inc., 303 A.D.2d 824, 755 N.Y.S.2d 766 (3d Dep't 2003). In this case, a physician sought a court order restoring his hospital privileges. The court, noting the limited scope of judicial review regarding claims of an "improper practice" affecting medical staff privileges, found that the plaintiff had failed to establish a right to injunctive relief.

The plaintiff's claims arose after a hospital nurse filed a report alleging patient neglect. In response to the report, the hospital, by its Vice President of Medical Affairs and its Institutional Care Committee, conducted an investigation and concluded that the plaintiff had neglected a patient and had falsely altered the patient's medical records. After numerous hospital medical and executive committees likewise concluded that the plaintiff had provided substandard care and falsely altered the record, the Board of Directors revoked the plaintiff's privileges.

In accordance with Public Health Law § 2801-b, the plaintiff filed a complaint with the Public Health Council wherein he sought the restoration of his privileges. The Public Health Council upheld the revocation, however, giving rise to the plaintiff's suit and the Supreme Court's grant of summary judgment in favor of the defendant hospital.

On appeal, the court noted that judicial review of the hospital's privilege determination was limited to "whether the purported grounds [for the revocation] were reasonably related to the institutional concerns set forth in the statute, whether they were based on the apparent facts as reasonably perceived by the administrators, and whether they were assigned in good faith." Based upon its review of the record, the court found that the grounds for the hospital's action were "plainly related to patient care" and that there were "sufficient apparent facts" as perceived by the hospital's governing body to support its decision. The court also failed to find evidence to support the contention that either the reporting nurse or the hospital had any "ulterior motive." The court thus affirmed the Supreme Court's grant of summary judgment in the hospital's favor.

Physician's Suit Concerning Medical Staff Privileges Barred by Failure to Exhaust Administrative Review by Public Health Council

Indemini v. Beth Israel Medical Center, __ N.Y.S.2d __, 2003 WL 22413725 (1st Dep't 2003). In this case, the Appellate Division for the First Department unanimously held that the court lacked jurisdiction to consider a resident-physician's complaint, based on a long-established

principle that requires a physician to present her claim regarding medical staff privileges to the Public Health Council prior to seeking judicial relief.

The physician plaintiff filed suit after the hospital terminated her employment in the hospital's residency program. The physician appealed after the Supreme Court dismissed her complaint for lack of subject matter jurisdiction. The Appellate Division agreed with the lower court's determination, holding that notwithstanding "artful pleading," section 2801-b of the Public Health Law mandates preliminary review by the Public Health Council before a physician seeking reinstatement of hospital privileges may bring suit.

Under the circumstances, the court found that the reasons given for the plaintiff's termination, all of which related to her competency as a physician, fell squarely within the realm of the Public Health Council's expertise. In view of the statute's purpose of "promoting conciliation . . . and 'avoiding costly and protracted litigation,'" the court ruled that the plaintiff's failure to exhaust her administrative remedy divested the court of jurisdiction.

Narcoleptic Anesthesiologist's Discrimination Suit Against University Hospital Found to Be Without Merit

Timashpolsky v. State University of New York Health Science Center at Brooklyn, 761 N.Y.S.2d 94 (2d Dep't 2003). The plaintiff, an anesthesiology resident at defendant hospital, had his employment terminated after failing to respond to emergency beeper pages on three occasions. The plaintiff was diagnosed with narcolepsy. The plaintiff commenced an action alleging, *inter alia*, "that his termination violated Executive Law § 296(1)(a) and Administrative Code of the City of New York § 8-107(1), which prohibit an employer from discharging an individual because of a disability."

The court noted that to state a prima facie case of employment discrimination due to a disability under both the Executive Law and the New York City Administrative Code, "a plaintiff must show that he or she suffers from a disability and that the disability caused the behavior for which he or she was terminated." Once a prima facie case is established, "the burden of proof shifts to the employer to demonstrate that the disability prevented the employee from performing the duties of the job in a reasonable manner or that the employee's termination was motivated by a legitimate nondiscriminatory reason."

If the employer states a valid nondiscriminatory reason for the termination, "the burden shifts back to the plaintiff to raise a triable issue of fact as to whether the stated reasons for discharge were pretextual."

The Appellate Division found that the hospital established its entitlement to judgment as a matter of law because "[t]he plaintiff's narcolepsy prevented him from performing his duties in a reasonable manner despite the hospital's reasonable attempt to accommodate his needs." The court also found that the hospital demonstrated a legitimate nondiscriminatory reason for the termination.

Appellate Division Dismisses Registered Nurse's Discrimination Lawsuit Against Hospital

Laub v. St. Vincent's Medical Center of Richmond, 761 N.Y.S.2d 97 (2d Dep't 2003). The plaintiff, a registered nurse, took a leave of absence from the hospital to enter a rehabilitation program to combat her abuse of the prescription painkiller Demerol. The plaintiff was permitted to return to the hospital on condition that she agree to certain terms, including adherence to the hospital's attendance policy, acting in a professional manner and maintaining acceptable performance appraisals. The plaintiff signed a letter containing these terms, which provided that a violation would result in the termination of her employment.

The hospital subsequently terminated the plaintiff's employment. She then commenced an action, *inter alia*, "to recover damages for employment discrimination under Executive Law Article 15 alleging that the defendant discharged her because it perceived her as a drug user." The Appellate Division reversed the motion court and granted the hospital's motion for summary judgment and dismissed the plaintiff's discrimination suit.

The Appellate Division held that the hospital "made a prima facie showing of entitlement to judgment as a matter of law by demonstrating that it had valid nondiscriminatory reasons for the plaintiff's discharge." Specifically, the court noted that "the plaintiff had been given two written warnings regarding absenteeism, had committed an error in submitting documentation accompanying a urine specimen, and had a substandard job performance evaluation, all of which violated the terms of employment to which she had agreed, after returning from her medical leave of absence." As a result, the court held that plaintiff had "failed to raise a triable issue of fact as to whether the defendant's reasons for her discharge were pretextual."

Appellate Court Reverses Supreme Court in Upholding Patient's Right to a Jury Trial in Guardianship Proceeding

In re Department of Social Work of Beth Israel Medical Center, 764 N.Y.S.2d 87 (1st Dep't 2003). The appellant was admitted to Beth Israel Medical Center (the "Medical Center") for treatment of an infected foot ulcer. She suffered from certain

functional disabilities and her boyfriend, with whom she resided, allegedly abused the appellant.

Hospital personnel entered her apartment and found it to be neglected. Additionally, Visiting Nurse Service refused a referral for home health care. For these reasons, the Medical Center commenced a guardianship proceeding and counsel was appointed for the appellant.

Counsel for the appellant timely demanded a jury trial, in accordance with Mental Hygiene Law § 81.11(f). The Supreme Court, however, decided to conduct a conference in chambers the day after the jury demand. At the conference, the Supreme Court indicated that it would conduct a "preliminary hearing" to evaluate appellant's competence and whether a guardian should be appointed.

Counsel objected on the basis that the statute did not provide for a preliminary hearing and once again demanded a jury trial. The Supreme Court denied the request for a jury trial and immediately commenced the preliminary hearing despite counsel's objection that she was prepared for a conference in chambers, but not for an immediate hearing.

Nevertheless, the hearing proceeded and the Medical Center was permitted to call witnesses in support of its application for a guardian. At the close of the hearing, over counsel's objection, the Supreme Court granted the Medical Center's application for a temporary discharge of the appellant to a nursing home.

The Supreme Court also determined that the appellant had failed to rebut the Medical Center's *prima facie* case and also had failed to raise any issues of fact regarding the need for a guardian. On this basis, the Supreme Court denied the appellant's demand for a jury trial and granted the Medical Center's application for an order finding that the appellant was an incapacitated person requiring the appointment of a guardian.

In unanimously reversing the Supreme Court and ordering a jury trial, the Appellate Division for the First Department noted that the Supreme Court had addressed the ultimate issue of incapacity rather than conducting a preliminary hearing to determine whether or not there were unresolved issues of fact.

The Appellate Court found that there were factual issues regarding why Visiting Nurse Service was not an available resource and the unavailability of alternative home care services that might foreclose the need for the appointment of a guardian. As a result of these unresolved factual issues, and because the Supreme Court failed to develop a factual record and did not provide counsel with an opportunity to do so, the Appellate Court held that a jury trial was required pursuant to Mental Hygiene Law § 81.11(f).

Claim of Violation of Nursing Home Residents' Rights Certified as Class Action

Fleming v. Barnwell Nursing Home and Health Facilities, Inc. (App. Div., 3d Dep't Oct. 30, 2003). In a malpractice, negligence and wrongful death action against a nursing home, the plaintiff added a cause of action pursuant to Public Health Law § 2801-d, which provides a private right of action for nursing home residents to recover for the deprivation of certain rights, and moved for class action certification of that claim. Plaintiff's specific allegation was that his decedent—and other unnamed class members who were residents of the facility—received inadequate heat and inedible food. He also moved for class certification of his negligence claim. The trial court had denied the motion for class action certification.

The Appellate Division upheld the denial of class certification of the negligence claim, but reversed the denial of the PHL § 2801-d claim, and permitted it to be certified as a class action. The Court noted that the statute gave nursing home residents a private right of action for denial of their rights. It then reviewed the criteria for class action certification in CPLR Article 9, and concluded that the plaintiff met the criteria, e.g.: that plaintiff's specific claim was typical of class claims, that plaintiff can fairly represent the class, and a class action appears to be the superior method of adjudicating this claim.

The decision is the first reported instance of the certification of a class action based on a claim under PHL Law § 2801-d.

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In the New York State Legislature

By James W. Lytle

Having reviewed in the last issue the recent legislative activity relating primarily to the regulation of health care facilities and services, this update will focus on the regulation of the licensed professions that render health care services. Although the issues may appear to be reasonably straightforward, the regulation of the licensed professions is consistently one of the more contentious set of issues that is confronted annually by the New York State legislature—particularly as it relates to the health care professions. While many legislative proposals considered by the Legislature face only minimal opposition and often pass without debate, most bills relating to the scope or authority of a licensed profession become extremely controversial. Proposals in this arena inevitably attract the competing views of the profession that seeks the enhancement of their practice and any number of professions that see their turf being invaded.

Among the reasons cited for the contentiousness of these issues are New York's well-earned reputation as the center of academic medicine and its record for training and retaining more medical specialists than any other state in the union. Any proposal that might authorize another profession to undertake tasks generally reserved to a specialist physician inevitably draws strong opposition from the state's Medical Society or specialist organization. Other professions view any expansion of a competing profession as a zero sum game. As a result, physicians are pitted against nurse practitioners, ophthalmologists against optometrists (and both against opticians), psychiatrists against social workers and psychologists, physical therapists against occupational therapists—and nurses against just about everybody. Not surprisingly, change is hard to come by in this field: New York will often find itself among the last states in the union to enact legislation that creates or expands a scope of practice for a health care profession.

It should also be noted that the regulation of health care professionals is undertaken principally, but not exclusively, by the Education Department. Most licensed health care professionals are subject to Education Department licensure and all of these, except physicians, are subject to discipline by the Education Department. (Physicians are disciplined by the Office of Professional Medical Conduct within the Health Department.) Certain health care personnel are licensed by the Health Department, including radiation technologists, specialist assistants and nursing home administrators, while still other vaguely health-related personnel are licensed by the Secretary of State, such as cosmetologists, barbers and others.

Perhaps the most significant enactment of the 2003 legislative session in this area relates to the prosecution of the unlicensed practice of a profession. Prior to the new legislation, the state Education Department's jurisdiction was limited to the prosecution of professional misconduct by licensed professionals and did not extend to the authority to prosecute the unlicensed practice of a profession. Under prior law, the state Education Department was required to refer cases of unlicensed practice to the Attorney General's office or to local prosecutors—where the referred cases often languished, given competing prosecutorial priorities. The new legislation (S.4960-A/A.1041-B, Chapter 615 of the Laws of 2003) would allow the Education Department to seek to enjoin the unlicensed practice and would authorize civil enforcement proceedings by the Department to obtain cease and desist orders and civil penalties against unlicensed persons.

While a number of professions are hoping that this new authority will curb the encroachment by unlicensed persons on the practice of professions, they have been advised by the Education Department not to expect a flurry of enforcement activity, at least in the short run. The absence of sufficient funding within the Department to undertake the investigations and prosecutions now authorized by the legislation has been cited as a continuing impediment to launching an aggressive approach to unlicensed practice—a fiscal status that is likely to remain for the foreseeable future.

Other bills that affect the health care professions that were signed into law included the following:

Medical equipment providers and respiratory care (S.1141/A.3476, Chapter 127 of the Laws of 2003): Increases the registration fee for medical equipment providers, now licensed by the Department of Health, and clarifies that respiratory therapy services rendered by such providers must be undertaken by licensed respiratory therapists.

Administration of medication in day care (S.5621/A.8987-A, Chapter 160 of the Laws of 2003): Allows day care providers to continue the current practice of administering medication to children in day care, with parental permission, through March 31, 2006, pursuant to regulations promulgated by the Office of Children and Family Services. While not

addressing professional practice per se, the legislation sparked a vigorous debate among certain health care professions over the propriety of non-licensed persons administering medication to children in day care settings.

Chiropractic continuing education (S.316-B/A.978-A, Chapter 269 of the Laws of 2003): Requires chiropractors to complete sixteen hours of professional continuing education every three years, adding this profession to many of the other licensed professions that are already subject to mandatory continuing education.

Specialist assistants (S.5518/A.8908, Chapter 375 of the Laws of 2003): Bans the creation of any new specialist assistant categories relating to the practice of surgery or in intensive care units of general hospitals, thereby curbing pre-existing authority that had been granted to the Commissioner of Health.

OCFS mental health practitioners (S.3057/A.8997, Chapter 419 of the Laws of 2003): Exempts mental health practitioners employed by the Office of Children and Family Services from certain provisions enacted by Chapter 676 of the Laws of 2002 relating to licensing mental health practitioners.

Pharmacist citizenship requirements (S.4621/A.8578, Chapter 508 of the Laws of 2003): Extends an exemption from citizenship for pharmacists until October 1, 2006, in light of a continuing shortage in this field and as a means to expedite licensure in cases when the citizenship process is pending.

Podiatrist assistant's X-ray authority (S.2760-B/A.1722-B, Chapter 544 of the Laws of 2003): Allows an assistant to a podiatrist to take an X-ray of the patient's foot under the direct supervision of a podiatrist in a podiatric office.

Respiratory therapy referrals (S.3332-A/A.5580-A, Chapter 583 of the Laws of 2003): Clarifies that respiratory therapy services may be performed pursuant to a prescription by a licensed physician or a certified nurse practitioner.

Midwives and clinical laboratory tests (S.1817-A/A.6907, Chapter 585 of the Laws of 2003): Adds professional midwives to the list of practitioners who can order clinical laboratory tests.

Meanwhile, the Governor exercised his veto authority on a number of other profession-related proposals, including a proposal that would have allowed Medicaid reimbursement for clinic-based certified social workers and a proposal that would have provided for the Secretary of State to license electrologists. At least seventy other bills languished in the legislature during 2003 that would have affected the professions in other ways—some of which may become the focus of renewed legislative activity during the coming legislative session.

Compiled by James W. Lytle, managing partner of the Albany offices of Manatt, Phelps & Phillips, LLP. The firm, which has offices in New York City, Washington, D.C. and California, represents a wide array of health care and other regulated entities and devotes a substantial part of its practice to the representation of health care clients before the legislature and state regulatory bodies.

In the New York State Agencies

By Francis J. Serbaroli

Health Department

Part-Time Clinics

Notice of emergency rulemaking. The Department of Health repealed section 703.6, added a new section 703.6, and amended section 710.1(c) of title 10 N.Y.C.R.R. in order to clarify and enhance the regulatory requirements that apply to part-time clinics and require prior limited review of all part-time clinic sites. Filing date: July 24, 2003. Effective date: July 24, 2003. *See* N.Y. Register, August 13, 2003.

HIV Testing

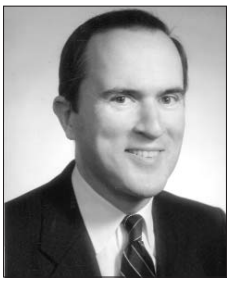
Notice of adoption. The Department of Health amended subpart 58-8 of title 10 N.Y.C.R.R. to revise standards for HIV testing. Filing date: July 24, 2003. Effective date: August 13, 2003. *See* N.Y. Register, August 13, 2003.

Monkeypox

Notice of emergency rulemaking. The Department of Health amended sections 2.1 and 2.5 of title 10 N.Y.C.R.R. to designate monkeypox as a communicable disease which health care providers are required to report to the Department. *See* N.Y. Register, August 20, 2003.

Smallpox Vaccine

Notice of proposed rulemaking. The Department of Health gave notice of its intent to amend sections 2.1 and 2.2 of title 10 N.Y.C.R.R. to enable the Department to monitor for complications associated with smallpox vaccination and enable it to request vaccinia immune globulin on a timely basis from the Centers for Disease Control, which is used to treat adverse reactions to the smallpox



vaccine. *See* N.Y. Register, August 27, 2003.

Expedite HIV Testing of Women and Newborns

Notice of emergency rulemaking. The Department of Health amended section 69-1.3(b) of title 10 N.Y.C.R.R. to enhance protection of newborns by requiring birth facilities to test for HIV exposure status within twelve hours after the infant's birth for all newborns whose mothers have not been tested for HIV during the current pregnancy or for whom HIV test results are not available at delivery. Filing date: August 25, 2003. Effective date: November 1, 2003. *See* N.Y. Register, September 10, 2003.

Newborn Screening

Notice of proposed rulemaking. The Department of Health gave notice of its intent to amend section 69-1.2(b) of title 10 N.Y.C.R.R. to add three disorders to the current New York State newborn screening panel, including: (1) cystic fibrosis (CF), (2) congenital adrenal hyperplasia (CAH), and (3) medium-chain acyl-CoA dehydrogenase deficiency (MCADD). *See* N.Y. Register, September 10, 2003.

Physician Profiling

Notice of emergency rulemaking. The Department of Health added part 1000 to title 10 N.Y.C.R.R. to implement the Patient Health Information and Quality Improvement Act of 2000, which requires the Department to collect information and create individual profiles on physicians that will be available for dissemination to the public. Information to be disseminated about the physicians includes criminal convictions and medical malpractice information. Filing date: August 29, 2003. Effective date: August 29, 2003. *See* N.Y. Register, September 17, 2003.

Live Adult Liver Donation and Transplantation

Notice of proposed rulemaking. The Department of Health gave notice of its intent to amend section 405.22 of title 10 N.Y.C.R.R. to establish minimum standards for live adult liver donation and transplant services at hospitals approved to provide such services. *See* N.Y. Register, September 24, 2003.

Environmental Laboratory Standards

Notice of emergency rulemaking. The Department of Health amended section 55-2.12 and added a new section 55-2.13 to title 10 N.Y.C.R.R. to establish minimum standards for laboratory testing of biological and chemical agents of terrorism. Filing date: September 11, 2003. Effective date: September 11, 2003. *See* N.Y. Register, October 1, 2003.

Smoking Cessation Products

Notice of proposed rulemaking. The Department of Health gave notice of its intent to amend section 85.21 of title 10 N.Y.C.R.R. and section 505.3 of title 18 N.Y.C.R.R. to add over-the-counter smoking cessation products to the list of Medicaid reimbursable products. *See* N.Y. Register, October 1, 2003.

Adult Day Health Care Regulations

Notice of emergency rulemaking. The Department of Health repealed parts 425 through 427 of title 10 N.Y.C.R.R. and added a new part 425 to title 10 N.Y.C.R.R to ensure that individuals receive adult day health care when appropriate, and that providers of such services are accountable for providing necessary and appropriate care. Filing date: September 17, 2003. Effective date: September 17, 2003. *See* N.Y. Register, October 8, 2003.

Severe Acute Respiratory Disease (SARS)

Notice of proposed rulemaking. The Department of Health gave notice of its intent to amend sections 2.1 and 2.5 of title 10 N.Y.C.R.R. to add Severe Acute Respiratory Disease (SARS) to the list of communicable diseases that providers are required to report to the Department. *See* N.Y. Register, October 15, 2003.

Insurance Department

Healthy NY Application Process

Notice of emergency rulemaking. The Department of Insurance amended sections 362-2.3 and 362-4.3 of title 11 N.Y.C.R.R. to simplify the Healthy NY application process by establishing a standardized application and modifying requirements for demonstrating income eligibility for the program. Filing date: August 11, 2003. Effective date: August 11, 2003. *See* N.Y. Register, August 27, 2003.

Physicians and Surgeons Professional Insurance Merit Rating Plans

Notice of emergency rulemaking. The Department of Insurance amended part 152 of title 11 N.Y.C.R.R. to establish guidelines and requirements for excess medical malpractice merit rating plans and risk management plans. Filing date: August 12, 2003. Effective date: August 12, 2003. *See* N.Y. Register, August 27, 2003.

Claim Submission Guidelines

Notice of emergency rulemaking. The Department of Insurance added part 230 to title 11 N.Y.C.R.R. to create claim payment guidelines that establish when a health care insurance claim is considered complete and ready for payment in order to resolve conflicting views between the health care industry and the insurance industry as to compliance with New York's prompt payment statute. Filing date: August 14, 2003. Effective date: August 14, 2003. *See* N.Y. Register, September 3, 2003.

Healthy New York Program

Notice of emergency rulemaking. The Department of Insurance added section 362-2.7 and amended sections 362-2.5, 362-3.2, 362-4.1, 362-4.2, 362-4.3, 362-5.1, 362-5.2, 362-5.3 of title 11 N.Y.C.R.R. in order to enable more uninsured businesses and individuals to afford health insurance under the Healthy New York program by reducing premium rates, simplifying eligibility and re-certification requirements, and adding a second benefit package. Filing date: September 19, 2003. Effective date: September 19, 2003. *See* N.Y. Register, October 8, 2003.

Compiled by Francis J. Serbaroli, Esq. Mr. Serbaroli is a partner in Cadwalader, Wickersham & Taft's 20-attorney health law department. He is the Vice Chairman of the New York State Public Health Council, writes the "Health Law" column for the *New York Law Journal*, and has served on the Executive Committee of the New York State Bar Association's Health Law Committee. He is the author of "The Corporate Practice of Medicine Prohibition in the Modern Era of Health Care" published by BNA as part of its Business and Health Portfolio Series.

The assistance of Cadwalader associates Joanne Oh and Vimala Varghese in compiling this summary is gratefully acknowledged.

For Your Information

By Claudia O. Torrey

On September 26, 2003, the Centers for Medicare and Medicaid Services (CMS) issued the final rule [Medicare and Medicaid Programs; Requirements for Paid Feeding Assistants in Long Term Care Facilities, 68 Fed. Reg. 55528 (Sept. 26, 2003) (to be codified at 42 C.F.R. parts 483 and 488)] permitting long-term care facilities to use paid feeding assistants (FA) for the express purpose of supplementing the services of certified nursing assistants (CNA). This work will be with facility residents who do not have a clinical eating condition that requires a CNA or other nursing personnel. The regulations became effective on October 27, 2003.

"While the nursing home industry applauds these new FA regulations, in general, nursing home advocates and some members of Congress DO NOT!"

Current federal law requires that a CNA, a registered nurse (RN), or a licensed practical nurse (LPN) complete seventy-five hours of training, as well as be certified competent in providing nurse and nursing-related tasks. The FA will have to complete only a minimum of eight hours in a state-approved training course (68 Fed. Reg. at 55539), and no extra money is being allotted under Medicare to skilled nursing facilities for the use of a FA (68 Fed. Reg. at 55537). It is assumed that a FA will be a minimum wage, non-nurse worker without **direct** supervision by an RN or LPN (68 Fed. Reg. at 55533). The FA could conceivably be on the facility payroll as clerical staff or housekeeping staff (68 Fed. Reg. at 55530).

While the nursing home industry applauds these new FA regulations, in general, nursing home advocates and some members of Congress **DO NOT!** The Nursing Home Community Coalition of New York State lists as some of its concerns: FAs replacing CNAs; FAs being inadequately supervised and poorly trained; and potential violations by the CMS of the federal Nursing Home Reform Law [*See* 42 U.S.C. 1395i(b)(5)(F) and 1396(b)(5)(F)]. On the day the regulations were issued, congressional leaders Sen. Charles E. Grassley and Rep. Henry A. Waxman issued a jointly signed letter stating their opposition to the regulations [at http://www.nsclc.org (last visited Oct. 25, 2003)]. Grassley and Waxman state in their letter:

> We agree that malnutrition and dehydration are serious problems in nursing homes, but this problem cannot be solved by using poorly trained, poorly screened, and poorly supervised workers to handle feeding responsibilities. Feeding an elderly resident who may be uncommunicative, and may have difficulty chewing or swallowing, is a complicated task that should be performed only by skilled and properly trained and supervised personnel.

The congressional leaders also cite the results of several investigative reports revealing the mistakes that trained CNAs can make (e.g., a report from the 14th District of New York, April 25, 2003).

Arguably, the pursuit of quality care is very important. The danger of a slippery slope is on the horizon, however, when perceived quality care is translated into a diminution of staff qualifications. That a lawsuit may be brought regarding these regulations is not farfetched.

Claudia O. Torrey, Esq. is a member of the American Health Lawyers Association, the American Bar Association, and a sustaining member of the New York State Bar Association.

Guest Editors' Note

By Ari J. Markenson and Sandra C. Maliszewski

Ari J. Markenson

This Special Edition of the NYSBA *Health Law Journal* on *The Regulation of Long Term Care in New York* is one of several of the recent undertakings of the new Health Law Section Special Committee on Long-Term Care. The Special Committee was created in 2003 to provide a forum for those members of the Section and the health law bar interested in the provider, payor and consumer aspects of the regulation of long-term care and the industry's associated legal issues. The committee's goals include helping to educate the Section and the health law bar on these issues as they have become more prevalent in an increasingly aging society.

It is no surprise to any of us that the American population is aging. Americans are living longer due to technological progress in medical care, particularly heart disease and cancer, the two leading causes of death in the United States, and more health-conscious living. Based on figures presented by the National Center for Health Statistics (NCHS), the average life expectancy has risen and continues to rise. During the past forty years, average life expectancy has risen from 69.2 to 80.2 years of age. By 2000, the life expectancy at 65 years of age had risen to 82.9 years of age; at 75 years of age to 86.3 years of age. Concomitantly, mortality rates have fallen for heart disease and cancer, which accounted for more than half of all deaths in this country each year. The U.S. Census Bureau has noted that while the elderly population 65 years of age and over represented approximately 35 million individuals in 2000, it is anticipated that this figure will reach 82 million by 2050.

As a significant portion of the population ages, the need for all types of long-term care will continue to grow. Although people will be living longer, there will also be more chronically ill individuals. Additionally, these individuals have lived a substantial portion of their lives in a consumer-driven information age and will expect more from the health care industry. Increased consumer and regulator interest in the quality of care provided has already become a significant issue for long-term care providers. The industry will also gravitate, by necessity, toward more long-term care options and state and federal health care programs will see increased utilization (and cost) for long-term care services.

Sandra C. Maliszewski

The changes have already begun. The industry has established various ways of coping with the increasing need for care and the consumer demand for the provision of care in alternative settings, particularly in the home. We have seen a transformation in elder housing and traditional provider types from nursing homes (nursing facilities and skilled nursing facilities) and home care to include assisted living, continuing care communities and independent living arrangements. We have also seen increases in the utilization of home and community-based services, including home care and hospice care.

Given these realities, there will most likely be an increase in long-term care industry and consumer need for advice, counsel and competent legal services from health care attorneys familiar with these issues. As a committee we developed this Special Edition to provide Section members and subscribers with a basic foundation of information on the regulatory atmosphere for the major types of long-term care providers, i.e., nursing homes, home care, hospice care and adult care facilities. We also sought to provide timely substantive articles on issues currently facing many of these providers. These articles cover topics such as reimbursement, regulatory oversight, labor issues and transactional issues.

To the readers of this Special Edition, we hope you find the articles included informative and interesting. We would also welcome your interest and participation in the committees' activities.

In closing, we would also like to acknowledge and thank Scott B. Lunin, Roni E. Glaser, Paul A. Gomez, Thomas G. Smith and Maurice W. Heller, members of the Special Committee on Long-Term Care, who did great work and took considerable time to assist in the planning of the Special Edition and to contribute the articles that are included.

Nursing Homes: Overview of Federal and State Regulation

By Ari J. Markenson

Introduction

The regulatory oversight of nursing homes is shared between the federal and state governments. Facilities participating in the Medicaid program are defined as nursing facilities (NFs), and those participating in the Medicare program are defined as skilled nursing facilities (SNFs). The difference primarily depends upon the type of care provided and covered under each program. Medicare traditionally covers skilled care while Medicaid covers indigent care from long-term custodial care to skilled care.

At the federal level, Congress has legislated minimum standards for the participation of SNFs and NFs in both programs. The standards govern minimum participation requirements and an inspection process to review a facility's compliance. These standards also set forth a prospective payment system (PPS) for facilities participating in Medicare. The Centers for Medicare and Medicaid Services (CMS) promulgated regulations and standards based upon the statutory requirements. Furthermore, CMS contracts with states, including New York State, to assess whether nursing homes meet these standards through annual surveys and complaint investigations. Nursing homes are subject to statutorily delineated sanctions in the event of noncompliance.

On the state level, while the state agency (in New York, the Department of Health, or DOH) has a contractual responsibility to CMS for enforcing federal minimum standards, the DOH also has authority to enforce state statutes and regulations relating to the licensure, operation, and reimbursement of nursing home care under the Medicaid program.

While not comprehensive, the following sections of this overview briefly discuss the primary federal and state laws, regulations, and policy directives concerning nursing home licensure, operations, and reimbursement.

I. Federal Law, Regulation, and Policy

A. Medicare Statutory Operational Requirements

Core federal operational requirements for SNFs in the Medicare program are codified at 42 U.S.C. § 1395(i)-3. These requirements are intended to assure that a SNF provides services to "attain or maintain the highest practicable physical, mental, and psychosocial needs of the nursing home resident." They encompass, *inter alia*, resident assessments, training of nurse aids, resident rights, and administration. They also encompass the survey and certification process, in which periodic surveys are performed by state survey teams, which include a survey of the quality of care furnished to residents, the accuracy of resident assessments and the adequacy of residents' plans of care, and a review of compliance with residents' rights requirements. These requirements delegate the responsibility for quality oversight to the Secretary of the U.S. Department of Health and Human Services (DHHS) but delegate the responsibility of certifying compliance with the survey requirements to the states. These requirements also provide for sanctions for noncompliance.

B. Medicaid Statutory Operational Requirements

Core federal operational requirements for NFs are codified at 42 U.S.C. § 1396r and largely mirror the Medicare operational requirements summarized above. Additionally, the Medicaid operational requirements address the obligations of the state in overseeing facilities participating in the Medicaid program; the conditions of participating in the Medicaid program; circumstances in which the state may grant a waiver of certain requirements to a facility; special rules where the state and the Secretary of DHHS do not agree on a finding of noncompliance; and special rules for timing of termination of participation where remedies overlap.

C. Medicare Statutory Reimbursement Requirements

Since 1998, Medicare's reimbursement system for skilled nursing facility care has been a PPS that includes an adjustment based on the Resource Utilization Groups to which Medicare residents are assigned. The U.S. Congress has raised the payment rates substantially for time-limited periods several times since. The system is still in a state of flux.

The primary statutory provisions relating to the prospective payment system can be found in 42 U.S.C. § 1395yy. Additional requirements related to the payment system and Medicare coverage in general can also be found in 42 U.S.C §1395f and 42 U.S.C. § 395y.

D. Medicare Regulatory Operational Requirements

The federal requirements for participation for long-term care facilities can be found in 42 C.F.R. § 483. These regulations encompass requirements relating to residents' rights, admission, transfer and discharge

rights, resident behavior and facility practices, quality of life, residents' assessments conducted by the facility, quality of care, and service requirements (dietary, physician, rehabilitative, dental, pharmacy, and infection control), physical environment, and administrative requirements.

Furthermore, requirements relating to the survey and certification process for facilities can be found in 42 C.F.R. § 488, subparts A, C, E and F and 42 C.F.R. § 498, relating to appeals of deficiency citations.

E. Medicare Regulatory Reimbursement Requirements

The federal regulatory standards for coverage and reimbursement for SNF care can be found in several parts of title 42 of the C.F.R. The standards primarily relate to the PPS, coverage for care and exclusions from coverage.

The Medicare PPS pays for skilled care based upon a resident's assignment into a resource utilization group (RUG) category. The RUGs groups used in the Medicare program are a version described as RUGs III. This is distinguished from the RUGs II system used in the New York Medicaid system and mentioned below. RUGs III assignments are made by facilities conducting clinical and functional assessments of their residents. Based on those assessments, known as the Minimum Data Set, or MDS, residents are assigned to Medicare per diem payment categories.

Primary standards for coverage can be found in 42 C.F.R. § 409, subpart C and D, Post hospital SNF Care. Prospective Payment provisions can be found in 42 C.F.R. § 413, subpart J, Prospective Payment for Skilled Nursing Facilities. Exclusions from coverage can be found in 42 C.F.R. § 411, 15.

F. CMS Manuals and Policy

1. Manuals

CMS's Publication 12 is the Medicare Skilled Nursing Facility Manual. The manual addresses coverage and reimbursement requirements for SNF providers and is the major policy companion to the applicable regulations. It is divided into five chapters covering general information about the program, coverage of services, payment procedures, admission procedures, and billing procedures. A copy of the manual is available on the CMS Web site at http://www.cms.gov/manuals/12_snf/SN00.asp. Updates and revisions to the manual and CMS policy can be found in CMS program memorandums and transmittals. These documents are too numerous to cite; however, searchable archives are available on the CMS Web site at http://www.cms.gov/manuals/memos/comm_date_dsc.asp.

The federal government has delegated to the states the responsibility for ensuring that SNF/NF providers comply with the requirements for participation through the survey and certification process. The CMS State Operations Manual addresses state requirements for conducting survey and certification activities. Chapter 2 of the manual includes a comprehensive discussion of the certification process for providers. Chapter 7 of the manual specifically addresses the survey and enforcement process for SNFs and NFs. Furthermore, Appendix P to the manual explains the survey procedures, Appendix PP contains the regulatory interpretive guidelines for surveyors conducting survey and certification activities, and Appendix Q sets forth guidelines for determining whether a facility's deficiencies constitute immediate jeopardy to residents.

Additional CMS policy related to resident assessments, MDSs, can be found in Appendix R of the State Operations Manual. As mentioned, the MDS is the primary care planning tool for SNFs and also is integral to assignment of a payment category in the Medicare PPS system.

The State Operations Manual and all its appendices can be found on CMS's Web site at http://www.cms.gov/manuals/PUB_07.asp

2. Agency Letters

CMS has a specific branch that is responsible for communicating policy to the state survey agencies. This branch is called the survey and certification group. The survey and certification group every so often sends letters to the directors of the state agencies concerning survey and certification issues. These letters can be instructive to providers in many ways. The letters are posted on the CMS Web site at http://cms.hhs.gov/medicaid/survey-cert/default.asp.

II. New York Law, Regulation and Policy

A. State Statutory Operational Requirements

The statutory powers of the New York State Commissioner of Health to regulate health care facilities in the state, including residential health care facilities (RHCFs), i.e. nursing homes, are set forth in Public Health Law (PHL) § 2803. Additionally, licensure requirements are generally contained in the hospital licensure provisions of Article 28 of the PHL. These provisions include but are not limited to PHL sections; section 2801-a, establishment or incorporation of hospitals, section 2802, approval of construction, and section 2805, approval of hospitals; operating certificates.

In addition, sections of Article 28 of the PHL apply to specific situations arising in the operation of a licensed nursing home. These sections address resident

rights, resident abuse, security deposits, veterans, receivership, and revocation of an operating certificate. They include PHL section 2801-d, private actions by patients of residential health care facilities; section 2803-c, rights of patients in certain medical facilities; section 2803-d, reporting abuses of persons receiving care or services in residential health care facilities; section 2805-f, money deposited or advanced for admittance to nursing homes, waiver void, administration expenses; section 2805-o, identification of veterans by nursing homes and residential health care facilities; section 2806-b, residential health care facilities, revocation of operating certificates; and section 2810, residential health care facilities, receivership.

Unlike the federal statutory requirements, which set forth in more detail day-to-day operational requirements, most of these types of specific requirements for facilities on the state level are contained in the Official Compilation of Codes, Rules and Regulations of New York ("NYCRR") as will be described below.

B. State Medicaid Statutory Reimbursement Requirements

Similar to the day-to-day operational requirements, most of the reimbursement standards are set forth in regulatory provisions. There are, however, several sections of the PHL and the Social Services Law (SSL) that generally address reimbursement issues. PHL § 2808 addresses rates of payment to RHCFs or nursing homes. Additionally, PHL § 2805-e relates to annual reports of RHCFs to the Commissioner and section 2808-b relates to the certification of financial statements and financial information of licensed facilities.

The general coverage and reimbursement provisions for Medical Assistance, i.e., Medicaid, in the SSL also address coverage for nursing home services. These provisions are generally contained in Article 7, title 11 of the SSL.

C. State Regulatory Operational Requirements

State regulations governing operational requirements for nursing homes can be found in part 415 of title 10 of the NYCRR. The requirements almost entirely mirror the federal requirements in 42 C.F.R. § 483 mentioned above. They do, however, contain several differences. These subtle differences are not described in this overview, although practitioners should be aware of them and look to both sets of requirements when advising their clients.

The minimum standards contained in part 415 include requirements relating to residents' rights, resident behavior and facility practices, quality of life, quality of care, clinical services (nursing, medical, dietary, rehabilitation, dental, pharmacy, laboratory, infection control, and radiology/diagnostic services), record keeping, administration and organization of the facility, physical environment, and specialized programs (HIV/AIDS, ventilators, behavioral problems and traumatic brain injury).

D. State Medicaid Regulatory Reimbursement Requirements

Medicaid reimbursement for RHCF services to a resident depends upon a number of factors. Facilities are generally provided a base rate (determined on a historical base year cost plus trending adjustments), which is then adjusted periodically by a case mix calculation. This case mix adjustment is arrived at by performing resident assessments (in this case, the Patient Review Instrument, or PRI) in order to assign a resident to an RUG II category. The RUG II categories are not as expansive as the Medicare RUG III categories mentioned earlier. They also do not translate into a direct per diem payment as they do under the Medicare PPS. Rather, they are used to determine a facility's case mix or overall acuity of residents.

PRI assessments, cost-based reimbursement principles, and other reimbursement related standards can be found in several sections of title 10 of the NYCRR. PRI instructions and standards can be found in 10 NYCRR § 400.11–§ 400.14. Specific cost-based reimbursement principles and standards can be found in 10 NYCRR § 86-2 and Article 9, §§ 450–458.

Practitioners should also be aware that due to the historical role of the former Department of Social Services in administering the Medicaid program, certain requirements relating to reimbursement are still contained in title 18 of the regulations of the former department. For example, standards relating to the payment for reserved beds and residential health care in general can be found at 18 NYCRR § 505.9.

E. Medicaid Manuals and DOH Policy

The Medicaid Management Information System (MMIS) in New York is administered by the DOH, Office of Medicaid Management and through a contractor, Computer Sciences Corporation (CSC). Medicaid billing manuals are available from CSC for nursing homes. This manual describes the Medicaid electronic billing procedures, codes, policy and other pertinent information. Unfortunately, the manual is not available to the public online. Paper copies can be ordered from CSC.

While there are no specific interpretive guidelines relevant to the 10 NYCRR part 415 requirements, DOH, Division of Quality Assurance and Surveillance for Nursing Homes and ICF/MRs routinely publishes "Dear Administrator" letters to nursing homes. These

letters discuss important policy pronouncements and interpretations. The DOH has begun putting recent letters on its Web site at http://www.health.state.ny.us/nysdoh/consumer/nursing/homenurs.htm. Unfortunately, there are only a few letters on the site and some of the more important letters governing admission and discharge issues, visitation, and CPR policies are not yet on the site. Copies of prior letters can usually be obtained by contacting the Division of Quality Assurance and Surveillance for Nursing Homes and ICF/MRs.

III. Additional Issues

End-of-life care and health care decision-making issues play an important part in the everyday activities of operating a nursing home. In that respect, federal and state laws and regulations governing these issues are important to practitioners advising these providers.

Federal law governs a Medicare provider's responsibility to respect and promote residents' rights to make their own decisions about their health care. These rights are primarily ensured by the Patient Self-Determination Act, Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 1001-508, 4206, 2751, 104 Stat. 1388 (1990) and its associated regulation, 42 C.F.R. § 489.102.

State law also governs a licensed provider's obligation to respect and promote residents' rights to make their own decisions. These basic rights can be found in 10 NYCRR § 400.21. Furthermore, requirements relating to health care proxies, do-not-resuscitate orders and guardianships are also relevant. PHL Article 29-C governs health care proxies and 10 NYCRR 405.43 and PHL Article 29-B governs do-not-resuscitate orders. Guardianships, depending upon the nature of the ward, are governed by either Article 81 of the Mental Hygiene Law or Article 17-a of the Surrogate's Court Procedure Act.

Providers and their counsel should be aware of these federal and state provisions in addition to the operational and reimbursement provisions discussed in the primary sections of this overview.

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Home Health Care: Overview of Federal and State Regulations

By Roni E. Glaser

Delivery of home health care services in New York is governed by state law and regulations as well as by federal Medicare and Medicaid statutory and regulatory mandates. This article will provide an overview of the various regulatory schemes affecting health care services provided in the home.

I. Federal Law and Regulation

A. Medicare and Medicaid—Operational Requirements

In New York State, certified home health agencies (CHHAs) may provide home health care services that are reimbursable by Medicare under Title XVIII of the Social Security Act. Codified in section 1891 of the Social Security Act (42 U.S.C. 1395bbb) and part 484 of the Secretary's regulations, the requirements for provider participation in the Medicare program are known as the "Conditions of Participation." These Conditions of Participation include protection by the agency of certain rights of patients, notices of changes of ownership and control, requirements for training and competency of aides, supervision of aides and adherence to plans of care, reporting of information, and other clinical and operational requirements.

Section 1891 also requires surveys of Medicare-certified agencies to be conducted at least every three years, and more often if circumstances warrant it. It provides for decertification if Medicare identifies deficiencies that involve immediate jeopardy to the health and safety of patients, or intermediate sanctions if it identifies deficiencies that do not immediately jeopardize the health and safety of patients. Intermediate sanctions can include civil money penalties not to exceed $10,000 for each day of noncompliance, suspension of payments due under the Program, and appointment of a temporary management to oversee operations of the agency while improvements are being made to come into compliance.

Both licensed and certified agencies in New York State may participate in the Medicaid program under Title XIX of the Social Security Act. Although the federal government establishes general guidelines for the program, Medicaid operational requirements are primarily the domain of each state. States establish their own eligibility requirements, the scope of services for which they will pay, and reimbursement rates for payment. States are required to offer Medicaid reimbursement for home health care for patients who are eligible for skilled nursing services. They may also receive federal funds if they provide reimbursement for rehabilitation and physical therapy services and for home and community-based care to patients with chronic conditions.

B. Medicare and Medicaid—Reimbursement Requirements

Since October 1, 2000, Medicare has reimbursed providers for home health care services through a Prospective Payment System (PPS) under section 1895 of the Social Security Act, 42 U.S.C. 1395fff. This system of reimbursement replaced the former retrospective reasonable-cost-based system. PPS uses a 60-day episode as the basic unit of payment, and provides adjustments for unanticipated events such as partial episode payments, adjustments for significant changes in condition, and other circumstances. Providers receive half of the expected payment at the inception of care and the remainder at the close of the 60-day episode.

While 50 percent of Medicaid reimbursement in New York State is received from the federal government (approximately 40 percent comes from the state and 10 percent from local social services districts), the state administers its own Medicaid reimbursement methodology. States are given broad discretion as to the method of payment they adopt. New York State has adopted a cost-based reimbursement mechanism that involves the submission of cost reports and the setting of rates based on a two-year retroactive incorporation of the costs incurred in a reporting year into the current year's rates.

II. State Law and Regulation

A. Operational Requirements

New York State regulates home health care agencies pursuant to Article 36 of the Public Health Law. Under PHL section 3602(2), a home care services agency is

> an organization primarily engaged in arranging and/or providing directly or through contract arrangement one or more of the following: Nursing services, home health aide services, and other therapeutic and related services which may include, but shall not be limited to, physical, speech and occupational therapy, nutritional services, medical social services, personal care services, homemaker services, and housekeeper or

chore services, which may be of a preventive, therapeutic, rehabilitative, health guidance, and/or supportive nature to persons at home.

Generally, no agency which provides these services may operate in New York State without the authorization of the Commissioner of Health, in the form of a license or an operating certificate.

New York recognizes two types of home care agencies: licensed home care services agencies (LHCSAs) and certified home health agencies (CHHAs). The former may provide home care services to individuals whose source of payment is Medicaid, private insurance or self-payment. The latter may provide services whose sources of reimbursement include any of those, but may also provide home care services to recipients of Medicare. CHHAs must undergo a certificate of need process which includes a determination of public need and financial feasibility by the Commissioner of Health. Long Term Home Health Care Programs (LTHHCPs), sometimes referred to as "nursing homes without walls" or "Lombardi Programs" (after their sponsor in the state legislature) may be operated only by hospitals or nursing homes that hold operating certificates under Article 28 of the Public Health Law, or by CHHAs. Patient capacity for LTHHCPs is also subject to an analysis of public need under a CON process. Currently, the Commissioner has imposed a moratorium on the establishment of new CHHAs, though additional patient capacity for LTHHCPs, also long subject to a moratorium, has recently been awarded in certain geographic localities in which the state believes that public need can be established.

Regulations of the Commissioner of Health pertaining to the approval and operation of home care agencies may be found at 10 NYCRR 760 through 763 (for CHHAs and LTHHCPs) and 10 NYCRR 765 and 766 (for LHCSAs). The rules for applications to operate or to change the ownership of CHHAs and LHCSAs are similar, though the former include additional rules for determination of public need and verification of financial resources to operate an agency, which rules do not apply to LHCSAs. Minimum standards for operation of programs by CHHAs and LHCSAs are also similar, though those for CHHAs more closely incorporate federal Medicare guidelines, and are thus stricter in certain respects. They both touch on areas including patient rights, admission and discharge, patient assessment and plans of care, maintenance of records, responsibilities of the governing body, personnel requirements and others.

B. Reimbursement Requirements

Medicaid reimbursement requirements for personal care services provided by home health care agencies are found at 18 NYCRR § 505.14. Section 505 also addresses private duty nursing and other services sometimes provided by home care agencies. Under the state Medicaid regulations, social services districts provide medical assistance to recipients and act as their case manager, either directly or through contracts with private home care agencies. Section 505.14 contains operational requirements pertaining only to Medicaid-reimbursed services, which supplement the Department of Health's program regulations. It also establishes a rate-setting methodology which entails the submission of actual operating costs for a rate year and the determination of a rate by the Department of Health utilizing the agency's allowable costs as reported, adjusted by trend factors, but not to exceed established ceilings. This rate includes an adjustment for profit for proprietary agencies, or surplus for voluntary agencies. New York City's personal care program, administered by the City Human Resources Administration, is an exception to this rate-setting methodology, and uses an RFP bidding process to select its vendors and set their rates.

While any licensed home care services agency in New York State is permitted to render services reimbursable by Medicaid, in reality such services may only be rendered pursuant to contracts with county social services agencies. Counties frequently maintain closed lists of vendors with whom they contract, that only periodically open up as need dictates.

A good tool to keep abreast of New York State's Medicaid news, including program requirements and billing and reimbursement issues, is the monthly publication of the Department of Health Office of Medicaid Management, "Medicaid Update," which is sent by e-mail and can be requested by sending an e-mail to medupdte@health.state.ny.us. A good Internet resource for information on Medicaid and Medicare, including access to the federal Home Health Agency Program Manual and other manuals, Program Transmittals and Program Memoranda, can be found at www.cms.hhs.gov/providers/hha.

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Hospice Care: Overview of Federal and State Regulation

By Ari J. Markenson and Sandra Maliszewski

Introduction

Hospices, similar to most health care providers, are primarily regulated in the licensure, operational and reimbursement arenas. Federal law, regulation and policy govern Medicare reimbursement for hospice care, as well as participation in the Medicare program through conditions of participation. State law, regulation and policy primarily dictate licensure, operational standards for hospices and Medicaid reimbursement. Set forth below are the major sources of law, regulation and policy relevant to licensure, operations and reimbursement applicable to hospice care providers.

I. Federal Law, Regulation and Policy

A. Medicare Statutory Operational Requirements

Statutory provisions governing the operational requirements for hospice care can be found in 42 U.S.C. § 1395x(dd). These provisions broadly set forth the parameters for hospice providers participating in the Medicare program. The statute describes the types of services to be provided by a hospice, the core and non-core services, basic staffing and operational requirements, and definitions of "terminal illness," among other requirements.

B. Medicare Statutory Reimbursement Requirements

A patchwork of several statutory provisions address coverage and reimbursement for hospice care. 42 U.S.C. §§ 1395d(a)(4) and (d) address the coverage periods applicable to hospice care. 42 U.S.C. § 1395e(a)(4) addresses beneficiary co-insurance obligations. 42 U.S.C. §§ 1395f(a)(7) and (i) set forth conditions for Medicare payment and coverage. 42 U.S.C. §§ 1395y(a)(1), (6) and (9) describe limits on coverage for services.

C. Medicare Regulatory Operational Requirements

The federal regulations for hospice providers can be found in 42 C.F.R. § 418. Several subparts include the operational requirements for hospices to participate in the Medicare program. The following is a brief description of the regulatory coverage in those subparts.

Subpart A, 42 C.F.R. §§ 418.1–418.3 covers general issues such as statutory citations.

Subpart B, 42 C.F.R. §§ 418.20–418.30 addresses issues of eligibility for hospice care, terminal illness certifications, change of provider and election of coverage.

Subpart C, 42 C.F.R. §§ 418.50–418.74 contains conditions of participation, which include standards relating to: general issues, governing body, medical director, professional management, plans of care, continuing care, informed consent, in-service training, quality assurance, interdisciplinary groups, volunteers, licensure, and central records.

Subpart D, 42 C.F.R. §§ 418.80–418.88, contains conditions of participation relating to the core services required to be provided directly by employees of hospices; these include nursing services, medical social services, physician services, and counseling services.

Subpart E, 42 C.F.R. §§ 418.90–418.100, contains conditions of participation relating to non-core services, including physical, occupational and speech-language pathology, home health aide and homemaker services, medical supplies, short-term inpatient care, and direct inpatient care.

D. Medicare Regulatory Reimbursement Requirements

The regulatory requirements relating to reimbursement in the Medicare program can also be found in 42 C.F.R. § 418. Set forth below is a brief description of the regulatory coverage in the applicable subparts.

Subpart F, 42 C.F.R. §§ 418.200–418.204, explains the basic coverage requirements for Medicare beneficiaries receiving hospice care. The requirements address basic coverage issues, what services are covered and special coverage issues, such as respite care and bereavement counseling.

Subpart G, 42 C.F.R. §§ 418.301–418.311, addresses specific reimbursement issues for hospices in the Medicare program. These regulations set forth requirements regarding basis payment procedures, payment for physicians, payment rates, caps and limitations on payment, reporting and recordkeeping and administrative appeals.

Subpart H, 42 C.F.R. §§ 418.400–418.405, addresses requirements relating to Medicare beneficiary liability for co-insurance and services not considered hospice care.

E. CMS Manuals and Policy

CMS' Publication 21 is the Medicare Hospice Manual. The manual addresses coverage and reimbursement requirements for hospice providers and is the major policy companion to the applicable regulations. It is divided into four chapters covering general informa-

tion about the Medicare program, coverage of services, admission and billing procedures and payments. A copy of the manual is available on the CMS Web site at http://www.cms.gov/manuals/21_hospice/hs0-fw.asp. Updates and revisions to the manual and CMS policy can be found in CMS program memorandums and transmittals. These documents are too numerous to cite, however, searchable archives are available on the CMS Web site at http://www.cms.gov/manuals/memos/comm_date_dsc.asp.

The federal government has, in most cases, delegated to the states the responsibility for ensuring that providers comply with conditions of participation through the survey and certification process. The CMS State Operations Manual addresses state requirements for conducting survey and certification activities. Chapter 2 of the manual includes a comprehensive discussion of the certification process for providers. Appendix M to the manual explains the survey procedures and regulatory interpretive guidelines for surveyors conducting certification activities for hospice providers. The manual can be found on CMS' Web site at http://www.cms.gov/manuals/PUB_07.asp

II. New York Law, Regulation and Policy

A. State Statutory Operational Requirements

The state legislature has set forth statutory provisions governing hospices. The provisions and where they can be found differ depending upon the type of hospice, i.e., hospice provided at home or in an in-patient facility.

Article 40 of the Public Health Law (PHL) addresses hospice providers in general. The statutory provisions describe the necessary approval and oversight process, operational standards such as personnel, referral and admissions and discharges, organization and administration, patient/family rights, types of services including palliative care programs and hospice recruitment and retention programs.

There are further provisions relating to hospices found in Article 28 of the PHL. Specifically, PHL §§ 2802 and 2803 in connection with PHL §§ 4006 and 4010 address the construction of new hospice facilities and units.

B. Medicaid Statutory Reimbursement Requirements

Rates of payment to hospice providers and conditions for coverage under the Medicaid program are addressed in both the PHL and the Social Services Law (SSL). PHL §§ 4012 and 4012-a provide for payments to hospices. Payment for in-patient hospice care provided in general hospitals is specifically discussed in PHL §§ 2807 and 2807-c.

The general coverage and reimbursement provisions for Medical Assistance, i.e., Medicaid, in the SSL also address coverage for hospice services. These provisions are generally contained in Article 7, title 11 of the SSL.

C. State Regulatory Operational Requirements

Various DOH regulations govern hospice services depending upon the types of hospice, i.e., home provided or in-patient. The establishment of a hospice is discussed in 10 NYCRR § 711 (general standards), section 717 (new hospices facilities and units), section 790 (establishment), section 791 (construction) and section 792 (certification). Specific day-to-day operational standards are more fully set forth in 10 NYCRR §§ 793 and 794.

10 NYCRR § 793 governs organization and administration of a hospice provider. These standards address the governing authority of the provider, contracts, administration, staff and services, personnel, patient referrals/admissions/discharges, records and reports, and leases.

10 NYCRR § 794 addresses patient and family care and services. The requirements discuss patient and family rights, care planning, medical records and inpatient and residential services.

D. State Medicaid Regulatory Reimbursement Requirements

Rates of payment to hospice providers are primarily addressed in 10 NYCRR § 86.6, in particular §§ 86-6.2 and 86-6.7(a). Sections 86-6.3 and 86-6.4 focus on reimbursement for attending and consulting physician services and reporting requirements. Section 86-6.6 discusses supplemental financial assistance programs. Additionally, reimbursement for room and board in nursing facilities is addressed in section 86-6.7.

E. MMIS Provider Manual and DOH Policy

The Medicaid Management Information System (MMIS) in New York is administered by the DOH, Office of Medicaid Management and through a contractor, Computer Sciences Corporation (CSC). Medicaid billing manuals are available from CSC for hospices. This manual describes the Medicaid electronic billing procedures, codes, policy and other pertinent information. Unfortunately, the manual is not available to the public online. Paper copies can be ordered from CSC.

The DOH Division of Home and Community Based Care has primary oversight responsibility for hospice providers. The division has not developed specific interpretive guidelines relevant to hospice statutory or regulatory requirements and it does not regularly publish guidance to providers. Specific guidance can normally be obtained by contacting the division's staff.

III. Additional Issues

A comprehensive look at legal and ethical issues for hospice providers and physicians offering end-of-life palliative care is beyond the scope of this overview. The issues, however, permeate the everyday care provided to patients. These include impediments to prescribing effective narcotics for pain control, problems encountered in explaining palliative care to patients and families and in perceived physician-assisted suicide. Additionally, issues regarding appropriate health care decision making also arise. While a discussion of case law and ethical issues on these topics is too complex to provide here, a short description of some of the applicable federal and state law on health care decisions follows below.

Federal law governs a Medicare provider's responsibility to respect and promote a resident's right to make their own decisions about their health care. These rights are primarily ensured by the Patient Self-Determination Act; Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 1001-508, 4206, 2751, 104 Stat. 1388 (1990) and its associated regulation 42 C.F.R. § 489.102.

State law also governs a licensed provider's obligation to respect and promote a resident's right to make their own decisions. These basic rights can be found in 10 NYCRR § 400.21. Furthermore, requirements relating to health care proxies, do-not-resuscitate orders and guardianships are also relevant. PHL Article 29-C governs health care proxies and 10 NYCRR § 405.43 and PHL Article 29-B govern do-not-resuscitate orders. Guardianships depending upon the nature of the ward are governed by either Article 81 of the Mental Hygiene Law or Article 17-a of the Surrogate's Court Procedure Act.

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Adult Homes: Overview of State Regulation

By Paul A. Gomez

I. General

Adult care facilities or "adult homes" are primarily governed by state law and regulation. There is no substantial federal law or regulation that governs their day-to-day operations. Adult homes are established and operated for the purpose of providing long-term residential care, room, board, housekeeping, personal care and supervision, medication management, and case management services to five or more adults unrelated to the operator.[1] These are adults who, though not requiring continual medical or nursing care as provided in facilities licensed pursuant to the Public Health Law Article 28 (PHL) (e.g., hospitals, nursing homes) or Mental Hygiene Law Articles 19, 23, 31 or 32 (MHL) are unable or substantially unable to live independently.[2]

Previously, adult homes were regulated by the Department of Social Services. Following the abolition of the Department of Social Services, the Department of Health assumed the duties and powers of the Department of Social Services with respect to adult homes.

The Department establishes standards for the operation of adult homes. These standards include, but are not limited to resident rights, the level of care required for admission, protection of residents' funds, provision of personal care, maintenance of records and environmental standards.[3]

Adult homes are funded primarily by residents who pay either private pay rates or Supplemental Security Income (SSI) rates set by the state. If a resident qualifies, Medicaid may reimburse for health care services.

II. Inspection Reports

Adult homes are subject to inspection by the Department of Health. However, the Department of Health and the Office of Mental Hygiene (OMH) may jointly inspect homes with both a past history of violations, and where 25% or more of the residents were released or discharged from any facility operated or certified by an Office of the Department of Mental Hygiene. The Department of Health conducts one full inspection every 12 months for most adult homes, or every 18 months for those homes determined by the Department to be in the highest state of compliance.

The Department, after inspection, must issue an inspection report identifying the areas of operation in which the adult home meets or exceeds compliance standards, and those areas where the adult home has allegedly failed to comply. Further, for each area in which a violation is alleged, the Department must specify the instructions for corrective action necessary to achieve compliance.[4] Within 30 days of issuance of the inspection report, the adult home must correct all legitimate citations, or submit a plan of correction acceptable to the Department if more than 30 days are required to implement the corrective action.[5]

"Adult homes are established and operated for the purpose of providing long-term residential care, room, board, housekeeping, personal care and supervision, medication management, and case management services to five or more adults unrelated to the operator."

III. Enforcement

The Department generally refers cases of alleged continued noncompliance to the Department's Division of Legal Affairs for enforcement unless the violations found on an inspection are minimal and corrected promptly.[6] For licensed adult homes, the Department may restrict licenses, impose civil penalties, or both.[7] For adult homes that are operating unlicensed, the Department may seek civil penalties or closure, and may even refer the case to the New York State Attorney General for criminal prosecution. Typical civil monetary penalties proposed by the Department range anywhere from $5 to $1,000 per day.

Rectification, or correction of an alleged violation is a defense in many cases.[8] Generally, when an adult home shows it has corrected an alleged violation within 30 days of receiving the inspection report or was correcting the alleged citation pursuant to a plan accepted by the Department, no civil penalty will be imposed.[9] However, correction of an alleged violation is not always a complete defense to the imposition of civil penalties. For example, it will not serve as a complete defense if the alleged violation is said to endanger or harm a resident, or is alleged to be the result of a breakdown of systemic practices.[10] Nevertheless, correction may still be used to mitigate the penalties imposed.

The Department must serve a Notice of Hearing with a Statement of Charges at least 30 days before a hearing.[11] Sometimes, the Department will consider set-

tlement possibilities before serving the proposed or actual Statement of Charges. The adult home generally has to answer the Statement of Charges and provide a list of witnesses within 10 days before the hearing.[12] The Department and the operator both have the right to be represented by counsel, to present evidence and witnesses, to cross-examine witnesses, and to request adjournments. Hearings often take more than one day, and in some cases, can stretch over months. The Administrative Law Judge (ALJ) may allow post-hearing submissions up to 60 days after the end of the hearing. The ALJ must issue a decision based on the hearing record no more than 90 days after the conclusion of the hearing. The final determination of the ALJ may be appealed by seeking judicial review pursuant to N.Y. CPLR Article 78 within four months after the determination.

Endnotes

1. N.Y. Soc. Servs. Law § 2(25) (hereinafter "SSL").
2. SSL § 2(21).
3. SSL §§ 460–461-h *et seq.*; 18 N.Y.C.R.R. part 487 *et seq.*
4. SSL § 461-a(2)(c); 18 N.Y.C.R.R. §§ 486.1(i)(1), 486.2(i)(1), (3), 486.5(a)(3).
5. *Id.* at 486.2(j).
6. *Id.* at 486.1(d), 486.4.
7. SSL § 460-d(4)(b); 18 N.Y.C.R.R. § 486.4.
8. 18 N.Y.C.R.R. § 486.5(a)(3).
9. *Id.*
10. *Id.* at 486.5(a)(4).
11. 18 N.Y.C.R.R. part 493 *et seq.*
12. *Id.*

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New York's Medicaid Reimbursement System for Nursing Homes: A Good Plan Spoiled

By Thomas G. Smith

Four of every five elderly residents in the more than 600 nursing homes throughout New York State are indigent. As a result, the cost of caring for 80% of the state's nursing home population is borne entirely by county, state and federal governments through the Medicaid program.

This astonishing reality means that those who own and operate nursing homes in New York State are almost entirely beholden to government ratesetters to provide them with Medicaid reimbursement adequate to meet their operating costs. Beyond question, a fair and rational Medicaid reimbursement system is essential to the economic survival of most nursing homes.

In New York, it is the Department of Health that annually sets each nursing home's facility-specific Medicaid rate under a system adopted in 1986 known as the Long-Term Care Case Mix Reimbursement System ("the case mix system"). The same DOH also vigorously enforces what are arguably the nation's most stringent quality of care standards, compelling nursing facilities to provide adequate staffing along with a host of mandated rehabilitative services, medications, etc. to the elderly poor covered by the Medicaid program.

"[T]he cost of caring for 80% of the state's nursing home population is borne entirely by county, state and federal governments through the Medicaid program."

When first adopted in 1986 to great acclaim from the New York State health care community and beyond, DOH's case mix system (using a resource utilization group or "RUG-II" methodology) rationally addressed the need to promote fiscal efficiency and economy in the delivery of nursing home services; the need to provide financial incentives for nursing homes to care for the state's medically neediest residents; and the need to compel nursing facilities with imprudent spending habits to lower their costs to the level of their peers in the same geographic regions.[1]

Regrettably, DOH's touted case mix system was never allowed to fulfill its goals. Instead, virtually from the outset, the carefully crafted provisions of the case mix system and the RUG-II methodology were emasculated by a series of major "adjustments," first imposed by DOH amendments to its regulations and, more recently, by the legislature's budget-driven statutory changes.

This article will provide a broad overview of the 18-year history of New York's Long-Term Care Case Mix Reimbursement System; examine several major "adjustments" made first by the Department of Health and more recently by the state legislature; review how the courts have dealt with challenges to several such adjustments; examine what is left of the original 1986 reimbursement system; and analyze whether the system is adequately reimbursing the current necessary costs of the state's nursing homes.

The Adoption of the Long-Term Care Case Mix Reimbursement System in 1986

The Medicaid Program for nursing homes consists of an inter-governmental, cost-sharing system (roughly funded by 50% federal, 40% New York State and 10% local county dollars) designed to pay for medical services provided to those unable to afford the cost of their care. As a condition of receiving these federal funds, New York must comply with the federal Medicaid Act and its quality of care standards.[2] Unlike other states, New York has long chosen to provide a wide range of services that are optional under federal law, thereby requiring nursing facilities in New York to incur far more operating costs than facilities in other states.[3]

From its inception in 1965 until 1981, the Medicaid Act required states to retrospectively reimburse nursing homes the "reasonable costs" they incurred in each prior year of operation. In 1981, Congress abandoned this retrospective reimbursement system by adopting the Boren Amendment, a provision of the Medicaid Act that encouraged states to adopt their own Medicaid reimbursement plans, to promote "the efficient and economical delivery of [nursing home] services."[4] Under the Boren Amendment, these new state plans, and any amendments made to them, required federal approval, and states were required to assure the federal review agency that the rates paid to efficiently and economically operated nursing facilities were "reasonable and adequate to meet the cost which must be incurred to provide services in conformity with applicable state and federal laws. . . .[5] New York's Public Health Law § 2807(3) was subsequently amended to require the Health Commissioner to determine and certify the ade-

quacy of DOH's Medicaid rates under the same substantive standard.

In 1985, after extensive study, New York adopted the case mix system as a means of reimbursing the operating costs of nursing facilities. The case mix system, which took effect January 1, 1986, constituted a modified average pricing system largely driven by the RUG-II methodology, which measured each facility's relative reimbursement needs in terms of the personnel and other health care resources needed to address the particular acuity levels of each facility's current residents. The system further compared each facility's historical costs incurred in the 1983 "base" year to those of its peers in the same geographic region of the state in setting rates beginning 1986 and thereafter.[6]

Since wages and fringe benefits comprise roughly 75% of each nursing home's overall operating costs, the RUG-II methodology specifically focused upon the most effective means to account for these "direct" labor costs. Because of huge differences in wages paid across the state (e.g., upstate vs. downstate facilities, or rural vs. urban facilities), the case mix system divided the state into sixteen geographic regions and developed a formula designed to neutralize differences in wages and fringe benefits from region to region. Instead of basing reimbursement directly upon each home's *own* 1983 labor costs, the original case mix system in 1986 reimbursed all facilities within each region based upon a peer average formula known as the "regional average wage rate."[7]

For example, each facility within the Rochester region received reimbursement in 1986 based upon the Rochester region's $7.00 per hour average wage rate in 1983, rather than at each facility's actual (higher or lower) 1983 wage rate. Thus, two homes in the Rochester region whose actual wage costs were $9.00 per hour and $5.00 per hour, respectively, received reimbursement under the case mix system in 1986 at the identical $7.00 per hour regional wage rate, trended upward for three years of inflation. As a result, the higher-cost home was forced to economize, and the lower-cost home was rewarded for its economy.[8]

The case mix system also used a series of "ceilings" and "bases" upon particular categories of costs incurred by facilities in an effort to discourage a facility from spending beyond its peers, and at the same time to reward facilities that maintained the lowest operating costs in 1983. The system paid those lowest-cost homes reimbursement at a "base price"—i.e., a floor for reimbursement somewhat higher than such homes' actual 1983 costs trended forward. This "bonus" enabled these lowest-cost facilities to reinvest in their operations to ensure quality care and to better compete with their peers in the new, cost-conscious reimbursement environment.[9]

The New Emphasis on Each Facility's Case Mix

An essential part of New York's 1986 system for reimbursing a facility's direct operating costs was the development of a case mix index, or "CMI," for each facility in the state. Each facility's particular CMI was calculated based upon semiannual assessments of the functional levels or "acuity" of each resident in the facility. Using a lengthy scorecard, qualified assessors were charged with the task of scoring each resident's acuity on a patient review instrument (PRI). The scores of each patient were then compiled and the average PRI score among residents in the facility became its CMI for reimbursement in that calendar period.[10] A major goal of the case mix system was to create financial incentives to reward homes for taking the sickest residents.

Thus, a resident suffering from dementia and severe functional loss would obtain a much higher PRI score than a mentally fit, ambulatory resident in need of less assistance with the activities of daily living. And, the more dependent and needy the residents cared for, the higher that facility's Medicaid reimbursement rate.

The use of the case mix index, the regional average wage rate, and base and ceiling costs to create incentives and disincentives in the rates among facilities within the same geographic region were key components of the highly touted case mix system that took effect at the start of 1986. The careful balances achieved in the case mix system were almost immediately undermined, however, by a series of "adjustments" that DOH chose to impose.

DOH's Various Regulatory "Adjustments to the Case Mix System"

A. The Recalibration Adjustment

Barely seven months after the new case mix system was implemented for the 1986 rate year, DOH announced the first of its proposed amendments to the system. Effectively, DOH surmised that the CMIs calculated for each facility based upon PRI assessments of their patients' conditions in 1985 were uniformly inaccurate and "optimized" to take advantage of the new emphasis on patient acuity under the case mix system.[11]

As a result, DOH adopted a "Recalibration Adjustment," downgrading the Medicaid rates of nursing homes statewide by a uniform 3.035% "regardless of actual change—if any—experienced by a facility in its CMI."[12] Thus, the Medicaid reimbursement rates paid to the state's nursing homes beginning January 1, 1987,

were roughly 3% less than the rates to which they were entitled under the original 1986 case mix system.

B. The Adjustment to RIPAF

Just ten months into the 1986 rate year, DOH announced that one of the key components of the system, the use of regional average wage rates for reimbursing labor costs, needed to be substantially "adjusted" in order to "more equitably distribute existing funds." The reason? A small number of high-spending, publicly owned nursing homes (operated by counties throughout the state) were aggrieved by new reimbursement rates that did not compensate them for their extraordinary labor costs.[13]

These public facilities, unlike most others outside New York City, were burdened by long-term labor contracts with unionized workers. Hence, these public homes discovered that the rates paid to them under the 1986 case mix system simply did not account for their higher-than-average operating costs, and they could do nothing about it.

"DOH adopted the Base Price Reduction despite the fact that its own studies revealed that below-base homes were actually incurring widespread shortfalls in their Medicaid reimbursement rates compared to their actual operating costs in 1989, notwithstanding the extra revenues they received as below-base facilities."

Based on the pleas of these county-owned facilities (comprising about 8% of the state's nursing homes), DOH elected to wholly revamp the new system of wage reimbursement for *all* facilities, creating a variable "corridor" around the regional average wage rate. Instead of reimbursing facilities at the average wages incurred by their peers in the same geographic regions in the 1983 base year, DOH created the "Adjustment to RIPAF," a change which turned the peer average reimbursement system on its head. Where the original case mix system compelled high-wage facilities to become more economical and provided incentives for low-wage facilities to meet the high quality care standards, the adjusted system returned *all* nursing homes outside New York City to reimbursement based not on the average labor costs of their regional peers, but based primarily upon their actual 1983 wages no matter how high or low.[14]

C. The Base Price Reduction

The use of base prices for reimbursement of the facilities' direct and indirect costs was a fundamental component of New York's case mix system. Payment to the most economical facilities at the base-level prices assured these facilities of reimbursement for costs at this established floor, even if they somehow managed to spend less in particular categories.[15]

Under the case mix system, roughly 40% of the state's nursing facilities benefited in some manner from the established base price in reimbursing their direct or indirect costs, receiving a financial incentive or reward for their particular below-base spending. As a practical matter, this additional income was often offset by reimbursement deficiencies in the prospective rates, caused by extraordinary increases in personnel costs after 1983 driven by a statewide nursing and nurse aide shortage. Thus, for many facilities, particularly outside New York City, the "cushion" they received as a below-base provider simply helped them stay financially afloat.

In early 1989, DOH conceded that its RUG-II reimbursement methodology based upon a snapshot of six-year-old, 1983 nursing home operating costs was failing to adequately meet the actual costs of operations in 1989. In effect, the labor shortage in nursing personnel that occurred after 1983 had driven facilities' labor costs upward at a far faster rate than reflected in the state's annual inflation factors. As a result, DOH declared that "the nursing crisis in the health care industry is a well documented problem . . ." resulting in "a need to provide additional funding to facilities to help offset the increased costs they are experiencing to retain nursing services."[16]

In mid-1989, to address this crisis, DOH determined to distribute an additional $20 million per year to all nursing homes throughout the state as an additional reimbursement enhancement to account for the "unreimbursed growth of nursing salaries" both regional and statewide.[17] Instead of funding this $20 million enhancement through an appropriation of new budgetary funds, however, DOH determined instead to adopt the Base Price Reduction as the vehicle to fund that enhancement. This regulatory adjustment sharply reduced the reimbursement rates of below-base homes from their established base prices to a level at, or slightly above, their lower 1983 actual operating costs.[18]

DOH adopted the Base Price Reduction despite the fact that its own studies revealed that below-base homes were actually incurring widespread shortfalls in their Medicaid reimbursement rates compared to their actual operating costs in 1989, notwithstanding the extra revenues they received as below-base facilities. In fact, DOH recognized that facilities below the base had

"reinvested the additional revenues back into operations" to maintain their quality of care.[19] Nonetheless, DOH imposed the Base Price Reduction in June 1989, thereby reducing the Medicaid rates paid to the state's most efficient and economical homes by some $50 million per year. Incredibly, DOH officials conceded that their adoption of the Base Price Reduction as a major change in the 1986 case mix system was done "precipitously with very little notice," was a "quick decision," and was made without adequate time for DOH to consider the effect of this adjustment upon the state's established 1986 case mix system.[20]

How the State and Federal Courts Responded to DOH's Regulatory Adjustments

Predictably, New York's nursing homes and their trade associations brought a series of legal challenges to these and other adjustments that DOH imposed upon its 1986 case mix system. In large part, the facilities succeeded—at least temporarily—in holding DOH accountable for violations of both state and federal law.

A. Recalibration

The Recalibration Adjustment was immediately challenged in an Article 78 proceeding brought by the New York State Association of Counties, an organization representing publicly owned nursing homes. Trade associations representing private facilities brought companion actions as well.

In a stinging rebuke of DOH's conduct in adopting the 3.035% across-the-board rate reduction, the New York Court of Appeals found that DOH had acted arbitrarily in concluding that "paper optimization" had solely caused an increase in the CMIs of facilities statewide.[21] The Court found that:

> DOH failed to substantiate what therefore amounted only to a theory and assumption—arrived at swiftly and certainly not after any reasonable or measured period of empirical documentation, assessment and evaluation—that patient deterioration, i.e., actual increased resource utilization, played no part in the increase in CMIs. Its predicates are entirely conclusory.[22]

In writing for the majority of the court, Judge Bellacosa found that the case mix system had been developed "after extensive study," and that the 3.035% reduction to the direct component of all facility's Medicaid rates "clashed with the design and intendment of the RUG-II methodology."[23] The Court observed that:

> DOH seems to be taking back from facilities with one hand that which it proffered them individually with the other—incentives for improved care for the relatively more needy, reimbursed accordingly. This approach to administrative rulemaking must not be countenanced within the limited, though searching, judicial review.[24]

The result for facilities participating in this and related litigation was an order requiring DOH to repay facilities the 3.035% withheld from their Medicaid rates in affected years.[25]

B. The Adjustment to RIPAF

Beginning in 1988, the Adjustment to RIPAF was initially challenged by a group of 33 upstate facilities (later joined by the New York State Health Facilities Association on behalf of its 300 members) in both state and federal court actions.

In the federal court proceeding entitled *Pinnacle Nursing Home v. Axelrod*, the District Court initially issued an injunction against DOH's use of the Adjustment to RIPAF in calculating the rates of 33 nursing homes in upstate New York. The Court ruled that DOH had failed to adhere to the procedural requirements of the federal Boren Amendment in adopting this Adjustment as an amendment to its Medicaid plan (comprising the case mix system).[26]

The procedural mandates contained in the Boren Amendment required New York to make bona fide, objective, correct and empirically based "findings" in order to justify that the rates paid to facilities following implementation of the Adjustment would still be adequate to meet their necessary operating costs. Recognizing that the Adjustment to RIPAF emasculated the reimbursement system's reliance upon a regional average wage rate for reimbursing labor costs, the District Court held that the Adjustment to RIPAF benefited *all* high-cost nursing homes (not just unionized, publicly owned facilities) "at the expense of lower cost facilities such as plaintiffs," who were the intended beneficiaries of the case mix system's reliance upon a regional average wage rate for reimbursement.[27]

The Second Circuit agreed, and declared the Adjustment to RIPAF null and void until DOH satisfied the procedural requirements of the Boren Amendment for future years. The Court of Appeals rejected DOH's contentions that these legal requirements were "mere surplusage," and chastised DOH for amending its Medicaid system based upon "little more than a policy decision to reimburse high cost facilities unsupported by any findings whatsoever."[28]

Following this federal court victory, the plaintiffs (now joined by their trade association) reactivated a series of Article 78 proceedings in state Supreme Courts, seeking retroactive recalculation of their rates dating back to 1987 without use of the stricken Adjustment to RIPAF. In *Avon Nursing Home v. Axelrod* (the lead proceeding), the New York Court of Appeals rejected the state's arguments that no retrospective relief was warranted because the Boren Amendment violation was retroactively curable. Instead, the New York Court of Appeals affirmed state Supreme Court's order requiring New York to recalculate the rates of adversely affected plaintiffs without use of the RIPAF Adjustment for rate years 1987-1992.[29]

C. The Base Price Reduction

The Base Price Reduction, implemented in mid-1989 by DOH, was challenged in an Article 78 proceeding brought by New York State Health Facilities Association (NYSHFA) on behalf of its affected members. NYSHFA based its legal challenge on two separate grounds: (1) the contention, identical to that made in *Pinnacle v. Axelrod,* that the state had failed to make adequate "findings" to justify use of the Base Price Reduction under the Boren Amendment's mandates; and (2) the contention that, in adopting the Base Price Reduction, DOH had acted precipitously and irrationally, just as it had in adopting the earlier, judicially stricken Recalibration Adjustment.[30]

In state Supreme Court, NYSHFA succeeded on both grounds, obtaining an order requiring the state to recalculate Medicaid rates for aggrieved NYSHFA facilities without use of the Base Price Reduction from its inception in 1989. The Appellate Division affirmed on the ground that DOH had acted arbitrarily and capriciously in adopting the Base Price Reduction, but found it unnecessary to reach the issue of DOH's compliance with the Boren Amendment.[31] At the Court of Appeals, DOH succeeded in obtaining a reversal, based largely on the Court's according DOH "a high degree of judicial deference" in the exercise of its Medicaid ratesetting powers.[32]

The Court of Appeals held that, in reviewing a ratesetting regulatory determination for rationality, it must examine "not only the factual data relied upon by DOH, but also whatever broader judgmental considerations have been applied based upon the expertise and experience of the agency. . . ."[33] The Court of Appeals however, did not dismiss NYSHFA's petition, but rather remitted the proceedings to Supreme Court with instructions to apply this more deferential standard of judicial review.

After that further review and application of that requisite deference, the Supreme Court of Albany County again found the Base Price Reduction to violate both state and federal law. Shortly after this decision was rendered, the parties negotiated a comprehensive settlement resulting in payment of approximately $150 million in new reimbursement dollars to aggrieved facilities adversely affected by the Base Price Reduction in rate years 1989-1995.[34]

The Legislature's Budget-Cutting Statutory Adjustments

Beginning in 1995, and continuing in all years thereafter, the state undertook a new approach to changing the case mix system. Instead of relying upon DOH to adopt new *regulations* imposing Medicaid rate cuts or redistributions, New York began what has now become an annual ritual of changing the Medicaid ratesetting system by *legislative* action.

Effectively, this change from regulatory to statutory amendments adversely affected the ability of nursing facilities to hold the state accountable under the Article 78 "arbitrary and capricious" standard for review of administrative agency actions. By adopting Medicaid rate cuts as statutory amendments to the case mix system, the state largely immunized itself from review of legislative changes under state law rationality standards, leaving facilities to seek relief primarily under federal or constitutional law. And, to further immunize states from judicial review of their Medicaid ratesetting, Congress repealed the federal Boren Amendment effective October 1, 1987—assuaging the governors of New York and other states stung by the federal court's repeated invalidations of their Medicaid ratesetting actions.[35]

The first major statutory change in New York was proposed by Governor Pataki for the budget year beginning April 1, 1995, and ending March 31, 1996. The final bill modified and adopted by the legislature contained a series of amendments to New York's case mix system including the elimination of any trend factor for 1995 (effectively denying the existence of any health care inflation for 1995); delaying the payment of any rate appeals to the next fiscal year; reducing nursing home reimbursement by $56 million based upon the state's promise to reduce unnecessary regulatory mandates; and increasing an assessment on nursing home gross receipts from 1.8% to 5.6%. The net impact of these statutory changes was to reduce nursing home reimbursement across the board by approximately $240 million in fiscal year 1995-1996.[36]

New York's 1996-1997 Budget Act contained similar reductions in the rates otherwise paid under the case mix system. This time around, however, the state introduced cuts in the Medicaid rates otherwise owed under the case mix system to nursing homes across the state in the range of 11.8% to 21.5%—aggregating some $270 million.[37] Similar rate reductions have been imposed in each fiscal year thereafter. As a result, the total statutory reductions from 1995 to 2003 in nursing home reimbursement rates otherwise owed under the case mix system exceeds a whopping $2.6 billion.

What's Left of 1986 Case Mix System?

Plainly, the carefully developed and well-studied system implemented in 1986 for reimbursing New York's nursing homes bears little resemblance to the case mix system as it exists today in its heavily amended form. The Adjustment to RIPAF and the Base Price Reduction, both of which were originally invalidated by the state and federal courts, have been re-adopted by DOH and are now once again reducing the reimbursement rates of the state's most cost-efficient nursing facilities. A new form of Recalibration Adjustment is in place, further reducing reimbursement rates statewide, and the enormous rate cuts introduced by legislation in 1995 and in each year thereafter continue to emasculate the original case mix system, and upset its careful balance of penalties and rewards.

Ironically, one major component of the case mix system that, by design, was intended to be periodically updated has never changed. That is DOH's steadfast reliance upon 1983 operating costs as the "base" for calculating Medicaid rates in each year up to and including 2004. Thus, year 2004 represents the 21st anniversary of the bygone year upon which nursing homes' Medicaid rates are presently calculated.

Amazingly, a nursing home's spending needs and habits in 1983 continue to be the major "determinant" of the adequacy or inadequacy of that facility's Medicaid reimbursement 21 years later. Needless to say, much in this world has changed since 1983 when, among other things:

- President Reagan was still in his first term of office;
- the Baltimore Orioles won the World Series with second-year shortstop Cal Ripkin leading the way; and
- the Berlin Wall was still years away from being torn down.

Unquestionably, the enormous upheaval that has occurred in the health care marketplace in New York State since 1983 makes DOH's continued reliance upon 21-year-old economic realities and 21 years of chain-linked annual inflation factors to predict 2004 economic realities highly dubious, if not *per se* irrational.

"New York's case mix system, in its present, emasculated condition, is no longer a viable methodology for achieving the reasonable and adequate Medicaid reimbursement required by New York law and necessary to the economic survival of the state's long term care facilities."

Does the Current System Provide Adequate Reimbursement?

So, do the resulting Medicaid rates accurately reflect nursing homes' actual necessary operating costs in the 21st century? For the great majority of facilities, the answer is a resounding "no." DOH's own data for rate year 2000 reveals that, except for New York City metropolitan homes, facilities in all other regions of the state suffer large and growing shortfalls in their Medicaid rates (i.e., the difference between their actual current costs of caring for Medicaid residents and their Medicaid reimbursement rates). Facilities in upstate regions, in particular, experience staggering Medicaid shortfalls ranging from 10% in Albany to 12% in Rochester to a whopping 27% in the Erie region.[38]

Even when the extra revenues that homes receive from private-paying residents are added to the equation, DOH's data projects that, on average, nursing homes in 2003 incur overall net losses of 3%, with roughly 20% of facilities in the state reporting overall losses for three consecutive years. DOH's data further reveals that the operating loss percentages (calculated by subtracting operating expenses from operating revenues and then dividing the result by operating revenues) in 2003 were estimated to range, for example, from 7% at homes in Erie County, to 9% in Onondaga County, to 24% in Livingston and Schenectady Counties, to a whopping 58% in Chautauqua County.[39] And, an April 2003 study published by the New York Association of Homes and Services for the Aging reveals that current Medicaid shortfalls at nursing homes statewide amount to more than $500 million per year, with more than 70% of New York's homes losing money caring for Medicaid residents.[40]

Plainly, New York's case mix system, in its present, emasculated condition, is no longer a viable methodolo-

gy for achieving the reasonable and adequate Medicaid reimbursement required by New York law and necessary to the economic survival of the state's long term care facilities. Major reconstruction is needed to avoid the financial collapse of countless nursing homes, and to assure that the elderly poor continue to receive the high-quality care that the state demands.

Endnotes

1. 10 NYCRR 386-2 (1988); *See New York State Association of Counties v. Axelrod,* 78 N.Y.2d 158 (1990) ("*Association of Counties*").
2. *Pinnacle Nursing Home v. Axelrod,* 928 F.2d 1306, 1310 (2d Cir. 1991).
3. "NYS Mandated Nursing Home Costs Above OBRA," paper commissioned by New York State Senate, May 1991.
4. *See* H.R. Rep. No. 158, 97 Cong. 1st Sess. 293 (1981), reported in 1981-2 U.S. Code of Cong. & Admin. News at 396, 744.
5. 42 U.S.C. § 1396a(a)(13)(A), repealed Oct. 1, 1997; the Boren Amendment was incorporated as part of the Omnibus Budget Reconciliation Act of 1980 (OBRA of 1980), Pub. L. 96-499, § 926(b), 1980-5 U.S. Code of Cong. & Admin. News 5526, 5744, and was expanded under the Omnibus Budget Reconciliation Act of 1981 (OBRA of 1981), Pub. L. 97-35, 1981-1 U.S. Code of Cong. & Admin. News (95 Stat.) 357, 809. The same substantive law requirement of "reasonable and adequate" rates to meet necessary costs is contained in New York Public Health Law § 2807.
6. *See Association of Counties*, 78 N.Y.2d at 162–163; *Pinnacle Nursing Home*, 928 F.2d at 1310–1311.
7. *Pinnacle Nursing Home,* 928 F.2d 1306, 1310.
8. *Id.*
9. *See Lakeshore Nursing Home v. Axelrod*, 181 A.D.2d 333 (3d Dep't 1992); *New York State Health Facilities Ass'n ("NYSHFA") v. Axelrod*, 194 A.D.2d 752 (3d Dep't 1993).
10. *Association of Counties*, 78 N.Y.2d at 162.
11. *Id.* at 167–168.
12. *Id.* at 163–164.
13. *Pinnacle Nursing Home*, 928 F.2d at 1310–1311.
14. *Pinnacle Nursing Home v. Axelrod*, 719 F. Supp. 1173, 1177 (W.D.N.Y. 1989); *See Lakeshore Nursing Home v. Axelrod*, 181 A.D.2d 333 (3d Dep't 1992).
15. *NYSHFA v. Axelrod*, 194 A.D.2d 752 (3d Dep't 1993).
16. 10 NYCRR § 86-2.10(r)
17. *Id.*
18. 10 NYCRR §§ 86-2.10(c)(iii) and (d) (iv).
19. Department of Health's RUG-II Monitoring and Evaluation Report.
20. *NYSHFA v. Axelrod;* Minutes of May 1989 State Hospital Review and Planning Council meeting.
21. *Association of Counties,* 78 N.Y.2d at 167–169.
22. *Id.* at 168.
23. *Id.* at 167.
24. *Id.* at 167.
25. Subsequently, DOH tried again to justify recalibration with new approaches. After being rebuffed by the Court of Appeals again in its attempt to impose a new Recalibration Adjustment for 1989-1991 in *Jewish Home v. Commissioner of Health,* 84 N.Y.2d 252 (1994), DOH eventually succeeded in obtaining judicial approval of a substantially modified and downsized recalibration adjustment for rate years 1992 and thereafter. *New York Ass'n of Homes and Services for the Aging, Inc. v. Commissioner of Health,* 87 N.Y.2d 978 (1996).
26. *Pinnacle Nursing Home,* 719 F. Supp. 1173 (W.D.N.Y. 1989).
27. *Pinnacle Nursing Home,* 719 F. Supp. at 1177.
28. *Pinnacle Nursing Home v. Axelrod,* 928 F.2d at 1313, 1315.
29. *Avon Nursing Home v. Axelrod,* 83 N.Y.2d 977 (1994). Nonetheless, DOH readopted the exact same Adjustment to RIPAF as a new Medicaid amendment effective April 1, 1995. That amendment has been stricken for 1995-1997 by the recent ruling of Albany County Supreme Court in *St. James v. DeBuono,* __ N.Y.S.2d __ (decided June 3, 2003), appeal pending.
30. *NYSHFA v. Axelrod,* 194 A.D.2d 752 (3d Dep't 1993).
31. *Id.*
32. *Consolation Nursing Home v. Axelrod,* 85 N.Y.2d 326, 331, (1995).
33. *Id.*
34. Notwithstanding this settlement, DOH re-adopted the same Base Price Reduction as a new Medicaid plan amendment on April 1, 1996. That 1996 amendment is presently challenged by NYSHFA in various Article 78 proceedings pending in Albany County Supreme Court.
35. New York Public Health Law § 2807, however, containing an identical substantive requirement of "reasonable and adequate rates," continues in effect today.
36. 1995-1996 New York State Budget, L. 1995, ch. 81.
37. 1996-1997 New York State Budget, L. 1996, ch. 474, §§ 233-248.
38. Department of Health data on RHCFs, published for rate year 2000.
39. NYSHFA 2003 Report of Operating Profitability of New York State Residential Health Case Facilities, summarized by county, prepared from Department of Health data.
40. *Medicaid Payments to New York's Nursing Homes: Fact vs. Fiction*, NYAHSA, Apr. 25, 2003.

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Civil Liability of Officers and Directors for Abuse and Neglect of Patients and Residents: Recent Issues and Trends

By Maurice W. Heller

New York has led the nation in providing civil recourse to patients for abuse and neglect they allegedly suffered at long-term-care facilities. More than a decade before the federal government grappled with the problem of abuse and neglect in long-term care, New York enacted provisions of Article 28 of the Public Health Law, which provided long-term-care patients with private rights of action to sue the facility, as well as its owner-operator, for compensatory and punitive damages for, among other things, abuse and neglect by facility employees.[1] If, however, a facility manager, officer or director is not also an owner, does he bear liability in New York for the abuse and neglect of patients, even where such abuse and neglect is the proximate result of his management decisions? As might be expected, the answer is not completely clear.

Background: What Is Abuse and Neglect?

Long-term-care patients, who are typically elderly and infirm, are recognized as peculiarly vulnerable, and acts that might not otherwise be tortious or actionable if committed against the general population can cause a long-term-care patient significant physical and mental harm. On a national level, in response to public concerns over the quality of care in nursing homes, Congress attempted to deal with the matter by enacting certain provisions of the Omnibus Budget Reconciliation Act of 1987 (OBRA). This new law provided, among other things, that nursing home residents have the "right to be free from physical or mental abuse, corporal punishment, involuntary seclusion, and any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms."[2] The regulations promulgated by the Health Care Financing Administration (HCFA), now the Centers for Medicare and Medicaid Services (CMS), defined "abuse" as the "willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish" and "neglect," as the "failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. [3]

OBRA mandated surveys and inspections of nursing homes to ensure compliance with its provisions and provided civil penalties and sanctions for violators.[4] In addition, the regulations required that nursing homes investigate all reports of abuse and neglect at the facility, and report the same to CMS and the appropriate state agency.[5] While OBRA contains its own enforcement regime, it specifically declined to preempt state and federal remedies otherwise available to nursing home patients who have suffered from substandard care, including abuse and neglect.[6]

"Despite all of the advances represented by OBRA, the problem of abuse and neglect at long-term-care facilities has not been solved."

Nowhere, however, did OBRA expressly grant long-term-care patients or their representatives a private right of action to sue the facilities that allegedly did them harm. Surely, from the point of view of the patient, this is a serious flaw that diminishes the protections offered by OBRA. Whether OBRA impliedly provides a private right of action, either in conjunction with the federal civil rights laws or otherwise, has been the subject of debate.[7] Many states, including New York, have statutes allowing such private rights of action. Perhaps unwittingly, OBRA has aided the proliferation of private suits in states that permit them by creating this survey and reporting regime, which made survey results citing instances of substandard care and the self-reporting of the same by long-term-care providers available to potential plaintiffs and their counsel.

Despite all of the advances represented by OBRA, the problem of abuse and neglect at long-term-care facilities has not been solved. Abuse and neglect of the resident population in long-term care continues to be cited repeatedly by study after study as a pervasive problem in search of a solution.[8]

The New York Scheme

By the time OBRA became law, New York already had in place a fairly comprehensive scheme providing

redress to aggrieved long-term-care patients. The New York Patient's Bill of Rights provides that "every patient shall be free from mental and physical abuse and from physical and chemical restraints."[9] In addition, section 2801-d of the Public Health Law gives patients in "residential health care facilities" the right to sue such facilities for the deprivation of any "right or benefit," which includes

> any right or benefit created or established for the well-being of the patient by the terms of any contract, by any state statute, code, rule or regulation or by any applicable federal statute, code, rule or regulation, where noncompliance by said facility with such statute, code, rule or regulation has not been expressly authorized by the appropriate governmental authority.[10]

"Residential health care facility" is defined as "a nursing home or a facility providing health-related service."[11]

This private right of action allows a patient to sue not only the facility for abuse and neglect, but "controlling persons" of the facility, which includes "any person who by reason of a direct or indirect ownership interest (whether of record or beneficial) has the ability, acting either alone or in concert with others with ownership interests, to direct or cause the direction of the management or policies of said facility."[12]

New York also imposes upon operators, employees, and independent contractors of residential health care facilities the obligation to investigate and report instances of abuse and neglect to the Department of Health.[13] In addition, the statute provides that "any other person may make such a report if he or she has reasonable cause to believe that a person receiving care or services has been physically abused, mistreated or neglected."[14] Those who report such instances "have immunity from any liability, civil or criminal, for having made such a report."[15] Any licensed person who commits acts of abuse or neglect, or who fails to report the same, "shall be guilty of unprofessional conduct in the practice of his or her profession,"[16] presumably establishing a basis for civil liability.

Despite this comprehensive statutory scheme, New York long-term-care facilities continue to suffer from problems relating to abuse and neglect of patients. Of 671 New York nursing homes surveyed in 2002, over 32% were cited for deficiencies resulting in actual harm or immediate jeopardy to patients, slightly above the national average.[17]

Directors, Officers and Managers

When already existing common law rights and remedies are taken into account, a patient in New York who has suffered from abuse and neglect can sue the facility, the owner of the facility, the care worker who mistreated her, the physician who failed to treat her and the nurse who neglected her. Nevertheless, one class of persons seems to have been left out of the New York plan, namely officers, directors and managers of long-term-care facilities that do not have ownership interests in the facility. While these persons are not "controlling persons" or direct caregivers, their decisions with respect to matters such as the allocation of resources at a facility could have direct and immediate consequences. Accordingly, the scope of their civil culpability under New York law is an important avenue of inquiry.

"[O]ne class of persons seems to have been left out of the New York plan, namely officers, directors and managers of long-term-care facilities that do not have ownership interests in the facility."

Under the general corporate law as adopted in New York, officers and directors of a company can be held personally liable for torts committed by the company's employees against third parties only if it can be shown that the officer or director actually participated in the alleged wrongful conduct; the officer's or director's official relationship with the company is not enough, in and of itself, to hold him liable.[18] This doctrine has recently been applied in the long-term-care context. In *Olszewski v. Waters of Orchard Park*,[19] the executor of the estate of a former nursing home resident sued the nursing home, the corporate owner of the nursing home, a consulting company which provided administrative services to the nursing home, the corporate owner of the nursing home property, and the sole shareholder and president of the corporate owner of the nursing home, alleging that his decedent suffered injuries while a resident at the nursing home which led to his death. The lower court granted the motion of three of the defendants, including the individual shareholder/president, to dismiss.

On appeal, plaintiff cited local news articles which discussed "the conduct undertaken at facilities operated under the direction of defendant [shareholder/president], including" the facility at issue, and that "[t]hese include concerns that the facilities were understaffed to care for the residents entrusted to them which resulted in residents sustaining serious injuries."[20] Nevertheless,

there was no attempt by the plaintiff, either in the complaint or elsewhere during the proceedings below, to directly link the individual shareholder/president with a corporate decision to understaff the facility at issue.[21] Accordingly, the Appellate Division Fourth Department found that "plaintiff did not adequately allege any basis for holding [the shareholder/president] personally liable for decedent's death," and, restating New York law, that "[a] corporate officer is not held liable for the negligence of the corporation merely because of his official relationship to it. It must be shown that the officer was a participant in the wrongful conduct."[22] Accordingly, the Appellate Division affirmed the dismissal of the action.

"How attempts to impose civil liability upon officers and directors in the long-term-care context will fare in New York remains to be seen."

The *Olszewski* decision begs the question as to what would be considered an allegation adequate to hold the individual shareholder/president liable. It is conceivable that the result in the *Olszewski* case would have been different had the plaintiff credibly alleged that the individual shareholder/president was directly involved in a decision to reduce staff at the facility to levels that endangered the well-being of the facility's patients. Indeed, New York law will hold a corporate officer or director liable if it can be shown that the officer or director was "a participant in," was personally involved in, or directly supervised, the actionable conduct.[23]

How attempts to impose civil liability upon officers and directors in the long-term-care context will fare in New York remains to be seen. But for the *Olszewski* case, there is a dearth of New York case law on this subject. The scope of liability of hospital officers, such as medical directors, has been addressed by the New York courts. Following the clearly established line of New York cases, the courts have generally found that a medical director cannot be held liable for the negligence or wrongful acts of others at the hospital solely based upon his status as a medical director.[24] Rather, the courts have required proof that the medical director personally committed a tort or malpractice, or directly supervised the person who did.[25]

Despite this oft-repeated mantra, the Appellate Division, Second Department apparently decided, at least in one instance, that the status of a hospital officer would be enough to give rise to a legal presumption of liability. In *Wilson v. McCarthy*,[26] the court found that the chief of a hospital's obstetrics department had, as a matter of law, been delegated by the hospital "procedural and rulemaking authority over the medical conduct of all doctors practicing in said department" and, because of this authority, could be "held liable for treatment not personally given by him to the patient."[27] The precedential force of this decision may, however, have been limited by a decision of the same court some years later. In *Latiff v. Wyckoff Heights Hospital*,[28] in a seemingly identical situation, the Second Department, citing *Wilson v. McCarthy*, required proof that a hospital's director of pediatrics had been delegated the authority to "promulgate rules and regulations for the care and monitoring of newborns" and, accordingly, could not be held liable for his failure to do so.[29] Even under *Latiff*, however, it appears that if it were proven that the director of pediatrics had indeed been delegated the authority to promulgate these rules and regulations, then he could have been held liable for not doing so.

What this all portends for the issue at the heart of this article is not completely clear. The Fourth Department in the *Olszewski* case may have left the door open for a plaintiff to assert a cause of action against an officer of a long-term-care facility for acts of abuse and neglect committed by facility staff upon a showing that the officer or director participated in decisions which left the facility understaffed. This assumes, of course, that such understaffing could be shown to have been the proximate cause of the conditions that led to the patient's injury. Moreover, if the decision of the Second Department in *Wilson v. McCarthy* indeed means that a hospital department head is presumed to have been delegated certain rulemaking power by the hospital, and if that decision is still good law, could that doctrine be applied in the long-term-care context? For example, long-term-care facilities are required under the regulations promulgated under OBRA, to "develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property."[30] Can the New York courts presume, or make a finding, that a duty to develop and implement such policies and procedures has been delegated to the facility's administrator or compliance officer? If so, where there has been a failure to develop and implement them, can the compliance officer be held personally liable in a civil lawsuit for injuries which allegedly resulted from this breach? There appears to be nothing under New York law that would preclude such a possibility.

Conclusion

While civil suits for abuse and neglect by long-term-care patients or their representatives against officers, directors, and managers of long-term-care facilities with no ownership interests in such facilities are not expressly authorized by statute, it appears that the gen-

eral corporate law, as applied in New York, would allow such suits under certain circumstances. These would certainly include situations where it can be shown that the officer, director or manager was directly involved in the commission of the abuse or neglect, or where the officer, director or manager directly supervised the person who committed the abuse or neglect. Less certain, but still possible, is the question of whether New York would impose liability against officers, directors or managers who have made management decisions, such as reductions in staffing, which result in conditions which give rise to abuse and neglect, or fail to act pursuant to duties delegated to them by the facility which, again, give rise to such conditions.

Endnotes

1. New York Pub. Health Law §§ 2801-d, 2803-c and 2808-a (hereinafter "PHL").
2. Omnibus Budget Reconciliation Act of 1987, Section 9311, 42 U.S.C. § 1395i-3(c)(1)(A)(ii) and 42 U.S.C. § 1396r(c)(1)(A)(ii).
3. 42 C.F.R. § 488.301; *See* United States General Accounting Office, Nursing Homes: Many Shortcomings Exist in Efforts to Protect Residents from Abuse, Mar. 4, 2002, GAO-02-448T; Gitner, *Nursing The Problem: Responding To Patient Abuse In New York State*, 28 Colum. J.L. & Soc. Probs. 559 (1995).
4. 42 U.S.C. § 1395i-3(g), (h), 42 U.S.C. § 1396r(g), (h).
5. 42 CFR § 483.13.
6. 42 U.S.C. § 1395i-3(h)(5) 42 U.S.C. § 1396r(h)(5).
7. *Compare Tinder v. Lewis County Nursing Home Dist*., 207 F. Supp. 2d 951 (E.D. Mo. 2001) (potential right of action under 42 U.S.C. § 1983) *with Brogdon ex rel. Cline v. National Healthcare Corp*., 103 F. Supp. 2d 1322 (N.D. Ga. 2000) (no private right of action).
8. *See, e.g.*, Abuse of Residents Is a Major Problem in U.S. Nursing Homes, Minority Staff, Special Investigations Division, Committee on Government Reform, U.S. House of Representatives, July 30, 2001; Abuse Complaints of Nursing Home Patients, Department of Health and Human Services Office of Inspector General Office of Evaluation and Inspections, May 1999, OEI-06-98-00340; United States General Accounting Office, Nursing Homes: Prevalence of Serious Quality Problems Remains Unacceptably High, Despite Some Decline, July 17, 2003, GAO-03-1016T; GAO Report, March 4, 2002, *supra*; United States General Accounting Office, Nursing Homes: More Can Be Done to Protect Residents from Abuse, March 1, 2002, GAO-02-312.
9. PHL § 2803-c(3)(h); 10 N.Y.C.R.R. § 415.3.
10. PHL § 2801-d(1).
11. PHL § 2801(3).
12. PHL § 2808-a.
13. PHL § 2803-d(1).
14. PHL § 2803-d(2).
15. PHL § 2803-d(4).
16. PHL § 2803-d(5).
17. GAO Report, July 17, 2003.
18. *Felder v. R and K Realty*, 295 A.D.2d 560, 744 N.Y.S.2d 213 (2d Dep't 2002); *Trustco Bank v. S/N Precision Enterprises, Inc.*, 234 A.D.2d 665, 650 N.Y.S.2d 846 (3d Dep't 1996); *Clark v. Pine Hill Homes*, 112 A.D.2d 755, 492 N.Y.S.2d 253 (4th Dep't 1985).
19. 303 A.D.2d 995, 758 N.Y.S.2d 716 (4th Dep't 2003).
20. Brief of Plaintiff-Appellant at p. 10.
21. *See* Record on Appeal.
22. *Olszewski, supra*. A deliberate decision by a nursing home administrator to reduce staff in the face of known danger to patients is clearly wrongful, and can lead to criminal liability. *See State v. Serebin*, 350 N.W.2d 65 (Wis. 1984).
23. *Clark v. Pine Hill Homes, Inc*., 112 A.D.2d 755, 492 N.Y.S.2d 755 (4th Dep't 1985).
24. *Donnelly v. Finkel*, 226 A.D.2d 671, 641 N.Y.S.2d 872 (2d Dep't 1996); *Concha v. Local 1115*, 216 A.D.2d 348, 628 N.Y.S.2d 172 (2d Dep't 1995); *Ellis v. Brookdale Hospital*, 122 A.D.2d 19, 504 N.Y.S.2d 189 (2d Dep't 1986).
25. *Id*.
26. 57 A.D.2d 617, 393 N.Y.S.2d 770 (2d Dep't 1977).
27. *Id*., 57 A.D.2d at 617, 393 N.Y.S.2d at 771.
28. 144 A.D.2d 650, 535 N.Y.S.2d 2 (2d Dep't 1988).
29. *Id*., 144 A.D.2d at 651, 535 N.Y.S.2d at 3.
30. 42 C.F.R. § 483.13(c).

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Recent Challenges to the Companionship Services Exemption in the Home Health Industry

By Roni E. Glaser

Recently, the home health industry has been the target of lawsuits challenging the application of the companionship services exemption to the Fair Labor Standards Act of 1938 (FLSA) to home health aides. Section 213(a)(15) of title 29 of the United States Code provides that:

> [t]he provisions of section 206 (except subsection (d) in the case of paragraph (1) of this subsection) and section 207 of this title shall not apply with respect to . . . any employee employed on a casual basis in domestic service employment to provide babysitting services or any employee employed in domestic service employment to provide companionship services for individuals who (because of age or infirmity) are unable to care for themselves (as such terms are defined and delimited by regulations of the Secretary).

This so-called "companionship services exemption" discharges employers from having to pay minimum wage and overtime compensation in accordance with the FLSA to domestic service employees. Generally, home health aides are considered domestic service employees and therefore fall under the companionship services exemption.

This article will explore the companionship services exemption, its interpretation, and the policy reasons behind the exemption. Then, it will consider three recent challenges in New York by home health aides to the application of the companionship services exemption. These include a challenge to the validity of the exemption itself, a challenge invoking the "general household work" exception to the exemption, and a challenge to the "private home" status of a place in which companionship services are rendered.

The History of the Companionship Exemption

The FLSA was enacted in 1938 to regulate minimum wages, maximum working hours, and child labor in industries within interstate commerce.[1] While the FLSA initially was extremely limited in the types of employees it covered, since 1938, the coverage of the FLSA has expanded.[2] In 1974, domestic service employees were added to the categories of employees covered by the minimum wage and maximum hours provisions through amendments to the FLSA. However, these amendments also created the companionship services exemption, excluding from the FLSA's minimum wage and overtime requirements those domestic service employees who provide companionship services to the elderly in their homes.[3]

The creation of a companionship services exemption was supported by important public policy considerations. Caregivers who are exempt from the FLSA can provide lower cost services, and thus, the companionship services exemption enables more elderly and disabled people to receive needed services that might otherwise be unaffordable.[4] If the cost of services increases, private individuals not receiving federal and state assistance may not be able to obtain the necessary services provided by these caregivers.[5] Furthermore, caregivers such as home health aides who are included in the companionship services exemption, provide services that allow individuals to remain in their homes when they are elderly or disabled. One purpose of the companionship services exemption was to enable guardians of elderly or disabled individuals to have their dependents cared for in their private homes instead of in institutions.[6] For some of these individuals, the only alternative to home care and the receipt of companionship services would be institutionalization.[7]

There have been enormous changes in the home care industry since 1975, when the regulations implementing the companionship services exemption were published. As a result of these changes, the Secretary of Labor sought, on January 19, 2001, to amend the regulations to narrow the circumstances under which the exemption could be claimed.[8] The proposed amendments included a change in the definition of companionship services which would deny the application of the exemption if the employee was employed by someone other than a member of the family in whose home he or she works. The amendments also proposed to revise the duties which would qualify for the exemption, and to clarify the criteria to be used to determine whether employees qualify as "trained personnel" who are not exempt under the companionship services exemption. However, after receiving and considering numerous public comments, including those from municipalities which expressed concern about the fiscal impact of narrowing the companionship services exemption, the Secretary withdrew the proposed amendments on April 18, 2002.[9] Thus, as the law cur-

rently stands, and particularly in view of the Secretary's withdrawal of his proposal to limit the exemption, the companionship exemption continues to apply to home health aides unless an exception to the exemption applies.[10]

Challenge One: Home Health Aides Exempt from the FLSA Minimum Wage and Overtime Compensation Requirements

In a recent case brought in the Eastern District of New York, *Coke v. Long Island Care at Home, Ltd.*,[11] a live-in personal care aide employed by a licensed home care services agency sued her employer, claiming she worked greater than forty hours per week but was not paid a rate of one and one-half times her regular rate of pay.[12] She claimed that the Secretary's regulations defining companionship services as including services rendered by employees of a private agency were overbroad and invalid and that Congress did not intend to limit its coverage of domestic service employees by such an expansive interpretation of the FLSA.[13]

Courts have generally upheld the companionship services exemption to the FLSA's overtime and minimum wage provision as applied to services provided by home health aides.[14] For example, in a New York State case, *Ballard v. Community Home Care Referral Service, Inc.*, an employee was not entitled to receive one and one-half times her regular hourly wage as overtime compensation because she was a home health aide and therefore was covered by the companionship services exemption.[15] The court noted that home health aides and other people employed in similar capacities are covered by the companionship services exemption since their work involves the day-to-day care of elderly or infirm individuals.[16]

Exempt companionship services have also been held to include the services of a certified nursing assistant and home health aide employed by a private agency whose tasks included caring for patients under a nurse's supervision, assisting patients with personal care, assisting with rehabilitative activities, helping the patients take their medications, and performing specific procedures with nurses;[17] a home health care aide who provided day-to-day care for elderly or disabled individuals including tasks such as meal preparation, bed making, washing clothing, and other related domestic services;[18] employees who assisted their clients with dressing, grooming, and administering medication, performed household chores, and who provided household management training to aide their clients in becoming more independent;[19] and an in-home certified nursing assistant for a quadriplegic patient, whose tasks included dispensing medication, changing catheters, exercising, bathing, and dressing the patient, running errands, and helping with the patient's finances.[20]

Harris v. Dorothy L. Sims Registry,[21] however, relying principally on the Department of Labor's commentary in its proposal to amend its regulations,[22] found the companionship exemption to be inapplicable to home health care workers employed by private agencies, determining that the Secretary's existing definitions (sought to be revised in its Notice of Proposed Rulemaking, or NPRM) were too broad and therefore invalid. However, since the Secretary's NPRM was withdrawn, the *Harris* reasoning could not be applied in *Coke*, and that Court upheld the companionship services exemption as it continues to be defined under the Secretary's interpretative regulations promulgated pursuant to the authority explicitly granted to him under the FLSA. The *Coke* case is currently on appeal to the Second Circuit.

Challenge Two: Home Health Aides Who Perform General Housework That Is Incidental, i.e., Does Not Exceed Twenty Percent of the Total Weekly Hours Worked, Are Covered by the Companionship Exemption

According to the Secretary's regulations, exempt companionship services may include any amount of "household work *related to the care of the aged or infirm person* such as meal preparation, bed making, washing of clothes or other similar services."[23] They may also include "the performance of general housework: Provided however, that such work is incidental, i.e., does not exceed 20 percent of the total weekly hours worked."[24] If plaintiffs do not present specific evidence that they spent more than twenty percent of their time doing general household work, they are not entitled to overtime compensation or minimum wage.[25] Further, when the court finds that most of an employee's household work is related to the care of the client, the work is not included in the twenty percent "general housework" limitation, and the employee is covered by the companionship services exemption.[26]

In determining what is "general household work," one court determined that the test should be whether particular tasks are necessary for the care or habilitation training of a particular client.[27] If so, then they are not general household work counting toward the twenty percent maximum in the exemption.[28] Other services that have been held not to be subject to the twenty percent figure have included companionship services performed by the wife of a disabled husband when she gave her husband medication, helped him dress, bathe and walk, and cleaned the house,[29] and therapy and nursing services, personal care, ambulation, exercise, household services and the provision of medicine.[30] On

the other hand, general maintenance services including cleaning laundry areas, general household cleaning, washing cars, cleaning the garage, and maintaining the yards and grounds at a facility housing mentally and physically handicapped adults were considered general household work and were thus subject to the twenty percent figure set forth in the regulation.[31]

In a case currently before the court in the Southern District, a home health aide alleges that she rendered services that included general housework for greater than twenty percent of her working hours. The aide was assigned by a home care agency to render services to patients pursuant to "plans of care" required by the state to be developed by the agency's supervising nurses in consultation with patients' physicians. All services performed by the aide pursuant to these plans of care would have been related to the care of a particular patient. General housework *not* related to the care of a patient would have been outside the scope of the instructions provided to the aide by the agency, as communicated to the aide in company policies, in the aide's job description and in patients' plans of care. It remains to be learned during discovery exactly what services are alleged by the aide to have been rendered for greater than twenty percent of the aide's working hours that were not related to the care of the patient but were within the scope of the aide's assignment by the agency. As the above-cited cases suggest, the burden will be on the plaintiff employee to present specific evidence that her assigned work responsibilities included spending more than twenty percent of her time doing general household work not related to the care of a patient.[32]

Challenge Three: The Determination Whether a Home Health Aide Working for a Client Living in a Non-Traditional Home Environment Such As an Adult Home or Assisted Living Facility Is Considered to Be Working in the Client's "Private Home" Is Extremely Fact-Specific

A recent suit brought in the Eastern District of New York by a personal care aide employed by a home health agency challenges whether a New York State-licensed (but privately operated) adult home should be considered the private home of an individual so that the companionship services rendered to him while living in the adult home would fall within the companionship services exemption.

Under the companionship services exemption, domestic service employment refers to "services of a household nature performed by an employee in or about a private home (permanent or temporary) of the person by whom he or she is employed."[33] Unless the companionship services are rendered in a private home, the exemption does not apply. This issue arises when the companionship services are rendered in homes other than traditional single-family dwellings, e.g., group homes for the mentally or physically disabled, youth detention homes, or assisted living facilities. In many of these cases, the residence is the individual's permanent and only home, and may be owned or rented by the individual who receives companionship services there.

The legislative history of the companionship services exemption suggests that a private home is "a fixed place of abode of the individual or family . . . [that is] maintained by the individual or family in an apartment, house, or hotel. . . ."[34] A house used primarily as a boarding or lodging house that is a business enterprise used mainly to provide these services to the public is not considered a private home.[35] Of course, the distinction between an "apartment, house or hotel" and a "boarding or lodging house" is not clear. Thus, most courts have evaluated whether a home is a "private home" within the definition of domestic service employment on a case-by-case basis, with no single factor being dispositive.[36]

In *Bowler v. Deseret Village Ass'n Inc.*,[37] the Utah Supreme Court created a four-prong test to use when determining whether a residence is most similar to a private home, an institution, or a business enterprise. The factors included (1) the source of funding, (2) access to the facility by the general public, (3) whether the residence is organized as a for-profit or nonprofit, and (4) the size of the organization.[38] The court noted that private homes are defined along a continuum and therefore, no one factor in the test could be considered determinative. In *Bowler*, the facility housing disabled adults was held to be a private home because it was originally funded and created by family members of the disabled individuals residing there; it received no municipal, county, state or federal aid; the facility was not open to the public; it was a non-profit Utah corporation organized to care solely for the children of the families that financed the facility; and it only housed fourteen disabled residents.[39] The factors the court in *Bowler* used to determine whether the residence was a private home are generally part of the fact-specific analyses done by other courts to determine whether a residence is a private home.

In *Linn v. Developmental Services of Tulsa, Inc.*,[40] the employees provided services which looked like companionship services, including helping the individuals with personal care services such as feeding, bathroom needs, making beds, washing clothes, bathing, brushing teeth, and preparing meals. However, the employer acquired the residences for the clients, obtained furniture for the residents, kept keys to the residences, decided the number of people that could live in the homes, was responsible for the maintenance of the resi-

dences, and received approximately 95% of its funding to operate each home from the state. In addition, when clients chose the employer defendant to provide them services, they knew it would make decisions about where, how and with whom they were going to live. The residences in question were considered more similar to "state-maintained facilities" and institutions than to private homes, and consequently, the companionship services exemption was held not to apply and the employees were entitled to overtime and minimum wage under the FLSA.

Community-living residences were held to be "institutional" rather than "private" where clients did not have a possessory interest in their residences; clients who terminated their relationship with the non-profit defendant corporation employer could not remain in the housing; the defendant employer ran the homes as part of a care program and the residents were clients in that program; the defendant retained control over the residences; the defendant held the keys to the homes of all clients in the programs; and clients had to abide by rules incompatible with private homes.[41] Similarly, a facility managed by a for-profit corporation, which was designed to accommodate 96 people with the residences broken into four three-bedroom suites with individual kitchenettes and private bathrooms was also determined not to be a "private home" within the meaning of the regulation.[42] In that case, the employees of the defendant employer prepared all of the residents' meals in the communal sunroom, the defendant hired maintenance people to care for the property, and the residents did not have primary or complete control over their residences.[43]

State-funded institutional group residences for mentally retarded individuals were held not to be private homes for the purposes of the companionship services exemption in *Lott v. Rigby*, even though the residents lived exclusively in those homes and contributed to the maintenance of the homes.[44] The facility was a publicly funded institution and was a unit of the North Georgia Mental Health/Mental Retardation/Substance Abuse Center. The court noted that Congress intended private homes to be differentiated from state-maintained facilities, and that in order for a home to be considered "private," an individual or family should be the employer of the domestic service employee rather than the state or county. Additionally, the residence was not "maintained" by the clients even though they participated in its upkeep. Similarly, in *Adams v. Department of Juvenile Justice,* adult homes were not considered to fall within the companionship services exemption where the workers in question were houseparents employed by the City Department of Juvenile Justice.[45]

On the other hand, residences for developmentally disabled individuals were classified as private homes for the purpose of the companionship exemption in *Terwilliger v. Home of Hope, Inc.*[46] Factors suggesting that the residences were private homes and that the companionship services exemption should apply included: many of the clients had a possessory interest in their homes, had sole control over their keys except in emergency situations, and the clients themselves determined whether or not they wanted housemates.[47]

The courts are far from uniform in their treatment of non-traditional living arrangements as "private homes" under the companionship exemption. Issues of control, maintenance of premises, source of funding, the size of the home, accessibility by the public, and other factors have all been considered by the courts in making this fact-specific determination. The cases that have been reported thus far have all involved residence owners/operators whose employees provide companionship as part of the package of services offered by the program. The courts have not addressed the circumstance in which one person or entity owns and operates the residence, but another person or entity, such as a home health care agency which exercises no control over and performs no maintenance of the residence, privately contracts to provide the companionship services to persons living in their home. It remains to be seen whether factors which satisfy a court that a residence is not a "private home" will be imputed to the companion (or the agency that employs her) when the companion does not control the factors that have been considered by courts in making this determination.

Conclusion

Only recently have federal courts in the Second Circuit begun to consider the thorny issues relating to the companionship services exemption that have previously been considered in other jurisdictions. Several challenges are now before these courts.

Since many of the challenges presented in recent cases boil down to questions of fact, thorough records including the number of hours worked and the nature of the tasks performed should be maintained by employers of home health aides who wish to avail themselves of the companionship services exemption. The location of the work performed and the specific features of the living arrangements should be evaluated carefully before determining that the exemption may be taken. Moreover, employers should explain their compensation practices to their employees so that the employees understand the amount of overtime compensation to which they are entitled.

We should soon see how the Second Circuit will evaluate the many fact-specific issues in ruling on the

validity and applicability of the companionship services exemption in the home care arena.

Endnotes

1. *Coke v. Long Island Care at Home, Ltd.*, 267 F. Supp. 2d 332 (E.D.N.Y. 2003).
2. *Id.*
3. By regulations promulgated by the Secretary of Labor under the authority delegated to him in the FLSA, domestic service employment was defined as household services performed by an employee "in or around the permanent or temporary private home of the person by whom he or she is employed," 29 C.F.R. § 552.3, and companionship services were defined to include "household work related to the care of the . . . infirm person such as meal preparation, bed making, washing of clothes, and other similar services." 29 C.F.R. § 552.6. General household services exceeding twenty percent of the total weekly hours worked and services performed by trained personnel were carved out of the companionship services exemption. 29 C.F.R. § 552.6. These are known as the "general household work" and "trained personnel" exceptions to the companionship services exemption.
4. *McCune v. Oregon Senior Services Division*, 894 F.2d 1107, 1110 (9th Cir. 1989).
5. *Id.*
6. *Linn v. Developmental Services of Tulsa, Inc.*, 891 F. Supp. 574, 577 (N.D. Okla. 1995) citing *Lott v. Rigby*, 746 F. Supp. 1084, 1087 (N.D. Ga. 1990).
7. *Id.*
8. 66 Fed. Reg. no. 13, 5481–5489.
9. 67 Fed. Reg. no. 67, 16668.
10. *See* note 3.
11. *Coke v. Long Island Care at Home, Ltd.*, 267 F. Supp. 2d 332 (E.D.N.Y. 2003).
12. The plaintiff claimed that as a live-in employee, she worked during all or substantially all of the 24 hours that she was present in the patient's home. However, the issue of how many hours per day she could be deemed to have worked while required to remain on the patient's premises was not reached in this case.
13. 2001 U.S. Dist. Lexis 23263 (N.D. Ill. 2001).
14. *See, e.g. Sandt v. Holden*, 698 F. Supp. 64 (M.D. Pa. 1988); *Ballard v. Community Home Care Referral Service, Inc.*, 264 A.D.2d 747, 748 (2d Cir. 1999).
15. 264 A.D.2d 747, 748 (2d Cir. 1999). A New York State Miscellaneous Wage Order provides that if an employee is exempt from the FLSA under the companionship services exemption, the premium required to be paid for overtime hours worked is one and one-half the State minimum wage (at present, $5.15), or $7.73 per hour. 12 N.Y.C.R.R. § 142-2.2.
16. *Id.* at 748.
17. *Cox v. Acme Health Services, Inc.*, 55 F.3d 1304 (7th Cir. 1995).
18. *Ballard*, 264 A.D.2d. at 748.
19. *Terwilliger v. Home of Hope, Inc.*, 21 F. Supp. 2d 1294 (N.D. Okla. 1998).
20. *Armani v. Maxim Healthcare Services, Inc.* 53 F. Supp. 2d 1120 (D. Colo. 1999).
21. 2001 U.S. Dist. LEXIS 23263 (N.D. Ill. 2001).
22. *See* note 8.
23. 29 C.F.R. § 552.6. Emphasis added.
24. *Id. See, e.g., McCune v. Oregon Senior Servs. Div.*, 894 F.2d 1107 (9th Cir. 1990).
25. *Toth v. Green River Regional Mental Health/Mental Retardation Bd.*, 753 F. Supp. 216 (W.D. Ky. 1989).
26. *Id.*
27. *Terwilliger v. Home of Hope, Inc.* 42 F. Supp. 2d 1231 (N.D. Okla. 1999).
28. *Id.*
29. *Salyer v. Ohio Board of Workers' Compensation*, 83 F.3d 784, 787 (6th Cir. 1996).
30. *Cox v. Acme Health Servs., Inc.* 55 F.3d 1304 (7th Cir. 1995).
31. *Bowler v. Deseret Village Ass'n Inc.*, 922 P.2d 8 (Utah 1996).
32. *See, e.g., McCune v. Oregon Sr. Services Div.*, 894 F.2d 1107 (9th Cir. 1990); *Toth v. Green River Regional Mental Health/Mental Retardation Bd.*, 753 F. Supp. 216 (W.D. Ky. 1989).
33. 29 C.F.R. § 552.3.
34. H.R. Rep. No. 913, 93rd Cong., 2d Sess. quoted in *Linn v. Developmental Services of Tulsa, Inc.*, 891 F. Supp. 574, 578 (1995).
35. *Id.*
36. *See, e.g. Johnston v. Volunteers of America, Inc.*, 213 F.3d 559, 565 (10th Cir. 2000).
37. 922 P.2d 8 (Utah 1996).
38. *Id.*
39. *Id.*
40. 891 F. Supp. 574 (N.D. Okla. 1995).
41. *Madison v. Resources for Human Development, Inc.* 39 F. Supp. 2d 542 (E.D. Pa. 1999); pertinent part *affirmed*, *Madison v. Resources for Human Development*, 233 F.3d 175, 183–184 (3d Cir. 2000).
42. *Gay v. Extended Family Concepts*, 102 F. Supp. 2d 449 (N.D. Ohio, 2000).
43. *Id.*
44. 746 F. Supp. 1084 (N.D. Ga. 1990).
45. 143 F.3d 61 (2d Cir. 1988).
46. 21 F. Supp. 2d 1294 (N.D. Okla. 1998).
47. *Id.*

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Pitfalls of Negotiating a Nursing Home Acquisition Agreement

By Scott B. Lunin

Most purchases of nursing home operations are structured as asset purchase transactions. In many respects, the asset purchase agreement will be similar to an agreement for buying any other business. There are, however, particular areas of concern that need to be addressed in connection with the buying of a nursing home. Failure to adequately address these issues can have serious, unintended consequences for your client. This article will discuss some of the more significant issues that must be considered and addressed by the parties when negotiating an asset purchase agreement for the operation of a nursing home in New York State.

Provider Numbers

Virtually all nursing homes in the state of New York participate as providers of services in the Medicare and Medicaid programs. Facilities participating in the Medicare and Medicaid programs are reimbursed by the programs for services rendered to residents who are program beneficiaries. For many nursing homes, especially those located in the metropolitan New York City area, Medicaid reimbursement represents the vast majority of their revenue. Even if the purchaser of the operation of a nursing home is buying the assets of the seller, the purchaser has the choice of either (i) continuing to use the seller's Medicaid program provider number(s), or (ii) applying for new Medicaid program provider number(s). The choice made by the purchaser can have a significant impact on the purchaser's operation of the facility.

If the purchaser assumes the seller's Medicaid provider number(s), the state will require that the purchaser acknowledge that any overpayments made by the Medicaid program to the seller prior to the closing can be offset against reimbursement otherwise to be made to the purchaser (who has elected to continue to use the seller's Medicaid provider number(s)) after the closing. Nursing homes are subject to a variety of regulatory audits that can result in reimbursement overpayment determinations. The Medicaid program recovers overpayments by reducing reimbursement due providers. Depending upon the type of audit, an overpayment determination may reach hundreds of thousands, or even millions, of dollars. The possibility of the purchaser's having its Medicaid program reimbursement reduced by the state to recover overpayments made to the seller is a significant issue that must be addressed if the purchaser elects to continue to use the seller's Medicaid number(s). Some of the ways to reduce the risk to the purchaser of continuing to use the seller's Medicaid provider number(s) are discussed below under Due Diligence and Security.

If the continued use of the seller's Medicaid provider number(s) exposes the purchaser to the potential risk of large recoupments against its Medicaid program revenue, the obvious question is why, then, should the purchaser want to continue to use the seller's Medicaid provider number(s). The answer is that the decision not to continue to use the seller's Medicaid provider number(s) can also expose the purchaser to significant monetary risk. If the purchaser elects not to use the seller's Medicaid provider number(s), and applies for its own Medicaid provider number(s), the purchaser may experience a significant delay in receiving reimbursement under its new provider number(s). It can literally take months before the application for a new Medicaid number is processed, the facility's roster of residents is transferred to the purchaser's new provider number(s), billing can be and is submitted under the new provider number(s), and payment is actually received by the purchaser. During this period of time, no Medicaid reimbursement, which can represent over 90% of the purchaser's total revenue, will be received by the purchaser. The delay and uncertainty about when Medicaid revenue will be forthcoming will require the purchaser to provide for significantly greater amounts of working capital than would be needed if the purchaser were to assume the seller's Medicaid provider number(s) and receive the uninterrupted flow of Medicaid program reimbursement. Therefore, unless the purchaser is not able to adequately protect itself against the reduction of Medicaid program reimbursement resulting from recoveries of Medicaid overpayments paid to the seller, the purchaser will usually elect to continue to use the seller's Medicaid provider number(s).

Financing Issues

The purchaser of a nursing home will be required to submit a Certificate of Need application seeking regulatory approval to become the new operator of the facility. Regulatory approval will not be granted unless the Public Health Council of the New York State Department of Health is satisfied that the purchaser (and its principals) have sufficient character and competence and that both the proposed acquisition and operation of the facility are financially feasible. With regard to the financial feasibility of the proposed acquisition, the purchaser will need to demonstrate that it has, or can borrow, sufficient funds to pay the purchase price. With regard to financial feasibility of the proposed operation, the purchaser will need to demonstrate that it has sufficient working capital for the operation of the facility and that it will generate sufficient revenues to pay its liabilities (including repayment of any funds borrowed by the purchaser to pay the purchase price or for

working capital). Depending on whether the assets to be acquired by the purchaser include the facility real estate, the purchaser may have difficulty borrowing funds to pay the purchase price.

If the purchaser is acquiring the operation and the real estate, the real estate will provide substantial collateral for a loan. If the purchaser is acquiring a leasehold interest, the purchaser may have difficulty finding financing. Although leasehold mortgage financing may be offered by some lenders, it is not available on HUD-insured mortgaged properties. Even if leasehold mortgage financing is not prohibited by the mortgagee, lenders typically require specific provisions to be included in a facility premises lease, which usually requires the landlord to agree to a lease amendment. In the absence of leasehold financing, the purchaser, unless it is willing to put up other hard assets, is limited to offering lenders accounts receivable financing and personal guaranties. Aside from the importance to any purchaser of identifying how it will fund its financial obligations before it commits to a purchase agreement and puts money at risk, the purchaser of a nursing home will be required to disclose its proposed financing of the acquisition of the facility in its Certificate of Need application and the application will not be approved if the regulatory authorities are not convinced that the proposed financing is financially feasible.

Due Diligence

Since the purchaser of the operation of a nursing home will typically want to continue to use the seller's Medicaid provider number(s), adequate due diligence by the purchaser and its consultants becomes even more important to the purchaser. The purchaser will need an experienced reimbursement consultant to thoroughly review the status of the seller's Medicare and Medicaid program audits. Medicaid reimbursement rates for a nursing home in New York State are generally based upon facility-specific certified costs submitted by the facility for prior cost periods. The consultant should carefully review pending and completed audits of the seller's operating and property costs, and related reimbursement rate sheets, to determine whether the audits resulted or will result in Medicaid reimbursement overpayments to the seller, the amount of the overpayments, and whether the overpayments have been fully recovered. A nursing home's Medicaid reimbursement rates are also affected by the acuity of the residents residing in the facility. The consultant should review the status of the state's review of resident acuity information and its adjustment of the seller's reimbursement rates, if any, based upon periodic changes in resident acuity information. An accurate evaluation of these, and other potential audit liabilities, will enable the purchaser to evaluate the risk and size of potential audit liabilities that could be recovered from the purchaser after the closing if the purchaser determines to continue to use the seller's Medicaid provider number(s).

It is also extremely important that the purchaser's consultant fully evaluate the seller's cost reports and Medicaid program reimbursement rate sheets in order to advise the purchaser concerning the Medicaid reimbursement which the purchaser can expect to receive when it becomes the new operator of the facility. The purchaser does not simply continue to receive Medicaid reimbursement based upon the seller's Medicaid reimbursement rate. Assuming the purchaser is unrelated to the seller, the purchaser's Medicaid reimbursement rates will be based, in large part, upon the purchaser's costs immediately after the closing. In fact, the purchaser's Medicaid reimbursement rate may be significantly higher than the rate at which the seller was reimbursed by the Medicaid program. Without properly projecting the purchaser's Medicaid reimbursement rate, the purchaser cannot accurately evaluate the financial feasibility of the proposed transaction.

Security

The purchaser of a nursing home will typically assume the seller's ongoing contractual obligations and may assume some, or all, of the seller's financial liabilities existing at the time of the closing. Since the seller will no longer be operating the facility, and may have little, if any, sources of revenue after the closing, it is especially important that the purchaser take adequate steps to ensure that it will be able to enforce its rights, and recover from the seller any damages it may suffer as a result of the seller's failure to perform its contractual obligations after the closing. Assuming the principals of the seller have sufficient assets from which the purchaser may recover damages, the purchaser will want to have the principals of the seller personally guaranty the seller's post-closing obligations. The principals of the seller, on the other hand, will not want to incur personal liability under the transaction, especially if they operate the nursing home under a form of business entity which shields them from personal liability. The purchaser may accept limited personal guaranties and/or want to have a portion of the purchase price placed in escrow for a period of time after the closing to secure the seller's performance of its contractual obligations. The seller and the parties typically pursue extensive negotiations on security issues, which become even more important if the purchaser intends to assume the seller's Medicaid program provider number(s). Failure to secure adequate security can jeopardize the purchaser's ability to continue to operate the facility.

At-Risk Deposits

The seller of a nursing home operation, just like the seller of any other business, will want the purchaser to make a contract deposit and will usually want some or all of the contract deposit to be forfeited in the event the purchaser fails to close on the transaction. Unlike the transfer of many other businesses, however, the purchaser may be unable to close because required approvals have not been obtained. Public Health Council approval of the proposed

transfer of ownership of the facility will be required. Mortgagee and HUD consents may also be required. Sellers usually believe that they should receive a significant portion of the contract deposit if the purchaser does not obtain the necessary approvals because the seller will be taking the facility off the market for a significant period of time (typically a year) and the purchaser should assume the risk that it cannot obtain required approvals. Purchasers, on the other hand, believe that there are reasons for not obtaining required approvals that are beyond their control and for which they should not lose the contract deposit. Care must be taken to properly identify reasons for not closing that may be equated to the purchaser's "fault," for which the purchaser may forfeit some or all of the contract deposit, and reasons beyond the purchaser's control, that would not warrant loss of the deposit. Some of the possible scenarios that should be addressed are: (i) who should bear the risk of the transfer not being approved by the mortgagee (or possibly HUD) or regulatory authorities, (ii) what will happen to the deposit if the purchaser's applications for regulatory approvals are not approved or disapproved, but no decision is rendered within the time period specified for closing in the purchase agreement, (iii) if applications for regulatory approvals are denied, should the ground(s) for the denials affect the return of the deposit, and (iv) what will happen to the deposit if the seller contributes to the purchaser's failure to obtain required approvals by failing to provide necessary information or otherwise not cooperating with the purchaser's applications for approvals. An additional issue that usually comes up is which party is entitled to the interest that accrues on the contract deposit while it is held in escrow pre-closing. Since the contract deposit is likely to remain in escrow for a longer period of time than other business transactions because of the requirement for regulatory approvals, entitlement to interest on the contract deposit may be a more significant issue for the parties.

Conditions to Closing

Asset purchase agreements typically list a variety of conditions precedent to closing that must be satisfied, or waived, before a party is obligated to close on the transaction. Both the seller and the purchaser will want the necessary approvals to have been obtained, representations they received to continue to be true, the other party to have complied with all pre-closing covenants and that there be no court order or judgment prohibiting the closing. But the purchaser should also be concerned, and should address, regardless of whether it is purchasing or leasing the facility, the physical condition of the nursing home and the status of its participation in the Medicare and Medicaid programs at the time of closing. The purchaser does not want to commence operations with significant physical damage or regulatory restrictions prohibiting the purchaser, on and after the closing, from operating the full complement of the facility's certified beds, or with restrictions placed upon its Medicare or Medicaid program participation or its ability to admit residents or receive reimbursement for its services. It is important that these issues be fully addressed in the purchase agreement so that the purchaser is not required to close if its ability to fully operate the facility and participate in the Medicare or Medicaid programs is impaired. Receipt of insurance proceeds may not adequately protect the purchaser in the event of significant physical damage to the premises. The purchaser will have many fixed operating and property costs that require high occupancy levels for the purchaser to operate profitably. The purchaser's inability to fill beds with residents will have a material adverse effect on the purchaser's operation of the facility.

Interim Agreements

Sellers are often anxious to be relieved of the financial obligation of operating a nursing home during the period between the date the purchase agreement is signed and the closing, and many purchasers are just as anxious to take over the operation of a facility under contract as soon as the purchase agreement has been signed. Due to regulatory prohibitions, however, except in limited receivership situations, a seller continues to be responsible for the operation of its nursing home until the purchaser has been approved and the closing has occurred and there are limitations on the involvement that a purchaser may have in the operation of a facility prior to obtaining regulatory approvals and closing on the transaction. If the purchaser is to be involved in the operation of the facility prior to closing, it is imperative that the respective rights and obligations of the parties be memorialized in a writing which reflects the true understanding of the parties and that the duties and responsibilities of the purchaser be carefully delineated so as not to run afoul of regulatory prohibitions. A purchaser's exercise of powers and authority reserved to the established and licensed operator of the facility may be determined to adversely affect the character and competence of the purchaser and could be grounds for the denial of the purchaser's application for regulatory approval of the proposed change of ownership of the facility. The New York State Department of Health carefully scrutinizes management and administrative services agreements entered into by nursing home operators and a poorly drafted agreement could have dire consequences for the purchaser.

Conclusion

There are many issues relating to the purchase of the operation of a nursing home that must be addressed in order to properly protect your client. Some of the more significant issues have been discussed above. The time to learn about these issues is before your client has executed the purchase agreement, not when you are forced to live with unfortunate contractual provisions at a closing.

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Enough Is Enough: The Need for Greater Cooperation Between the Department of Health and Adult Care Facilities

By Paul A. Gomez

Perhaps one of the least gratifying positions within long-term care in the state of New York is that of adult home operator. Not only are adult home operators expected to care for a challenging adult population, providing room, board, medication assistance, personal care, case management services, activities, housekeeping, laundry and other services, all at a whopping $27 per day per resident, but they are increasingly hounded at every turn by the Department of Health, which has become more prosecutorial in its focus as of late. This intensified prosecutorial focus has become all the more pronounced since the advent of an exposé series in the *New York Times* in May of 2002, alleging substantial deficiencies in the quality of care provided adult home residents, and a dereliction of duty on the part of the Department in its oversight of adult homes. The Department has responded to the resulting pressure brought to bear, both from public opinion and the political arena, by striving to appear engaged and vigilant in its oversight. Unfortunately, that vigilance has, for the most part, been channeled only through the enforcement process. The result is an apparent drive on the part of the Department to issue as many citations as possible. Predictably, this rush to issue citations wherever possible, particularly in the absence of any concurrent effort to educate and cooperate with adult homes, has led to a marked increase in the number of legally and factually erroneous citations.[1]

This article has briefly outlined the recent more prosecutorial approach the Department is taking toward adult homes, and will outline the primary areas of adult home operation to which the Department has directed its concentration. The Department's failure to comply with key statutes and regulations that are part and parcel of its inspection and oversight process will be explained and the substantial harm suffered by adult homes as a result of these failures will be analyzed. The article will conclude by explaining some of the latest legal developments in this area and discuss cause for hope that the current adversarial relationship between the Department and adult homes generally might become more amicable and cooperative in the not-too-distant future.

Department Focus

The Department has made it plain that their efforts to penalize adult homes into compliance focuses on five primary areas: 1) increased access to clinical, psychiatric and functional assessments by qualified health and mental health providers; 2) improved case management systems; 3) enhanced medication management systems; 4) improved social and recreational services; and 5) increased legal and resident advocacy support. In an effort to pursue these goals, the Department has emphasized the use of "multi-agency sweeps," which involve inspections not only by the Department of Health, which has primary oversight responsibility over adult homes, but inspections by staff from the Commission on Quality of Care (CQC) and the Office of Mental Health (OMH). These "sweeps" focus on adult homes with a history of past alleged violations where more than 25% of their resident populations were released or discharged from any facility operated or certified by an office of the Department of Mental Hygiene.[2] They have a disproportionate effect on adult homes located downstate, near the New York City greater metropolitan area and on Long Island, where there is a greater concentration of larger adult homes and in which resides a larger resident population receiving mental hygiene services.

That the Department regards the "sweeps" discussed above, and its inspection and enforcement process generally as central to its efforts to muster a vigilant public image is evident by the press releases it issues, touting the fact the fines from "sweeps" have ranged anywhere from $1,000 to $56,500. It is further evidenced by the increased volume of inspection reports issued as of late and that despite this current era of budget deficits and curtailed spending, the Department has managed to secure an additional $1 million for the hiring of several new surveyors to intensify the oversight and enforcement process.[3]

Failure to Follow Statutory and Regulatory Standards

The difficulties adult care facilities face as a result of the Department's prosecutorial enforcement are compounded by the Department's consistent failure to comply with statutes and its own regulations in the preparation and issuance of inspection reports. Chief among the statutory and regulatory requirements the Department has repeatedly failed to abide by are a failure to identify all areas of operation in an adult home that meet or exceed compliance standards, not just alleged violations, and a failure to identify the corrective action an adult home must implement in order to achieve compliance. This article focuses on the failure to identify the corrective action necessary for the adult home to achieve compliance.

The Department's provision of the necessary corrective action is of great importance. First, it is required clearly by both statute and regulation.[4] The Department typically takes the position that specifying what corrective action is necessary is completely discretionary. Indeed, it often refuses to specify what corrective action is necessary on grounds that the corrective action required is "obvious."[5] In reality, it is often anything but.

For example, adult homes often face citations for allegedly failing to meet "Environmental Standards."[6] These standards pertain to housekeeping and maintenance duties. A hypothetical example representative of the kind of citation issued pursuant to these standards is in order. Often, a citation is issued because a spilled soda is observed in the hallway, dust is observed on a fan blade and a few tiles are observed missing in a resident bathroom. Based on these examples, the Department alleges failure of the housekeeping and maintenance systems. An adult home may respond that no matter how excellent its housekeeping and maintenance systems are, there will always be some matter somewhere in the facility that needs attention. That fact is the product of an active adult population and staff that live and work in the facility 24 hours a day, seven days a week. This argument applies with all the more force the larger the adult home is. In addition, the adult home typically demonstrates that it corrected the specific examples that were alleged to constitute the violation and addressed the issue facility-wide.

At the next inspection, the Department will re-inspect areas of the adult home to determine whether compliance has been restored. The Department may find that a resident spilled a soda in a different area of the facility, that laundry, in the judgment of the surveyor, was not done timely, or that some rust was detected under a bathroom sink. Based on this, an adult home will likely be issued a second citation, labeled a "repeat" or "continuing" violation for allegedly violating environmental standards again. Too often, as was the case in this typical example, the adult home will find out that its corrective action was not sufficient only when it is issued an additional citation for an alleged violation of the same regulatory standard. At that point another year may have passed, for which the Department may impose a year's worth of penalties. To say that such a practice is unreasonable is an understatement.

Another common example involves citations issued under the broad category of Medication Management.[7] The broad regulatory standard at issue requires, among other things, that a system be established to provide assistance with medications for those residents who need it, and to observe and record ingestion of medications. A citation is often issued for failure to accurately record assistance with medications involving two residents. In response, the adult home, particularly large facilities, may argue that there are thousands, if not tens of thousands of instances of recorded assistance provided to residents every month. This means there are hundreds of thousands of such instances within a year. Logic dictates that no matter how good the system is, one cannot eliminate human error. One can only attempt to minimize its chance for occurrence. To that end, the adult home typically answers that it has re-instructed its medication staff in the fundamentals of medication assistance and proper recording of same. Given that the Department has in all likelihood failed to provide guidance for necessary corrective action, the adult home has been forced to guess as best it can what will suffice in the Department's eyes.

At a subsequent inspection, a surveyor may claim that the renewal of a resident's prescription was late arriving at the facility, resulting in a delay of the resident receiving his or her medication. Based on this, the adult home is issued a repeat citation, for allegedly failing to correct the violations listed in the previous inspection report. They are charged with a continuing violation even though the adult home undertook corrective action as best it could without the Department providing the required instructions, and the examples listed are of a completely different nature involving different residents. Statute and the Department's own regulations indicate that this scenario, lacking in cooperation and guidance, was not what the Legislature envisioned.

Harm Suffered by Adult Homes

As a result of the Department's policy and practice of failing to include instructions for necessary corrective action, the adult home must guess at its peril what is required or appropriate to comply with the law. If it is wrong, it will probably be sanctioned. The Department is obligated to provide instructions for the necessary corrective action because "[a] violation is not deemed rectified unless an operator implements and maintains the necessary corrective actions set forth by the [D]epartment in a report of inspection issued pursuant to this Part."[8] As one can imagine, the Department's consistent failure to include these required instructions leads to serious negative, and often, absurd consequences for adult homes.

Adult homes are routinely expected to defend themselves against allegations in inspection reports with no legal or factual merit. They are compelled by the Department to correct what very well might be a non-existent problem by steps which they must guess will be accepted by the Department. Since the Department, almost without exception, does not identify the corrective action, the likelihood increases that the adult home will be cited again in a follow-up inspection for a continuing violation. Certainly this is a damaging, absurd result.

Because faulty inspection reports are published so extensively, adult homes are harmed in many other ways as well. For example, allegations in inspection reports are published on the Department's Web site before the adult home has had a meaningful opportunity to contest them.

They are issued in press releases, are required to be posted in public areas of the adult home, are sent to referral sources and are available to the public through the Freedom of Information Law. The resulting damage includes loss of business in the form of referrals, damage to professional reputation, damage to relations with health care providers and unfavorable character and competence assessments.[9]

Other government agencies and bodies also rely on inspection reports, often to the detriment of the adult home. For example, the New York Attorney General and the Commissioner of Health commenced a special proceeding under Executive Law § 63(12) against the former operators and administrators of an adult home claiming that violations cited in inspection reports over a four-year period, particularly alleged continuing violations, constituted persistent fraud and illegality.[10] The proceeding assumed and reasserted as truthful the Department's unverified citations in inspection reports, which the adult home had no meaningful opportunity to contest. The Attorney General and the Department argued that based on the violations alleged, and in particular, the adult home's alleged failure to correct them, they were entitled to recover all monies paid by residents to the operators for the care and service they received over a four-year period, amounting to over $12 million. Thankfully for the adult home, the proceeding was dismissed. Nevertheless, a Notice of Appeal has been filed so that adult home, and many others who could find themselves in peril based on the same theories, are not necessarily out of the woods yet. All of the above shows the several, substantial ways by which adult homes suffer "injury in fact"[11] when issued inspection reports containing erroneous citations, and in particular, that fail to include instructions for necessary corrective action.

Conclusion

Much has been made in this article about the prosecutorial approach of the Department toward adult homes, and the resulting harm suffered by them. There is, however, hope on the horizon that the prosecutorial approach may be replaced by a different approach, based primarily on cooperation and education. Recently, the court in *Bayview Manor Home for Adults, et al. v. Novello*[12] held that the Department must comply fully with its statutory and regulatory requirements in preparing and issuing inspection reports. It also stated that the Department acts arbitrarily and capriciously when it fails to follow its own regulations, as it did here.[13] That means that the Department must issue inspection reports that contain what corrective action is necessary to rectify any violation it alleges. Naturally, that corrective action must remain within the confines of what is authorized by the statutory and regulatory standards at issue. If the Department complies fully with the County decision, this development has the potential to serve as a foundation for a more productive relationship between adult homes and the Department. Clear instructions for corrective action that serve the purpose of the regulatory standard cited would help not only the adult home by avoiding the additional expense and damage to professional reputation and honor that flow from citations, but more importantly, would help raise the quality of care and service provided to the residents. Further, a relationship predicated on cooperation and education rather than excessive punitive measures, and the litigation necessary to defend against them would help channel valuable resources, in time, money and creativity, directly toward the residents. That should be the primary aim of all parties concerned.

Endnotes

1. The frequency and nature of errors found in inspection reports issued by the Department are documented thoroughly within the petitioner's papers submitted in *Wavecrest Home for Adults, et al. v. Novello*, Index No. 2469-03 (Sup. Ct., Albany Co., filed Apr. 21, 2003), currently pending. That lawsuit seeks, among other things, a right to a pre-deprivation hearing to challenge erroneous citations in inspection reports before the damaging information they contain is published, causing irreparable harm to professional reputation.
2. http://www.health.state.ny.us/nysdoh/commish/2002/adult_home_release_11-26-2002.
3. *Id.*
4. N.Y. Soc. Servs. Law § 461-a(2)(c); 18 N.Y.C.R.R. §§ 486.2(h); (i) and 486.5(a)(3).
5. This was essentially the position taken by the Department in its supporting papers in *Bayview Manor Home for Adults v. Novello*, Index No. 7662-02 (Sup. Ct., Albany Co., Aug. 20, 2003).
6. 18 N.Y.C.R.R. §§ 487.11 *et seq.*
7. 18 N.Y.C.R.R. § 487.7(f).
8. 18 N.Y.C.R.R § 486.5(a)(3).
9. *See* Complaint ¶ 28-34; *Wavecrest Home for Adults et al. v. Novello*, Index No. 2469-03 (Sup. Ct., Albany Co., filed Apr. 21, 2003).
10. *Spitzer, et al. v. Seaport Manor, et al.*, Index No. 52275-02 (Sup. Ct., Kings Co.).
11. *Empire State Ass'n of Adult Homes, Inc. et al. v. Novello*, 193 Misc. 2d 543 (Sup. Ct., Albany Co. 2002).
12. Index No. 7662-02 (Sup. Ct., Albany Co., Aug. 20, 2003).
13. *Id*.

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Hospice Care and Advance Directive Requirements: A Difficult Balance of Policy Concerns

By Ari J. Markenson

Introduction

Federal and state law protect a patient's right to make decisions about their own treatment and care. Strict regulatory application of a patient's right to self-determination in one context has in recent years conflicted with the concept and philosophy behind the provision of hospice care.

A patient who elects the Medicare hospice benefit must acknowledge, pursuant to 42 C.F.R. § 418.24 (b)(2), that he or she has been given a full understanding of the palliative rather than curative nature of hospice care, as it relates to the patient's terminal illness. The palliative vs. curative distinction, however, is not entirely straightforward when federal law and regulation are taken into account with respect to certain types of health care decision making.

The Federal Patient Self Determination Act of 1991 (PSDA) SSA 1866(f) sets forth certain standards for Medicare/Medicaid providers to follow in recognizing, educating and implementing a patient's right to self determination. As a result of the PSDA, the Centers for Medicare and Medicaid Services (CMS, formerly HCFA) enacted 42 C.F.R. § 489.102. This regulation requires hospices to:

- Maintain written policies and procedures concerning advance directives;
- At the time of initial receipt of hospice care, provide written information to patients concerning:
- Their rights under state law to make health care decisions; and
- The hospice's written policies respecting the implementation of such rights, including, subject to specific requirements, a clear and precise statement of limitation if the hospice cannot implement an advance directive on the basis of conscience;
- Document in a prominent part of the patient's record whether or not the individual has executed an advance directive;
- Not condition the provision of care or otherwise discriminate against a patient based on whether or not the patient has executed an advance directive;
- Ensure compliance with requirements of state law and inform patients that complaints may be filed with the state survey and certification agency;
- Provide for education of staff concerning its policies and procedures on advance directives; and
- Provide for community education regarding issues concerning advance directives.

Complying with CMS' interpretation of the PSDA and associated regulatory requirements has become difficult for hospice administrators in the context of implementing do-not-resuscitate orders (DNR). CMS has sought a balance between complying with the PSDA and associated regulations and the hospice philosophy of palliative care.

A DNR is in its most basic sense a directive not to provide cardiopulmonary resuscitation (CPR) to a patient. CPR is considered a heroic measure by most in the health care industry, arguably curative and rehabilitative in nature. Many in the hospice industry view the provision of CPR to hospice patients as directly in conflict with the palliative care philosophy. In this respect, hospices had traditionally encouraged all newly admitted patients to consent to DNR orders. In a small number of instances hospices refused to treat or admit patients who wanted to be resuscitated or the hospice had simply not employed staff trained in CPR. CMS has taken a position on the availability of CPR for hospice patients which provides that those approaches are not entirely in compliance with the PSDA. This CMS interpretation can conflict with the traditional notions of hospice care and the palliative care philosophy.

CMS Policy

In two separate "Survey and Certification" letters CMS sought to clarify advance directive requirements for providers, including hospices. In a March 18, 1997, letter, CMS addresses its concern over long-term care facilities who took the position that their facilities did not offer CPR and those residents who wanted CPR would have to go elsewhere. CMS specifically stated that this position was at odds with, and would violate, the PSDA requirements. The violation would occur in that these facilities were not providing residents the opportunity to formulate an advanced directive. According to CMS, the right to formulate an advance directive is unequivocally provided to patients in the PSDA.

In the March 18 letter, CMS quotes an earlier policy letter it authored and states:

> A Medicare or Medicaid certified long term care facility may not establish and implement a do not resuscitate policy for its residents. The right to formulate an advance directive applies to each individual resident without condition. A facility, therefore, that wishes to establish as a matter of policy that it is a "do not resuscitate facility" would violate the right of residents to formulate an advance directive, specified at sections 1876(c) and 1902(a)(57) and (58) of the Social Security Act and implemented by regulations at 42 CFR 489.102(a). Certified facilities are required to inform residents of their right to formulate an advance directive at their option.

In addition to this statement the letter does acknowledge a provider's right to express a conscience objection to an advance directive. This type of objection is specified in the PSDA and can be made assuming state law allows it.

On April 20, 2000, CMS issued another survey and certification letter specifically relating to hospice providers. CMS commented in the letter that it had not changed its policy nor the requirements of the PSDA or implementing regulations relating to DNR policies for hospice providers. In speaking directly to hospice providers CMS advised:

> Medicare certified hospice providers are bound by [the] requirements and may not refuse to have staff skilled in resuscitation or refuse to revive a patient who desires to be resuscitated. However, hospice providers may counsel patients at election as to the hospice's philosophy, including its philosophy on this issue, and patients whose views are at odds with the hospice's philosophy may elect to receive care from another source.

This second letter has sought to strike some balance between the palliative care philosophy and the requirements of the PSDA. CMS, it seems, has tried to recognize that certain patients, while understanding the nature of their illness, may want to have CPR performed. It is also possible that the patient's terminal illness may, in certain circumstances, not be the cause of a cardiac event and the patient would therefore want CPR in that circumstance. For example, a patient with cancer may inevitably suffer organ failure as a natural process of their disease. The patient, however, should they have a heart attack unrelated to their cancer, would desire to be resuscitated. Taking into account this class of patients who may want CPR in differing circumstances, CMS, through its letters, has continuously reaffirmed the requirements of the PSDA.

Conclusion

CMS' policy is not perfect and may not have entirely effectuated an exact balance of the issues. CMS' letters seems to provide that while a hospice cannot refuse to have capable staff or to provide CPR, they may in some way establish a policy or policies that could significantly discourage patients interested in receiving CPR. Furthermore, the statement that "patients whose views are at odds with the hospice's philosophy may elect to receive care from another source" does not take into account geographic areas where the available hospice(s) have chosen to establish policies inconsistent with providing CPR. This is not a remote possibility and has according to anecdotal reports occurred in certain rural areas. However, even in light of this inexact balance, CMS' position still seems to be the best middle ground. CMS could not have taken the position that the PSDA was inapplicable to hospices. The PSDA was enacted by Congress and clearly applies. Some constituency would have to effectuate a statutory change in order to exempt hospices from the requirements relating to DNR. Such a change is highly unlikely as neither CMS, hospices nor patients would in the end benefit significantly. Ultimately, hospice providers have to work through the "grey," as it is clear CMS expects them to comply with the PSDA requirements.

As mentioned, CMS expects appropriate compliance. Hospices can avoid misunderstanding, ensure compliance with the PSDA and properly follow a patient's wishes. Education and proper communication are the key elements to accomplishing that goal. Counsel to hospices can be helpful to administrative staff in sorting out federal and state law as well as the practical issues that may arise. Counsel can also assist in the development of the hospice's philosophy and policies to ensure that they meet the applicable PSDA requirements. Overall, in meeting its responsibilities a hospice must ensure that it develops appropriate policies, has appropriate staff, and educates and informs patients of their rights.

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New York State Bar Association Legislation Report

Health Law Section

September 10, 2003

S.5329 and A.8301

By: Senator Libous and Assemblyman Tonko
Committees: Mental Health
Effective Date: January 1 following enactment

AN ACT to amend the insurance law, in relation to enacting **"Timothy's Law"** to prohibit the exclusion or limitation of benefits for mental illness and chemical dependency in certain health plans.

LAW AND SECTIONS REFERRED TO: Insurance Law, Sections 3216, 3221, 4303, 4320 & 4322

REPORT WAS PREPARED BY THE SPECIAL COMMITTEE ON MENTAL HEALTH ISSUES

THE BILL IS APPROVED

New York law presently allows health insurance policies and plans to deny coverage for the diagnosis and treatment of mental, nervous or emotional disorders and chemical dependency or to limit the amount of inpatient and outpatient coverage of mental illness and chemical dependency treatment, when offered, and to require higher co-insurance, co-payments and deductibles (i.e., higher out-of-pocket expenses for covered individuals and their families), as compared with other health and medical services. In effect, these policies and plans are permitted to discriminate in the coverage they provide based upon diagnosis of mental illness and/or chemical dependency.

Timothy's Law will eliminate this discrimination and unequal coverage by requiring that mental health and chemical dependency coverage be provided by insurers and health maintenance organizations on terms comparable to other health care and medical services. The Federal Mental Health Act, enacted in 1996 and renewed in 2002, which prohibited some employers from offering such benefits subject to aggregate lifetime and annual limits that differ from such limits imposed for physical health care and treatment, does not go far enough to eliminate all disparate and discriminatory treatment of mental illness and chemical dependency coverage.

The Law is named after Timothy O'Clair of Schenectady, New York, who completed suicide at the age of 12 in 2001 after his parents' mental health benefits were exhausted.

Comments on S.5329 and A.8301

As the science of mental illness has evolved to where its diagnosis and treatment is both better understood and highly effective, the historical rationales for treating it disparately have largely dropped away. Today, mental illnesses are more effectively treated than many of the "physical" illnesses. For example, while schizophrenia has a treatment efficacy rate of up to 60%, major depression up to 65% and bi-polar disorder (manic depression) up to 80%, angioplasty, which is efficacious for only 41% of patients, is fully covered by most insurance and health plans. And yet the disparate treatment in coverage for mental illness remains as an artifact of an earlier time. The debate on this issue now is couched mostly in terms of civil rights and cost.

The Surgeon General reports that one in every five adults, or about 40 million Americans, experiences some type of mental disorder every year, and 5% of those have a serious mental illness such as schizophrenia, major depression or bi-polar disorder. However, he also reports that fewer than one-third of adults and half of children with a diagnosable mental disorder receive any level of treatment. Lack of insurance or health plan coverage is identified as one of the largest barriers to getting care. American employers lose over $80 billion a year in lost productivity due to the untreated or undertreated mental illnesses of their employees and their families. (*Mental Health:* A Report of the Surgeon General, 1999). Parents are forced to relinquish custody of their emotionally disturbed children in order to obtain Medicaid coverage for them, and Timothy O'Clair is not the only child or adult to have lost his life to this antiquated policy of discrimination.

For years various studies commissioned by parties to this debate have reported varying estimates of the increased premium costs of providing equality of cover-

age for mental illness and chemical dependency. In the meantime, actual experience in states where parity has been enacted, in the federal employee health plan which offers parity, and at large employers who have voluntarily adopted parity, has largely supplanted the need for estimates. In virtually all such instances, actual experience has shown that premium increases stemming from parity have been in the vicinity of 0.2% to 0.8% of health care premiums (see testimony of Henry Harbin, M.D., American Managed Behavioral Healthcare Association, March 13, 2002). Longitudinal studies of large employers' health claims experience have documented actual cost savings related to the coverage and treatment of mental illness (see Rosenheck, et al., "Effect of Declining Mental Health Service Use on Employees of a Large Corporation," *Health Affairs*, Sept./Oct. 1999). A recent PriceWaterhouseCoopers actuarial analysis of Timothy's Law concluded that it would increase New Yorkers' premiums by an average of $1.26 per person per month. A recent Zogby public opinion poll discovered that 81% of New Yorkers want mental illness and chemical dependency treated like any other illness, and in fact, would be willing to pay the increase themselves, if necessary. Furthermore, no large-scale disenrollment or discontinuation of coverage by employers has been seen in states, such as Vermont, that have enacted parity legislation.

Today, with science, actual cost data and recent projections and public opinion pointing toward equality of benefits, the debate has been reduced to the ideological disagreement over the concept of government mandates to business as opposed to remediating what is seen by many as the last frontier of legalized discrimination in New York.

Conclusion

In conclusion, the Special Committee on Mental Health Issues strongly supports passage of S.5329 and A.8301 to provide for mental health parity in health insurance and plans.

For the foregoing reasons, this bill is **APPROVED.**

Co-Chairs of the Committee: Henry A. Dlugacz, Esq. and J. David Seay, Esq.

In the Matter of Elcor Health Svcs. v. Novello, 100 N.Y.2d 273 (N.Y. 2003)

763 N.Y.S.2d 232
794 N.E.2d 14
In the Matter of Elcor Health Services Inc., Appellant, v. Antonia Novello, as Commissioner of Health of the State of New York et al., Respondents.
Court of Appeals of the State of New York.
Argued June 4, 2003.
Decided June 26, 2003.

APPEAL, by permission of the Court of Appeals, from an order of the Appellate Division of the Supreme Court in the Third Judicial Department, entered June 20, 2002, which modified, on the law, and, as modified, affirmed a judgment of the Supreme Court (Bernard J. Malone, J.; op 2001 N.Y. Slip Op 40054[U]), entered in Albany County in a proceeding pursuant to CPLR article 78, partially granting a petition to review a determination of the Department of Health that reduced petitioner's Medicaid reimbursement rate. The modification consisted of reversing so much of the judgment as partially granted the petition and denying the petition in its entirety.

Thomas G. Smith, for appellant.

Kathleen M. Treasure, for respondents.

New York State Health Facilities Association, *amicus curiae*.

Chief Judge Kaye and Judges Smith, Rosenblatt, Graffeo and Read concur.

Opinion by Judge Ciparick.

The primary question presented by this appeal is whether deference should be afforded to the Department of Health's interpretation of 10 NYCRR 86-2.30(i)(27) to require "actual improvement" by a patient before a residential health care facility can receive reimbursement for restorative therapy. We conclude that the Department's interpretation is not arbitrary and capricious, or irrational, and is therefore entitled to deference.

When a patient is admitted to a residential health care facility (RHCF) or nursing home, his or her physician is required to prepare a written plan of care for therapy services including rehabilitative therapy. A physical therapist then determines what specific type of rehabilitative therapy need be provided. Under the Medicaid reimbursement system, RHCFs are entitled to different rates of reimbursement depending in part upon the type of care their patients require and receive. In order to determine the appropriate reimbursement rate, each patient is placed into one of 16 categories known as Resource Utilization Groups (RUGs) (*see New York State Assn. of Counties v. Axelrod*, 78 N.Y.2d 158, 162 [1991]; *see generally Jewish Home & Infirmary of Rochester v. Commissioner of Dept. of Health*, 84 N.Y.2d 252 [1994]). The 16 RUGs are further divided into five hierarchical groups based on the patient's ability to perform the activities of daily living (ADL).

A qualified registered nurse assessor places each patient into a RUG category by completing a patient review instrument (PRI) (*see* 10 NYCRR 86-2.30[c][2]). PRIs must be completed for each patient every six months (*see* 10 NYCRR 86-2.11[b][1]); there is, however, an opportunity to evaluate new patients every three months (*see* 10 NYCRR 86-2.11[b][2]). Each RUG category is assigned a numerical value based upon the resources necessary to care for that type of patient, with a greater value assigned to categories that require more resources. The weighted average of a facility's patients in each category is its case mix index (CMI) (*see* 10 NYCRR 86-2.10[a][5]). As a result, the direct component[1] of a facility's Medicaid reimbursement rate (*see* 10 NYCRR 86-2.10[c]) reflects its CMI—the higher the CMI, the higher the reimbursement rate. In other words, a facility that has more patients requiring intensive services will receive a greater reimbursement rate.

Several PRI questions call for documentation qualifiers, which require certain medical record support in order to classify a patient properly. At issue here are documentation qualifiers for maintenance therapy and restorative therapy. To satisfy the documentation qualifier for restorative therapy, the instructions require that "[t]here is a positive potential for improved functional status within a short and predictable period of time. Therapy plan of care and progress notes should support that patient has this potential/is improving" (10 NYCRR 86-2.30[i][27]). The documentation qualifier for maintenance therapy requires that "[t]herapy is provided to maintain and/or retard deterioration of current functional/ADL status. Therapy plan of care and progress notes should support that patient has no potential for further or any significant improvement" (10 NYCRR 86-2.30 [i][27]).

The Department also prepared a Clarification Sheet to assist nursing homes in completing the PRIs. Explaining the documentation qualifier for restorative therapy, the Clarification Sheet states that there "must be a positive potential for significant improvement in a resident's functional status within a short and predictable period of time. Consequently, the therapy plan of care should support that the resident has this potential and is improving." The Clarification Sheet also indicates that restorative therapy must be provided for four consecutive weeks, five times a week for a total of at least 2.5 hours.

In May 1999, Elcor submitted its PRI data to the Department. In a subsequent audit to verify the accuracy of Elcor's PRI results (*see* 10 NYCRR 86-2.30[e][5]), the Department concluded that 29 of Elcor's patients had been improperly classified in the restorative therapy category.[2] Although the patients' physicians had ordered restorative therapy, the audit concluded that because the patient did not respond to therapy or improve, they should have been placed in the maintenance therapy—as opposed to restorative therapy—category. As a result, Elcor's CMI and corresponding Medicaid reimbursement were reduced. In addition, the Department directed Elcor to contract with an approved outside party to complete its PRIs (*see* 10 NYCRR 86-2.30 [f][1][ii]).

Elcor brought an article 78 proceeding to challenge the Department's determination downgrading the 29 residents from restorative therapy and adjusting the facility's CMI. Supreme Court found that the requirement that residents demonstrate actual improvement was a regulation that had never been properly promulgated or filed by the Department.[3] The court partially granted the petition by annulling the Department's adjustment to Elcor's CMI; it also reversed the Department's directive to require an outside party to complete the PRIs and remitted to the Department for a recalculation of Elcor's reimbursement rate without using the actual improvement standard. The Appellate Division denied the petition in its entirety, determining that the actual improvement standard was an interpretation of the Department's regulations and not an unpromulgated rule in violation of the State Administrative Procedure Act (295 A.D.2d 772, 773 [2002]). The court also found that the Department's interpretation of its regulation—requiring a resident to have both the potential for improvement and to actually improve—had a rational basis and was entitled to deference. This Court granted Elcor leave to appeal and we now affirm.[4]

Initially, we reject Elcor's contention, and Supreme Court's holding, that the actual improvement standard is an unpromulgated rule being applied without first being adopted through the steps set forth in the State Administrative Procedure Act (*see generally* State Administrative Procedure Act § 202). Specifically exempted from the definition of rule under the Administrative Procedure Act are "forms and instructions, interpretive statements and statements of general policy which in themselves have no legal effect but are merely explanatory" (State Administrative Procedure Act § 102[2][b][iv]). As we hold today, the actual improvement standard provided by the Department in the Clarification Sheet is a reasonable interpretation of the restorative therapy documentation qualifier, and thus is not an unpromulgated rule.

Having found the actual improvement standard to be interpretive, we next turn to the question whether such agency interpretation is arbitrary and capricious, or irrational. We reject Elcor's argument that the actual improvement standard is in violation of a federal mandate that nursing homes "must provide services and activities to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident in accordance with a written plan of care * * *" (42 U.S.C. 1396r[b][2]). We note that the Second Circuit found a similar claim to be without merit in *Concourse Rehabilitation & Nursing Ctr., Inc. v. Whalen* (249 F.3d 136 [2001]), holding that the actual improvement standard was not arbitrary and capricious because the State considered the costs of furnishing restorative therapy as required by the federal statute (*see Concourse*, 249 F.3d at 146). The court also found no "actual conflict" between the State's interpretation of its Medicaid plan and federal law for preemption purposes, stating that "[o]ne might as easily presume that the plan will result in more careful monitoring of patient's progress to ensure that unnecessary rehabilitative services are not being prescribed, or that the actual improvement standard will encourage providers to provide effective treatment" (*Concourse*, 249 F.3d at 146). We see no reason to differ with the Second Circuit's holding that the actual improvement standard does not violate federal Medicaid law.

The *Concourse* court, however, left open the question as to whether such interpretation violates State Medicaid law, observing that there "exists a colorable claim that the State's use of the `actual improvement' standard—which appears nowhere in the State plan—conflicts with the relevant State qualifiers and therefore violates the State's plan" (*Concourse*, 249 F.3d at 147). Elcor observes that reimbursement rates "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities" are required by statute (Public Health Law § 2807 Pub. Health[3]) and that application of the actual improvement standard impermissibly diminishes reimbursement rates. However, the Public Health Law can reasonably be read to support the actual improvement standard imposed by the Department since the statute

specifically contemplates "efficiently and economically operated facilities" (Public Health Law § 2807 Pub. Health[3]). Hence, it is not contrary to its purpose to allow reimbursement only for those patients who demonstrate actual improvement.

Elcor finally argues that the Department's interpretation of its regulation requiring patients to actually improve before reimbursement will be given for restorative therapy is irrational, urging that a plain reading of the restorative therapy qualifier only requires the patient to have the potential for improvement. Elcor maintains the Department's use of the virgule (or slash) in the regulation—"has this potential/is improving"—means "or." That the Department's interpretation might not be the most natural reading of the regulation, or that the regulation could be interpreted in another way, does not make the interpretation irrational. "[T]he commissioner's interpretation of a regulation is `controlling and will not be disturbed in the absence of weighty reasons'" (*Matter of Cortlandt Nursing Care Center v. Whalen*, 46 N.Y.2d 979, 980 [1979] *quoting Matter of Sigety v. Ingraham*, 29 N.Y.2d 110, 114 [1971]). The Department interprets the qualifier to require the plan of care to demonstrate the patient has potential for improvement at the beginning of therapy and the progress notes to demonstrate actual improvement during therapy. This interpretation does not conflict with the plain language of the regulation, is neither arbitrary and capricious nor irrational and, as a result, should not be disturbed (*see Matter of Marzec v. DeBuono*, 95 N.Y.2d 262, 266 [2000]).

Elcor's remaining contentions are likewise without merit.

Accordingly, the order of the Appellate Division should be affirmed, with costs.

Order affirmed, with costs.

Endnotes

1. A facility's Medicaid reimbursement rate is made up of four components: direct, indirect, noncomparable and capital (*see* 10 NYCRR 86-2.10[b][1][ii]). To determine a facility's direct component, its allowable costs for, among other things, nursing administration, patient activities, physical therapy and occupational therapy are considered (*see* 10 NYCRR 86-2.10[c]).
2. Of the 29 residents, 16 were downgraded from restorative therapy because their last therapy session had been on the last day of the PRI assessment period. Twelve other residents were downgraded because there had been no medical event precipitating therapy and either all of the relevant qualifiers were not met or the reported service was not done at all. An additional resident was downgraded because the PRI indicated the resident received physical therapy when the actual service was occupational therapy.
3. Supreme Court found the requirements that a patient experience a "precipitating event" or that the PRI be completed "other than day of discharge" did not need to be promulgated as regulations if they were not the only factors considered in determining the correct therapy category for a patient. These determinations are not at issue here.
4. The Department's argument that it had an appeal as of right to the Appellate Division from the Supreme Court judgment is not properly before this Court because the Department is not aggrieved by the Appellate Division order, which granted the Department leave to appeal to that court (*see* CPLR 5511 N.Y.C.P.L.R.).

NEWS flash

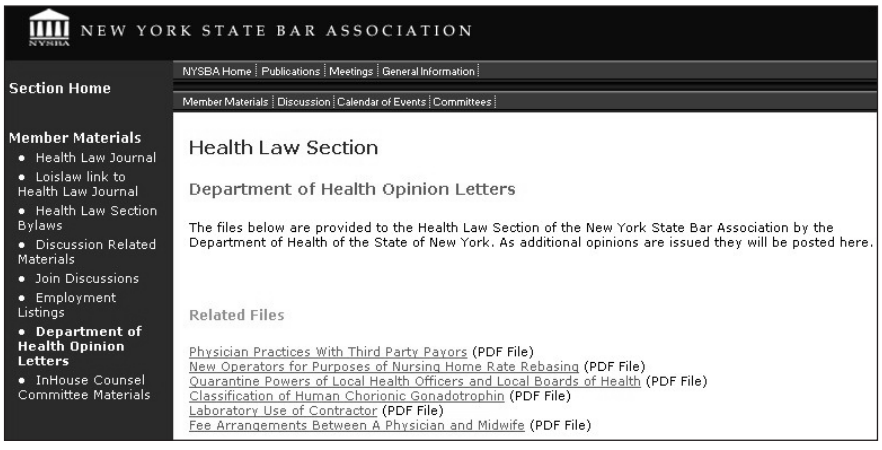
What's Happening in the Section

DOH Opinions Available on HLS Web Site

The Department of Legal Affairs of the New York State Department of Health, in response to requests by the Health Law Section, is now making available selected legal opinions issued by it. Those opinions, which will offer practitioners the Department's interpretation of the Public Health Law and DOH regulations, are being posted on the Health Law Section's Web site. (Go to nysba.org/health and click on the "DOH Opinions" link on the front page.)

In the first opinions posted on the NSYBA Web site, DOH addresses issues regarding :

- Physician Practices with Third Party Payors
- New Operators for Purposes of Nursing Home Rate Rebasing
- Quarantine Powers of Local Health Officers and Local Boards of Health
- Classification of Human Chorionic Gonadotrophin
- Laboratory Use of Contractor
- Fee Arrangements Between a Physician and Midwife



Several Health Law CLE Programs Given in the Fall

The Health Law Section and its Committees presented the following CLE programs in Fall 2003:

- **Returning to Work with HIV, Cancer or Other Chronic Illnesses.** This program, offered for the first time, took place in New York City September 25. It was organized by the committees on AIDS and the Law (Ross Lanzafame of Harter, Secrest & Emery LLP, Chair) and Consumer/Patient Rights (Randye S. Retkin of the New York Legal Assistance Group, Chair).
- **Representing Physicians, Nurses and Allied Health Care Professionals in Disciplinary Proceedings.** This program, offered in four locations in October and November, addressed all aspects of the disciplinary process, including OPMC, OPD, impairment issues and the hospital credentialing process. The program featured speakers associated with governmental oversight agencies, hospital attorneys and attorneys who represent both the individual health care professional and institutions during the disciplinary process. The overall planning Co-Chairs were Hermes Fernandez, Esq. of Bond, Schoeneck & King, PLLC, and Kenneth R. Larywon, Esq. of Martin Clearwater & Bell, LLP.
- **HIPAA: Myth and Reality.** This December program was organized at the request of many sections of NYSBA. Aimed at non-health care lawyers, it addressed important regulatory developments arising from the extension of federal protection to patient information. The overall program Chair was Anne Maltz, Esq. of Herrick Feinstein, LLP in New York City.

Section Annual Meeting to Focus on Law and Quality of Care

The program at the Health Law Section's Annual Meeting is entitled, "*First, Do No Harm: Does the Health Care Legal Environment Improve or Diminish the Quality of Health Care*?" Organized by James Horwitz, Counsel to Glens Falls Hospital, the program will examine a range of issues relating to the law and quality of care, including

- The Context of the Health Care Quality Debate
- Incentive to Promote Quality of Care
- The Use of Civil and Criminal Enforcement Laws to Promote Quality
- Does Reporting Medical Errors Improve Quality of Care?
- How Much Should the Patient Know?
- Maintaining the Confidentiality of Peer Review Activities: Keeping Secrets or Improving the Quality of Care?
- What Does the Prosecution of Medical Malpractice or Medical Misconduct Have to Do with Improving the Quality of Care?

In-House Hospital Counsel Legal Resource Guide Online

The In-House Counsel Committee has posted on the Section's Web site "A Legal Resource Guide for In-House Hospital Counsel." The Guide, which was first published in the Summer/Fall '03 issue of the *Health Law Journal*, was designed as a quick reference to basic primary and secondary source materials for in-house health care attorneys. Karen Illuzzi Gallinari and Sara Gonzalez were the principal authors.

Program in Long-Term Care Law Planned

The Special Committee on Long-Term Care is planning a program for May '04 on "Legal and Regulatory Issues in Long-Term Care: A Primer." The program, chaired by Ari Markenson, will be held in Rochester, Albany, Melville and New York City. For more information, see the NYSBA Web site.

Section Committees and Chairs

The Health Law Section encourages members to participate in its programs and to volunteer to serve on the Committees listed below. Please contact the Section Officers (listed on the back page) or Committee Chairs for further information about these Committees.

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The Health Law Section is pleased to announce the creation of two new Committees. The Special Committee on Long Term Care and the Public Health Committee are looking for new members. If you are interested in joining either of these Committees, please fill out the form below.

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