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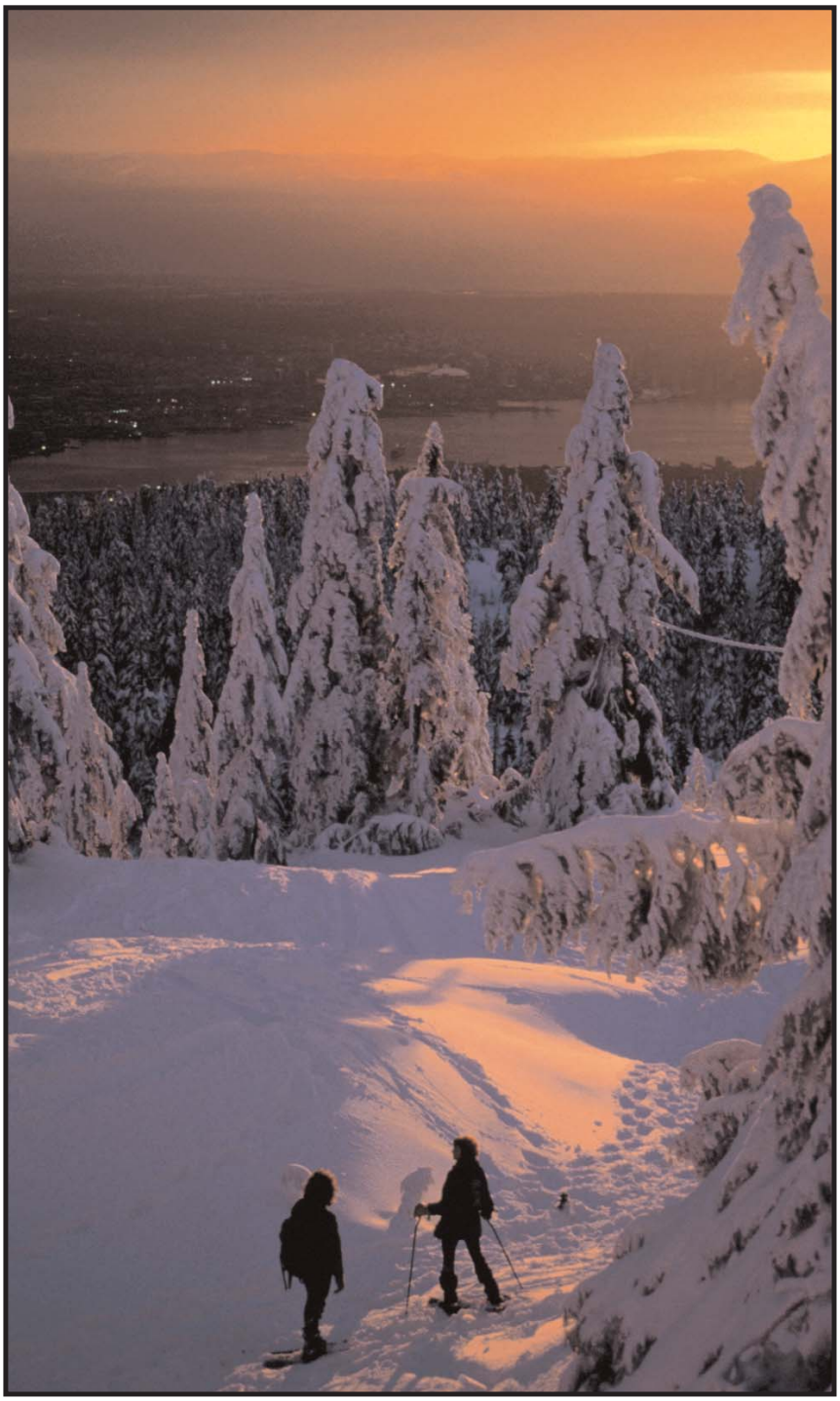

Inside

NYSBA

HEALTH LAW JOURNAL

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THE HEALTH LAW SECTION
NEW YORK STATE BAR ASSOCIATION

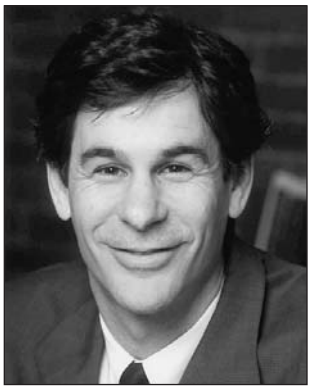
in cooperation with

ALBANY LAW SCHOOL

A Message from the Section Chair

"I wish people would start talking about complying with the laws, instead of talking about enforcing the law."

—Calvin Coolidge



This edition of the *Health Law Journal* will be published shortly before the Annual Program of the Health Law Section. Our theme this year is counseling our clients "to do the right thing." The first part of the Program will explore the governance and ethical obligations of not-for-profit health care institutions. The second segment will address issues that have evolved since health care institutions started to institute compliance programs about a decade ago. Sadly, when looking at the state of affairs not only in the health care industry, but also in corporate America, our theme is particularly timely. While we can debate whether the poster child of corrupt corporate governance is the energy, communications, mutual fund or, most recently, insurance industry, it is undeniable that the health care industry has had its share of bad press. Consider Columbia/HCA, Caremark, Warner-Lambert (now Pfizer), HealthSouth and Tenet. In fact, take a look at virtually any edition of the *BNA Health Care Fraud Reporter*, and you will see a list of entities or individuals indicted, convicted, sentenced, fined, penalized and/or excluded from government health care programs.

Now, I'm not an avid fan of the *Star Wars* series, but, in my humble opinion, there is a perpetual struggle between the good and the dark forces replayed in many corners of our society, including corporate America. It seems that, in many cases involving health care organizations, the darker side had been allowed to flourish quietly and insidiously until a light was shined on the organization and redress was obtained in an enforcement action, usually brought by the government. Had those organizations taken deliberate efforts to guard against the temptation of greed, and foster a culture of ethics and legal compliance, they could have rooted out the demons lurking deep inside them far less painfully than an enforcement action.

As many of you who represent small and large health organizations well know, promoting a positive culture requires a firm commitment from the top down, beginning with the board of directors. Indeed, irrespective of Sarbanes-Oxley, one of the first steps to instill such a culture is for a corporate board to examine itself, and adopt best practices that, in many respects, are intuitive. For-profit and not-for-profit boards alike must avoid conflicts of interest, maintain active oversight and establish clear lines of reporting. A board simply cannot imprint its values onto the soul of the corporation if it operates lethargically or distantly or hypocritically.

Once a board makes its own commitment to promoting a positive culture, an effective corporate compliance program can build upon that commitment and spread the values that the board embraces. That too, of course, means real action, and not just good intentions

"[T]here is a perpetual struggle between the good and the dark forces replayed in many corners of our society. . . . [I]n many cases involving health care organizations, the darker side had been allowed to flourish quietly and insidiously until a light was shined on the organization and redress was obtained in an enforcement action, usually brought by the government."

or mere lip service. It means writing and regularly updating policies and procedures, dedicating staff to implement the policies and procedures, routinely auditing corporate activities and, when necessary, taking remedial action. Sure, there are real costs associated with taking real action. There are also actual and perceived inequities that arise in the marketplace when competitors do not take the same safeguards or make the same commitment. As lawyers, we hear it all the time: "Everyone in the industry is doing it, so why can't we do it?" An organization must, however, maintain clear resolve, and not tepid acceptance, if it truly wants a culture of ethics and compliance to take hold.

The purpose of the Annual Program is to help us steer health care organizations in the right direction. Presenters will review best practices for a board, probe situations that trigger conflicts within a board (especially in a health system), offer pointers in institutionalizing a compliance program, recommend practices in dealing with vendors and suppliers, and suggest roles for attorneys in the compliance and governance areas. In short,

the Program will provide us with practical advice on how we attorneys can support organizational changes critical to effective governance and compliance.

That being said, I would be remiss if I did not share a couple of thoughts about the other side of the equation that ignores the earnest efforts of organizations to be in legal compliance. Often, health care organizations, including not-for-profit organizations with stretched resources, do their darndest to comply with an array of complex and all-too-often vague rules and regulations. Despite diligent efforts, however, I have witnessed enforcement agencies taking unreasonably aggressive positions that are designed to intimidate. For example, in several cases, I have seen enforcement agencies dismiss established and accepted billing and documentation practices and, without warning, apply their own arcane constructions of a regulation retrospectively in an attempt to recover "overpayments" and impose penalties.

Just like health care organizations, enforcement agencies, too, need to keep their *yin* and *yang* in check. Whether it is motivated by an attempt to obtain recoveries to narrow a governmental budget deficit, to build a personal reputation for a prosecutor, or to simply justify the existence of a bureaucratic agency, wild-eyed enforcement is neither smart nor fair. Rather, it diverts resources from the organizations, many of which operate hand-to-mouth and serve the neediest in our communities. Don't hear me wrong. I'm not advocating that enforcement agencies turn a blind eye to improper practices. I am only suggesting that enforcement agencies look at all relevant facts and circumstances before they adopt a new position under a long-standing rule and then thoughtlessly shoehorn that position into a claim for retrospective relief, including penalties.

Perhaps, in an enlightened world in the distant future, the specter of fraud and abuse will no longer exist. Until then, however, I submit that we can well serve the organizations that we counsel by reminding them, at every reasonable opportunity, that it furthers their interests to forcefully promote an honest and ethical culture. I also submit that, when the circumstances warrant, it is in everyone's interest for enforcement agencies to worry less about the game of "gotcha" and more about avoiding the wasteful consumption of resources that it takes to play that game.

Philip Rosenberg

In the New York State Courts

By Leonard M. Rosenberg

Second Circuit Court of Appeals Certifies Question to the New York Court of Appeals: Is a Medical Corporation that Was Fraudulently Incorporated Entitled to Be Reimbursed for Medical Services Rendered by Licensed Medical Practitioners?

State Farm Mutual Automobile Insurance Co., v. Mallela, 372 F.3d 500 (2d Cir. 2004). In this diversity action, the issue squarely presented to the Second Circuit Court of Appeals was whether an insurance company may refuse to compensate medical providers for health care services that are within the scope of the no-fault program in every way except that they are provided by health care professionals employed by medical practices that, under state education and business laws, are unlawfully incorporated.

In setting the context for its decision, the Second Circuit first cited New York's No-Fault statute, which permits injured parties to recover benefits from insurers for "basic economic loss," including medical expenses, that arise out of the use or operation of a covered motor vehicle. It also provides for a "Fee Schedule," which establishes permissible charges for specific services offered by particular kinds of providers. Regulations promulgated by the Superintendent of Insurance to implement that statute permit covered parties to assign their benefits to health care providers, who in turn submit claims to insurers for treatment and services given to the injured individual.

Those regulations state that a provider of health care services is not eligible for reimbursement if the provider fails to meet any applicable New York State or local licensing requirement necessary to perform

such service in New York. The regulations are designed to enforce New York's policy against the "corporate practice of medicine," i.e., the practice of non-physicians employing physicians or controlling their practices.

State Farm claimed that the defendants fell afoul of the implementing regulations, because the professional corporations at which the health care providers were employed were, in fact, operated and controlled by non-physicians, notwithstanding attempts to portray those entities as physician-owned. State Farm argued that the corporate defendants were therefore not entitled to receive assigned benefits under the no-fault program because of those regulatory violations, and sought declaratory and injunctive relief to enforce its position. State Farm did not contest that the health care services in question were rendered by anyone other than licensed health professionals.

The issue before the Second Circuit, therefore, was whether the illegal incorporation of a professional corporation so fatally taints the services provided by the professionals employed by it that these services—even if medically necessary, actually provided, and covered by no-fault automobile insurance in every other way—need not be compensated by an insurer. The federal appeals court chose not to decide the issue at this time, but elected to defer to the judgment of the New York Court of Appeals by certifying the question for resolution by that court. The court cited as justification for its ruling that New York law—statutory and regulatory—is unclear about which entity—either the professional corporation or the actual health care provider—needs to be licensed in order to effectuate a proper assignment of no-fault benefits. Thus, there is no existing "controlling precedent" in New York that governs this case.

Other factors that the Second Circuit found favored certification were that the issue is clearly recurring and appears to be of significant importance to the state of New York. The Second Circuit also feared that if it resolved the issue on its own and in favor of State Farm, it would spawn myriad other related issues that it felt unsuited to decide, for example, whether insurers could then deny claims on the basis of other violations of licensing laws, including technical ones such as the failure to pay an annual licensing fee. The New York State Court of Appeals has accepted the certification (2004 WL 1945318 (N.Y.)) but as of the date of the preparation of this summary, has not yet decided the matter.

Second Department Enforces Restrictive Covenant in Pediatrician's Employment Contract

Gazzola-Kraenzlin v. Westchester Medical Group, 782 N.Y.S.2d 115 (2d Dep't 2004). The plaintiff is a pediatrician who entered into an employment contract with defendant Westchester Medical Group. The plaintiff's employment commenced on November 15, 2001, and was to terminate on December 31, 2002. Under the terms of the contract, defendant had the right to terminate plaintiff upon 60 days notice "for any or no reason"—including the

expiration of the employment term. The contract contained a restrictive covenant prohibiting the plaintiff from practicing pediatric medicine within a 10-mile radius of the defendant's White Plains office for a term of two years. Plaintiff was also required to resign her staff privileges at any hospital within that 10-mile radius during the two-year term, and prohibited from soliciting individuals who had been patients of the practice in the year prior to the end of plaintiff's employment.

Defendant notified plaintiff on or about October 31, 2002 that her employment with the practice would end on December 31, 2002. The plaintiff then commenced suit to recover damages for breach of the employment contract and for a declaration that the restrictive covenants are unenforceable as a matter of law. The Supreme Court granted plaintiff's summary judgment motion and declared the contract's restrictive covenants unenforceable as a matter of law.

The Appellate Division, Second Department, reversed the lower court and upheld the restrictive covenants. Initially, the court noted that the plaintiff's employment terminated on the very date contemplated by the contract. The court reasoned that plaintiff's continued employment by defendant until this date constituted "good and sufficient consideration for the restrictive covenants." The court then found that the restrictive covenants themselves were "not unreasonable in either duration or area." The court noted that the requirement for plaintiff to resign her memberships and privileges at hospitals within the restricted area did not "impose an additional burden upon her beyond that resulting from the prohibition of her practice of pediatric medicine within that area." For these reasons, the Appellate Division determined that plaintiff had failed to establish her entitlement to summary judgment.

Court Rejects Insurer's Declaratory Judgment Action on Justiciability Grounds in End of Life Care Law Matter

Health Insurance Plan of Greater New York v. Calvary Hospital, Supreme Court, New York County (Index No. 104064-04) (November 8, 2004). New York's Access to End of Life Care Law, enacted in 1999, requires health care plans to provide specialized coverage for patients diagnosed with advanced cancer. So long as an attending health care practitioner certifies that a patient has no hope of reversal of the primary disease and fewer than 60 days to live, the health care plan is obligated to cover treatment at a facility specializing in the care of terminally ill patients. The statute provides for a mandatory and binding administrative appeal process through an external review agent if a health care plan disputes coverage.

Defendant Calvary Hospital exclusively provides palliative care for terminally ill cancer patients and is a facility covered by the End of Life Care Law. MH, a HIP subscriber, was diagnosed with terminal cancer in 2003 and transferred from Montefiore Hospital to Calvary pursuant to the End of Life Care Law in August 2003. He was treated at Calvary Hospital until his death in February 2004.

Contending that Calvary had not provided the requisite certification of no hope of reversal of primary disease and fewer than 60 days to live, HIP declined coverage for MH's treatment at Calvary and initiated an administrative appeal under the statute. The external review agent ruled that HIP was not required to reimburse Calvary for MH's treatment, reasoning that MH was terminally ill and Calvary's treatment was "merely palliative." Calvary did not appeal this decision and did not seek compensation from HIP for MH's treatment, estimated at over $100,000.

After prevailing in its administrative appeal, HIP commenced an action against Calvary, alleging that Calvary had engaged in "self-referral" in MH's case. Thus HIP sought a declaratory judgment that the required certification under the End of Life Care Law must come from an attending health care practitioner not employed or compensated by the hospital to which the terminally ill patient is referred.

Calvary moved for summary judgment on the grounds that HIP's action sought an interpretation of the End of Life Care Law in the absence of an actual controversy between the parties and was therefore not justiciable. Because the MH case was fully resolved by the external review, Calvary argued that an interpretation of the End of Life Care Law would have no effect on either parties' rights or interests. As such, Calvary argued, HIP's action requested an impermissible advisory opinion and was premature, as there was no actual controversy between the parties. Any prior controversy, Calvary contended, had been mooted by the external appeal agent's decision in HIP's favor.

HIP argued in response that the controversy was not moot because Calvary officials had spoken about the case, after the external appeal decision, both to a WNBC reporter on a televised broadcast and to HIP officials at a cocktail party. Even if the controversy had been mooted, HIP contended that an exception to the mootness doctrine applied in this instance. HIP further argued that the statutory interpretation was necessary in case Calvary sought to "self-refer" future patients under the End of Life Care Law.

The Supreme Court granted Calvary's summary judgment motion and dismissed HIP's complaint. The court noted that a justiciable controversy requires "a real dispute between adverse parties, involving substantial interests, for which a dec-

laration of rights will have some practical effect." The court concluded that the parties' dispute was mooted by the external appeal, because Calvary had not subsequently brought a claim for reimbursement for MH's care. In the absence of a pending dispute between the parties that would affect their rights or interests, the court reasoned, any statutory interpretation would constitute an impermissible advisory opinion. The court also noted that, although not at issue in the summary judgment motion, the external review agent, in its decision denying coverage for MH, appeared to have misconstrued the applicability of the End of Life Care Law.

The court rejected HIP's arguments on mootness and noted that the parties' moot controversy had not been "revived" by "remarks made on a television show" or by "idle cocktail party chatter." The court reasoned that such an argument, if accepted, could have far-reaching consequences and prevent public dialogue and commentary on legal disputes that have technically ended. The court also found that the exception to the mootness doctrine—for cases with significant public importance that are likely to repeat but typically evade review—did not apply. The court was not convinced that a dispute over End of Life Care certification would arise in the future because HIP had submitted no evidence to substantiate its claim that Calvary took the position it was entitled to "self-refer" patients, or that Calvary and HIP had ever disputed certification in any other End of Life Care coverage case. If a controversy regarding End Of Life Care Law certification arose in the future, the court reasoned, HIP would still have access to the external appeal process it prevailed upon in the MH case, or could seek judicial review of an active controversy at that time. Accordingly, the court dismissed HIP's complaint. [Ed. Note: Garfunkel, Wild & Travis, P.C. represented Calvary Hospital in this matter.]

Court Finds that Hospital's Regular Charges for Services Provided to Uninsured Patient Are Reasonable

Huntington Hospital v. Abrandt, 779 N.Y.S.2d 891 (Sup. App. Term, April 9, 2004). The Supreme Court, Appellate Term, affirmed a decision of the Suffolk County District Court that granted summary judgment to Huntington Hospital (the "Hospital") against an uninsured patient for services rendered and account stated. The patient claimed that the Hospital's charges were unreasonable because it accepted lower fees for patients covered by medical insurance or government programs such as Medicare and Medicaid.

The court held that the "performance and acceptance of services can give rise to an inference of an implied contract to pay for the reasonable value of such services." The court disagreed with the patient's argument that the Hospital's charges were not reasonable, finding that the fact that the Hospital may negotiate lower rates with insurance companies or the government does not indicate that the amounts charged to the patient were not reasonable.

Court of Appeals Holds that Judicial Approval Is Required to Enforce Not-For-Profit Hospital's Agreement to Reimburse Developer for Its Out-of-Pocket Expenses if Hospital Did Not Obtain Judicial Approval of Proposed Sale

64th Associates v. Manhattan Eye, Ear & Throat Hospital, 2 N.Y.3d 585, 780 N.Y.S.2d 746 (2004). A prospective purchaser (the "Purchaser") brought an action against a not-for-profit hospital (the "Hospital"), seeking to recover its out-of-pocket expenses in connection with the parties' judicially disapproved contract for sale of the Hospital's buildings. The Hospital, as a not-for-profit corporation, is subject to the Not-For-Profit Corporation Law ("N-PCL"). Pursuant to N-PCL § 510, certain not-for-profit corporations, such as the Hospital, require judicial approval prior to selling all, or substantially all of their assets. That is because, unlike a for-profit corporation, a not-for-profit corporation does not have shareholders to ensure the reasonableness of such transactions.

In this case, the Supreme Court, after a 13-day evidentiary hearing, disapproved the transaction because "it failed to take the hospital's business value into account and sought only to 'monetize' the real estate, despite offers from other entities that would preserve the hospital." As a result, the Hospital returned the Purchaser's $200,000 deposit but refused to reimburse it for $800,000 in expenses, contending that the judicial disapproval had nullified the contract. The Purchaser sued to recover its expenses pursuant to the contract's termination-payment provision. That clause provided that the Purchaser had the right to recover out-of-pocket costs, if judicial approval of the sale could not be obtained.

The Supreme Court dismissed the Purchaser's suit to recover expenses, holding that "[a]bsent judicial approval of a sale, the contract for sale never came into existence and is inoperative." The Appellate Division affirmed. The Court of Appeals reversed, holding that "any termination-payment clause or similar damages or reimbursement provision in a sales transaction of this kind should be reviewed under the N-PCL 511 standard of fairness, reasonableness and furtherance of corporate purpose." The Court of Appeals agreed with the Attorney General, who filed an amicus brief, that "provisions of this type may be valuable for not-for-profits, permitting their boards to negotiate beneficially." The Court of Appeals therefore remanded the action so the Supreme Court could determine "whether the reimbursement provision was fair and reasonable and in furtherance of the not-for-profit's corporate purpose."

Court of Appeals Upholds Denial of Authorization to Perform Independent Medical Examinations in Workers' Compensation Cases

Belmonte, et al, v. Snashall, 2 N.Y.3d 560, 780 N.Y.S.2d 541 (2004). In this case, physicians brought Article 78 proceedings to annul part of 12 N.Y.C.R.R. § 300.2, a regulation issued under the Injured Worker's Protection Act. The regulation requires physicians to be certified by the American Board of Medical Specialties ("ABMS") or American Osteopathic Association ("AOA") in order to perform independent medical examinations ("IMEs") for the purposes of determining eligibility for worker's compensation. Petitioners also sought to overturn the Workers' Compensation Board's ("WCB") decision denying Petitioners authorization to perform IMEs.

The New York State legislature added section 137 to the Injured Worker's Protection Act to prevent improper and fraudulent examination reports in worker's compensation cases. Section 137 states that "only a New York State licensed and board certified physician, surgeon, podiatrist or any other person authorized to examine or evaluate injury or illness by the board shall perform such independent medical examination" (Workers' Compensation Law § 137(3)(a)). Section 137 did not define the term "board certified" but did define the word "board" to mean the WCB. In accordance with section 137, the WCB promulgated 10 N.Y.C.R.R. § 300.2(b)(2)(ii)(a), which defines "board certified" to mean "a physician or surgeon who is certified by a specialty board that is recognized by the ABMS or AOA."

Petitioners challenged the regulation, arguing that "board certified" meant certified by the WCB, noting that the term had been interpreted similarly in other portions of the statute. Petitioners also challenged the WCB's denial of Petitioners' request for authorization to perform IMEs because the Petitioners were not board certified by the ABMS or AOA, although Petitioners were certified by specialty boards that were not recognized by the ABMS or AOA and had performed IMEs in their practice prior to the enactment of section 137. Respondents argued that their interpretation of "board certified" was entitled to deference because the construction of the term was within its expertise and that its interpretation was entitled to deference as an agency interpretation.

The Supreme Court, Albany County, held the term "board certified" referred to certification by the WCB, noting this interpretation of the term was consistent with the definition of "board" in section 137. The court further held that the WCB's interpretation was irrational and annulled the WCB's denial of authorization of the Petitioners' request to perform IMEs. The court converted the proceedings to a declaratory judgment action and declared 12 N.Y.C.R.R. §§ 300.2(b)(2)(ii)(a) and 300.2(b)(3) invalid. The Appellate Division affirmed, indicating that deference to the WCB was not required in matters of pure statutory construction, and that the legislative intent was to allow the Chair of the WCB to discipline IME providers by subjecting providers to WCB certification. The court also found that the WCB's interpretation of the "board certified" was incompatible with the statutory language.

The Court of Appeals reversed, holding that a plain reading of section 137 supported the conclusion that "board certified" means certification by a medical specialty board, indicating that the statutory definition should not be applied mechanically but in context. Recognizing that ABMS and AOA are organizations of approved medical and specialty boards, the Court held that the regulations are rational in relation to the goals of the Injured Worker's Compensation Act and its requirement that physicians performing IMEs be certified by a medical specialty board. Accordingly, the Court reversed the order of the Appellate Division and dismissed the petition and declared the subject regulations valid to the extent challenged in this matter.

Court Dismisses Medical Resident's Suit for Breach of Contract and Wrongful Termination

Amadasu v. Bronx Lebanon Hospital Center, Inc., 782 N.Y.S.2d 82 (1st Dep't 2004). Defendant Bronx Lebanon Hospital Center (the "Hospital") advised plaintiff that it would not be renewing his one-year medical residency contract. After the non-renewal notice, the Hospital terminated plaintiff's employment as a medical resident, due to his inappropriate and unprofessional treatment of a 13-year-old female patient during an unauthorized pelvic examination. Plaintiff brought a breach of contract action for wrongful termination against the Hospital and subsequently appealed from a Supreme Court, Bronx County, decision granting the Hospital's motion for summary judgment, and dismissing the complaint.

The Appellate Division affirmed, holding that the Hospital did not breach the contract by non-renewal, noting that the residency agreement called for a one-year term of employment renewable only by written mutual agreement. The court further held that termination from the residency program was neither arbitrary nor capricious, and was in accordance with the residency agreement's authorization of termination for "behavior deleterious to the Hospital or the Hospital's patients."

Hospital Patient Attacked by Intruder Entitled to Discovery of Certain Documents Not Covered by Privilege

Marte v. Brooklyn Hospital Center, 9 A.D.3d 41, 779 N.Y.S.2d 82. The plaintiff in this personal injury action was the victim of an attempted sexu-

al assault that occurred while plaintiff was a hospital inpatient, and after visiting hours closed that day. The patient sued the Hospital, and sought discovery of various documents, including: legal proceedings alleging the negligence of the defendants regarding security of the premises; incident reports of rape, attempted rape, sexual assault and other crimes that took place on the premises; records of complaints by visitors concerning security; internal directives concerning security measures for the premises; the Hospital's internal investigation, including but not limited to incident reports, photos, interviews, and other records of the incident; names and addresses of witnesses to the incident, including patients at the ward, visitors, volunteers and/or employees.

The Supreme Court granted Hospital's motion for a protective order with regard to such documents, reasoning that Education Law § 6527(3) exempts three categories of documents from disclosure, including "reports required by the Department of Health; pursuant to Public Health Law § 2805-*l*, including incident reports prepared pursuant to Mental Hygiene Law § 29.29." That court found "the reports of the attempted assault herein and the related material fall within the above category."

In its decision, the Appellate Division first found that under the intersection of the Education Law and the Public Health law, the attack is a "reportable" incident and the Hospital was thus required to investigate and report it.

However, the court held that the fact that the Hospital was required to report the incident does not necessarily mean that it did so, or that all the documents sought by the plaintiff were exempt from disclosure. The court noted that it is the burden of the entity seeking to invoke the privilege to establish that the documents sought were prepared in accordance with the relevant statutes. The court further noted that the Hospital's motion for a protective order did not reveal any statement by the Hospital that it actually prepared any incident reports for the Department of Health as required under Public Health Law § 2805-*l*. Thus, the court held that the Hospital had failed to establish its burden that any documents were prepared under Public Health Law § 2805-*l* and/or Education Law § 6527(3). Moreover, the court held that some of the documents demanded are not the type that would be subject to the privilege, such as records of complaints made by visitors, and the production of visitor logs.

On the other hand, the court noted that some of the demanded documents may, in fact, be privileged under Public Health Law § 2805-*l*, Education Law § 6527(3), and/or Public Health Law § 18(6), which prevents disclosure of third-party health records without authorization, and/or CPLR 4505, the physician/patient privilege, and/or the Federal Health Insurance Portability and Accountability Act of 1996 (hereinafter HIPAA), colloquially known as the Patient Privacy Act. For example, if the revelation of a patient's location in a hospital would, by simple deduction, also reveal that patient's medical status, such discovery would run afoul of CPLR 4505 and the intent behind HIPAA.

Accordingly, the court remanded the matter to the Supreme Court, for *in camera* review, of those documents for which the Hospital asserted a privilege under Education Law § 6527(3) and Public Health Law § 2805-*l*, as well as CPLR 4505 and Public Health Law § 18(6).

Parol Evidence Rule Precludes Pre-Contract Communications and Unclear Promise in Breach Case

New York City Health and Hospitals Corporation v. St. Barnabas Hospital, 782 N.Y.S.2d 12 (1st Dep't 2004). The New York City Health and Hospitals Corporation (HHC) sued St. Barnabas Hospital for breach of a Resident Rotation Agreement, alleging that the Hospital was required, but refused, to pay the salaries of pediatric residents employed by Lincoln Hospital, but who also performed services at St. Barnabas Hospital.

The Supreme Court, after a non-jury trial (Ira Gammerman, J.), found in favor of HHC, holding that it had established valid claims of breach of contract and equitable estoppel based on a memorandum and e-mails exchanged between the parties one month prior to the date of the Agreement.

The Appellate Division found that the decision "ignored well-established principles of contract interpretation and parol evidence as well as the language of the Resident Rotation Agreement." The Agreement expressly provided that residents were not entitled to payment or other consideration from St. Barnabas Hospital due to their participation in the residency rotation program. An addendum to the Agreement required Lincoln Hospital to "promptly pay all salary, benefits, taxes and other such employment-related items to or on behalf of the Residents . . ."

The Appellate Division found it most compelling that neither the Agreement nor the Addendum required St. Barnabas to reimburse Lincoln Hospital for the cost of the residents' salaries. Further, the merger clause of the Agreement was plain, and thus extrinsic evidence which varied the terms stated above was precluded.

Accordingly, the Appellate Division held that the Agreement was a completely integrated agreement which required Lincoln Hospital to pay for the residents, with no reimbursement obligation placed on St. Barnabas Hospital.

As to the alternative theory of promissory estoppel, the Appellate

Division held that there was no clear and unambiguous promise by St. Barnabas Hospital to reimburse Lincoln Hospital for the residents, and since the Agreement was clear and signed by both parties, reliance on any pre-contract communications was inappropriate. Thus, the court reversed the trial court and dismissed the complaint. [Ed. Note: Garfunkel, Wild & Travis, P.C. represented St. Barnabas Hospital in this matter.]

Court of Appeals Upholds Physician's Criminal Conviction for Aiding and Abetting the Unauthorized Practice of Medicine Under New York Education Law

People v. Santi, 2004 WL 2358196 (N.Y. Oct. 21, 2004). In this case, the Court of Appeals upheld the criminal conviction of a physician, Peter Corines, M.D., for aiding and abetting the unauthorized practice of medicine under New York Education Law § 6512(1) (a class E felony). The prosecution was based upon Dr. Corines' actions in allowing a suspended physician to administer anesthesia to his patients.

Defendant Ana Marie Santi worked at Dr. Corines' medical practice as an anesthesiologist until her medical license was suspended by the Department of Health in March 1998. She continued to work at the medical practice following her suspension. Dr. Corines, aware of her suspension, described her as his "medical assistant," and a jury found that he knowingly allowed her to administer anesthesia to patients on at least three occasions.

The Attorney General charged Corines and Santi with four counts of the unauthorized practice of medicine under the Education Law. A jury convicted both defendants, and Corines challenged his conviction, arguing that the plain language of the Education Law exempts licensed professionals from criminal prosecution. The Appellate Division upheld the conviction and Corines appealed to the Court of Appeals.

New York Education Law § 6512(1) provides, in part, that "[a]nyone not authorized to practice under this title who practices or offers to practice or holds himself out as being able to practice in any profession in which a license is a prerequisite to the practice of the acts . . . or who aids and abets an unlicensed person to practice a profession . . . shall be guilty of a class E felony."

Corines argued unsuccessfully to the Court of Appeals that the statute exempted licensed professionals from prosecutions because it states that "anyone not authorized to practice" may be prosecuted. The Court of Appeals, however, reasoned that such a reading of the statute would lead to an "unreasonable or absurd" application of the law in that such a reading would allow licensed professionals to engage in conduct that would otherwise be criminal. The Court held that "it cannot be reasonably contested that the [Education Law] attempts to provide for the safe interaction of the regulated professions and those individuals that would engage their services, namely, the public. Broadly stated, it is a statute clearly designed to promote the public's safety. Allowing licensed physicians to aid and abet unauthorized individuals in the unlawful practice of medicine does not in any way promote the general welfare or otherwise ensure public safety." Accordingly, the Court concluded that the Education Law does not exempt licensed professionals from prosecution under the statute and upheld Corines' conviction.

Compiled by Leonard Rosenberg, Esq. Mr. Rosenberg is a partner in the firm of Garfunkel, Wild & Travis, P.C., a full-service health care firm representing hospitals, health care systems, physician group practices, individual practitioners, nursing homes and other health-related businesses and organizations. Mr. Rosenberg is Chair of the firm's litigation group, and his practice includes advising clients concerning general health care law issues and litigation, including medical staff and peer review issues, employment law, disability discrimination, defamation, contract, administrative and regulatory issues, professional discipline, and directors' and officers' liability claims.

In the New York State Legislature

By James W. Lytle

January 2005 marks the beginning of the 228th annual session of the New York State legislature, which means it is time to preview, once again, the likely health care issues that may emerge during this legislative year. As civics students and regular readers of this column would surely know, with the advent of a new legislature elected last November, no legislation carries over from the last session and a whole new raft of proposals have already been introduced—many of which bear a striking resemblance to bills for which attempts have already been made, but failed, for enactment into law.

The results of last fall's election in New York may not appear to have been that dramatic. Although the Democrats gained several seats in the State Senate, control of that house remains firmly in Republican hands, and the Assembly Democrats actually added to their overwhelming majority in the State Assembly. Nevertheless, even the modest gains and losses in both houses were somewhat remarkable by New York standards. The fact that a handful of incumbents were defeated, either in the election or by primary, made this past fall unique for a legislature known as an incumbency machine. Public and media calls for reform of the legislative process have also reached new decibel levels, and this session will be carefully watched to see if a legislature widely described as dysfunctional can enhance its reputation.

Along with the vast majority of incumbents, a host of unresolved health care issues have returned to Albany. Our Section's long-standing support of the Family Health Care Decisions Act will be tested again, along with proposals on stem cell research, professional discipline, mental health parity, and many more. Two significant issues deserve special mention.

The Health Care Reform Act (HCRA)

The five-billion-dollar question is: What will the legislature do with respect to the future of the Health Care Reform Act (HCRA), which expires on June 30, 2005.

Since the demise of the hospital rate regulation system known as NYPHRM, HCRA has been the principal means by which New York State supports and finances various health and health-related programs in New York. Overall, HCRA's funding pools contain $4.8 billion that support graduate medical education, indigent care, various public health expenditures, the state's health insurance initiatives (Child Health Plus, Family Health Plus and EPIC, the elderly prescription drug program), mental health initiatives, workforce recruitment and retention efforts, tobacco prevention programs and a host of others. The funds are generated from a range of sources, including assessments on health insurers, surcharges on certain health care services, the charitable proceeds of the Empire Blue Cross for-profit conversion, and tobacco taxes, among others.

The battle lines are already forming: hospitals and their employees are hoping at least to maintain the level of support in HCRA for their sector; other health care sectors, such as nursing homes and home health care agencies, are seeking to enhance the level of support they receive; public health advocates are hoping to secure a stronger commitment from HCRA for their anti-tobacco and other efforts; and business and insurance groups are seeking to reduce the financial burdens placed on them to fund HCRA. Given the fiscal challenges facing county governments, many of which now devote their entire property tax revenue to fund their share of the state's Medicaid program, local governments are likely to play a role in the HCRA debate as well, looking for some relief from their Medicaid burden.

Although hospitals and health care workers are generally regarded to be the largest beneficiaries of HCRA, an increasing share of HCRA's largesse has been used to offset the state's recurring budget deficits. HCRA pools have been used to offset long-standing state expenditures for various initiatives (as in the case of EPIC, for example) or to support state personnel in public health and other roles. To a limited degree, HCRA has even been used to provide non-specific general fund relief to help close persistent state budget shortfalls. With another large budget deficit facing New York in 2005–06, the Pataki administration may be expected to propose measures that will redirect HCRA funds toward general fiscal relief for the state budget.

In addition to the host of fiscal issues likely to arise in HCRA's reauthorization debate, several policy and programmatic issues will also take center stage. The most contentious and controversial issue may relate to the manner in which hospitals meet their obligations to the un- or underinsured. A major component of HCRA is to provide funds to support care provided to indigent New Yorkers. Over the past several years, hospitals have been criticized by advocacy groups and the news media for undertaking overly

aggressive efforts to collect payments from patients who are not insured and who have not paid their hospital bills. Legislation was introduced last session that would establish standards for hospitals that would govern their provision of care to indigent New Yorkers and the manner in which they seek to collect payment. It is very likely that issues relating to these matters will be addressed as part of the HCRA reauthorization.

Implementation of the Medicare Prescription Drug Program

Commencing in January 2006, Medicare beneficiaries will be eligible for prescription drug coverage through the new Medicare Part D program. Although it is a federal program, Part D's implementation will have a significant impact on New York State, both from a fiscal and programmatic perspective, particularly in connection with the Elderly Pharmaceutical Insurance Coverage program ("EPIC") and the state's Medicaid program.

EPIC provides prescription drug coverage to nearly 350,000 low- to moderate-income New Yorkers over the age of 65. The overwhelming majority of these seniors are Medicare beneficiaries who will be eligible for Part D coverage, and many of them will also qualify for Part D's low-income subsidy, which provides prescription drug coverage with minimal cost-sharing. To the extent that these low-income seniors are enrolled in Part D, New York State stands to achieve substantial savings as their prescription drug costs are shifted to the federal government. Likewise, Part D could bear the prescription drug costs of seniors with "catastrophic" pharmaceutical expenses and thereby generate savings in the EPIC program, if these seniors enroll in Part D.

EPIC enrollees may, however, be reluctant to enroll in Part D because of confusion and suspicion surrounding the new program. For many EPIC enrollees, that suspicion is justified. Part D will provide a less generous benefit than EPIC for middle-income enrollees with average drug costs. Part D's cost-sharing requirements will make it a more expensive benefit, and the formularies and pharmacy networks offered by Part D plans may be more restrictive than EPIC's. Accordingly, seniors have already begun to press the state to maintain EPIC in its current form. At the same time, disability groups, who have long sought drug coverage through EPIC, have also begun mobilizing to use the savings associated with Part D to expand EPIC to include disabled Medicare beneficiaries under age 65.

As a result, the legislature and Executive Branch have the following options: (1) eliminate EPIC entirely (an unlikely result); (2) continue the program solely as a wraparound benefit to fill in the gaps in Part D coverage; (3) maintain the status quo and allow seniors to opt for EPIC or Part D or both; and/or (4) offer EPIC coverage to disabled Medicare beneficiaries.

Part D will also have major implications for the Medicaid program. As of January 1, 2006, Medicaid coverage of prescription drugs for over 500,000 New Yorkers who are eligible for both Medicaid and Medicare will cease. As a general matter, dually eligible beneficiaries will be able to access prescription drugs only through Part D plans. When the Medicare Modernization Act was first enacted, many observers believed that Part D would be a source of savings for state Medicaid programs. However, the Act's "claw-back" provisions severely limit the savings that can be reaped by states. Under these provisions, states must pay back to the federal government a percentage (declining from 90 percent to 75 percent over 10 years) of the amount they would have spent on prescription drugs for this population.

While the state claw-back payments to the federal government are based on the cost of the comprehensive drug benefit that beneficiaries received under Medicaid, it is unlikely that these beneficiaries will receive similarly comprehensive coverage under Part D. The formularies and pharmacy networks of the basic Part D plans available to Medicaid beneficiaries are likely to be more limited than the open formulary and broad pharmacy network offered by the state's Medicaid program. As a result, state policymakers will have to decide whether to provide wraparound, state-funded prescription drug coverage to dual eligibles. Absent such coverage, the state may be faced with increased institutional and other health care costs that might outstrip the cost of maintaining more comprehensive drug coverage, if dual eligibles are not able to obtain the drugs they need to prevent a deterioration in their condition.

Stay tuned.

Mr. Lytle is a partner in the Albany office of Manatt, Phelps & Phillips, LLP. **Mr. Lytle would like to acknowledge the assistance of his colleague from that office, Karen Lipson, with the preparation of this article.**

In the New York State Agencies

By Frank Serbaroli

Medicaid Enteral Nutrition Reimbursement Methodology

Notice of proposed rulemaking. The Department of Health gave notice of its intent to amend section 505.5 of Title 18 N.Y.C.R.R. to decrease Medicaid reimbursement for enteral nutrition. *See* N.Y. Register, August 25, 2004.

Treatment of Opiate Addiction

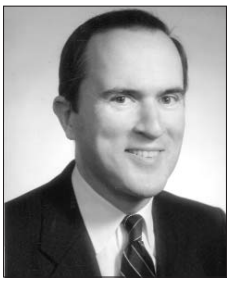
Notice of adoption. The Department of Health amended section 80.86 and added a new section 80.84 to Title 10 N.Y.C.R.R. to permit the treatment of opiate addiction in an office-based setting while curtailing the illicit diversion of controlled substances. Filing date: August 13, 2004. Effective date: September 1, 2004. *See* N.Y. Register, September 1, 2004.

Rate of Payment for Limited Home Care Services Agencies

Notice of proposed rulemaking. The Department of Health gave notice of its intent to add a new Subpart 86-8 to Title 10 N.Y.C.R.R. to reduce Medicaid expenditures for certain personal care services furnished to eligible residents of an adult home or enriched housing program by providing reimbursement directly to the limited home care services agency rather than an outside personal care provider or certified home health agency. *See* N.Y. Register, September 8, 2004.

Expedited HIV Testing of Women and Newborns

Notice of adoption. The Department of Health amended section 69-1.3 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 their current pregnancy or for whom HIV test results are not available at delivery. Filing Date: August 18, 2004. Effective Date: September 8, 2004. *See* N.Y. Register, September 8, 2004.

Managed Care Organizations

Notice of continuation. The Department of Health gave notice of its intent to amend Subpart 98-1 of Title 10 N.Y.C.R.R. to provide clearer guidance to the health care industry concerning the certification and operational requirements for managed care organizations. *See* N.Y. Register, September 22, 2004.

Environmental Laboratory Standards (Bioterrorism)

Notice of adoption. The Department of Health 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 21, 2004. Effective date: October 6, 2004. *See* N.Y. Register, October 6, 2004.

Resuscitation Equipment in Public Places

Notice of adoption. The Department of Health added a new section 801 to Title 10 N.Y.C.R.R., which provides for the availability of resuscitation equipment in certain public places including restaurants, bars, theaters and health clubs, to encourage emergency response by individuals who are trained in cardiopulmonary resuscitation who may not otherwise respond for fear of personal health risks. Filing date: September 30, 2004. Effective date: September 30, 2004. *See* N.Y. Register, October 20, 2004.

Criminal History Record Check

Notice of revised rulemaking. The Department of Health amended sections 763.13 and 766.11 and added section 400.23 to Title 10 N.Y.C.R.R. and amended section 505.14 of Title 18 N.Y.C.R.R. to protect nursing home residents and home care patients by requiring non-licensed nursing home and home care staff who provide direct care or supervision to patients to undergo criminal history checks. *See* N.Y. Register, October 27, 2004.

Part-Time Clinics

Notice of emergency rulemaking. The Department of Health amended sections 703.6 and 710.1 of Title 10 N.Y.C.R.R. in order to clarify and enhance the regulatory requirements that apply to part-time clinics and to require prior limited review of all part-time clinic sites. Filing date: October 19, 2004. Effective date: October 19, 2004. *See* N.Y. Register, November 3, 2004.

Payment for Psychiatric Social Work Services

Notice of emergency rulemaking. The Department of Health amended section 86-4.9 of Title 10 N.Y.C.R.R. to permit Medicaid billing for individual psychotherapy services provided by certified social workers in Article 28 Federally Qualified Health Centers. Filing date: October 14, 2004. Effective date: October 14, 2004. *See* N.Y. Register, November 3, 2004.

Nursing Home Pharmacy Regulations

Notice of emergency rulemaking. The Department of Health amended section 415.18(g) and (i) of Title 10 N.Y.C.R.R. to make a wider variety of medications available in nursing home emergency medication kits and to allow verbal orders from a legally authorized practitioner in order to respond quickly to the needs of residents. Filing date: October 19, 2004. Effective date: October 19, 2004. *See* N.Y. Register, November 3, 2004.

Controlled Substances in Emergency Kits

Notice of emergency rulemaking. The Department of Health amended sections 80.11, 80.47, 80.49 and 80.50 of Title 10 N.Y.C.R.R. to allow Class 3a facilities (nursing homes, adult homes and other long-term care facilities) to maintain controlled substances in emergency kits and administer them to a patient in an emergency situation. Filing date: October 20, 2004. Effective date: October 20, 2004. *See* N.Y. Register, November 3, 2004.

INSURANCE DEPARTMENT

Charges for Professional Health Services

Notice of revised rulemaking. The Department of Insurance amended Part 68 of Title 11 N.Y.C.R.R. to establish maximum permissible charges for professional health care services provided in no-fault insurance claims. *See* N.Y. Register, August 18, 2004.

Healthy NY 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, and 362-5.5 of Title 11 N.Y.C.R.R. to simplify the Healthy NY application process by establishing a standardized application and clarifying household income eligibility requirements and reducing Healthy NY premium rates to enable more uninsured businesses and individuals to afford health insurance. Filing date: September 8, 2004. Effective date: September 8, 2004. *See* N.Y. Register, September 29, 2004.

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: October 25, 2004. Effective date: October 25, 2004. *See* N.Y. Register, November 10, 2004.

Claim Submission Guidelines for Medical Service and Hospital Claims

Notice of emergency/proposed rulemaking. The Department of Insurance added Part 217 to Title 11 N.Y.C.R.R. to create claim payment guidelines setting forth what is needed to determine when a health care insurance claim is considered complete and ready for payment in order to resolve conflicting views between the health care providers and the insurance industry as to compliance with New York's prompt payment statute. Filing date: October 25, 2004. Effective date: October 25, 2004. *See* N.Y. Register, November 10, 2004.

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In the Journals

By Dale L. Moore

***Journal of Health Care Law & Policy* (Volume 7, Number 1)**

- Lisa Dubay, Christina Moylan & Thomas R. Oliver, *Advancing Toward Universal Coverage: Are States Able to Take the Lead?*
- Carol S. Weissert, *Promise and Perils of State-Based Road to Universal Health Insurance in the U.S.*
- Nancy-Ann DeParle, *Medicare at 40: A Mid-Life Crisis?*
- Diane Rowland, *Medicaid: Issues and Challenges for Health Coverage of the Low-Income Population.*
- Robyn Whipple Diaz, *Unequal Access: The Crisis of Health Care Inequality for Low-Income African-American Residents of the District of Columbia*.
- Daniel S. Shaivitz, *Medicate-To-Execute: Current Trends in Death Penalty Jurisprudence and the Perils of Dual Loyalty.*

***Journal of Health Care Law & Policy* (Volume 7, Number 2)**

- Barbara A. Noah, *Bioethics Malpractice: Risk and Responsibility in Human Research.*
- Rick Mayes, *Universal Coverage and the American Health Care System in Crisis (Again).*
- Rhonda Gay Hartman, *AIDS and Adolescents.*
- Michael B. Abramson, *Mad Cow Disease: An Approach to Containment.*
- J. Gregory Lennon, *Easing the Medical Malpractice Crisis: Restricting the Creation of Duty through an Implied Doctor-Patient Relationship.*
- Jeremy Coylewright, *New Strategies for Prisoner Rehabilitation in the American Criminal Justice System: Prisoner Facilitated Mediation.*

***The Milbank Quarterly* 2004 (Volume 82, Number 3)**

- Bradley D. Stein, Terri L. Tanielian, David P. Eisenman, Donna J. Keyser, M. Audrey Burnam & Harold A. Pincus, *Emotional and Behavioral Consequences of Bioterrorism: Planning a Public Health Response.*
- Lynda C. Burton, Gerard F. Anderson & Irvin W. Kues, *Using Electronic Health Records to Help Coordinate Care.*
- Maxwell J. Mehlman, *Cognition-Enhancing Drugs.*
- Jan Ostermann & Frank A. Sloan, *The Effect of Heavy Drinking on Social Security Old-Age and Survivors Insurance Contributions and Benefits.*

Other Articles:

- Michelle Brunsvold, *Medicating to Execute*, 79 CHICAGO-KENT LAW REVIEW 1291 (2004).
- Winn S. Collins, *The Commission's Delegation Dilemma: Is the European Food Safety Authority an Independent or Accountable Agency?*, 10 U.C. DAVIS JOURNAL OF INTERNATIONAL LAW & POLICY 277 (2004).
- Wendy Netter Epstein, *Bottoms Up: A Toast to the Success of Health Care Collaboratives—What Can We Learn?*, 56 ADMINISTRATIVE LAW REVIEW 739 (2004).
- Erin Ann O'Hara, *Apology and Thick Trust: What Spouse Abusers and Negligent Doctors Might Have in Common*, 79 CHICAGO-KENT LAW REVIEW 1055 (2004).
- Eleanor D. Kinney, *Medicare Coverage Decision-Making and Appeal Procedures: Can Process Meet the Challenge of New Medical Technology?*, 60 WASHINGTON & LEE LAW REVIEW 1461 (2003).
- Michael H. LeRoy, *From Docks to Doctor Offices After 9/11: Refusing to Work Under "Abnormally Dangerous Conditions,"* 56 ADMINISTRATIVE LAW REVIEW 585 (2004).
- Maxwell J. Mehlman, Robert H. Binstock, Eric T. Juengst, Rosell S. Ponsaran & Peter J. Whitehouse, *Anti-Aging Medicine: Can Consumers be Better Protected?*, 44 THE GERONTOLOGIST 304 (2004).
- Barbara Spellman, *Reflections of a Recovering Lawyer: How Becoming a Cognitive Psychologist Changed My Views about the Field of Psychology and Law,* 79 CHICAGO-KENT LAW REVIEW 1187 (2004).
- Allyn Taylor, *Governing the Globalization of Public Health*, 32 JOURNAL OF LAW, MEDICINE & ETHICS 500 (2004).
- Ellen Weber, *Bridging the Barriers: Public Health Strategies for Expanding Drug Treatment in Communities*, 57 RUTGERS LAW REVIEW (2005).
- Robin Wilson & Kelly McPherson, *Two Bites at the Apple: Holding Physician Practices Directly Liable for Medical Malpractice,* 59 JOURNAL OF THE AMERICAN MEDICAL WOMEN'S ASSOCIATION 164 (2004).

For Your Information

By Claudia O. Torrey

The following informational bullets cover a diverse range of topics:

- The November 2004 issue of the medical periodical *Nature Genetics* contains a very interesting supplement (*Nature Genetics Supplement*, Volume 36, Number 11 (2004)) on the potential connections between and among race, ethnicity, health, and genetics. This supplement was born out of a workshop held on May 15, 2003 in Washington, D.C., at Howard University's National Human Genome Center. The workshop, entitled "Human Genome Variation and Race: the State of the Science," was funded by the Irving Harris Foundation; the Genome Programs of the United States Department of Energy through its Office of Science; the National Institutes of Health through its National Human Genome Research Institute; and Howard University.

  Although we, as a human race, are more than the "sum of our genes," the workshop attempted to answer such queries as: Can a workshop on ethnicity, race, health, and genetics develop useful information to benefit human health?; Can policies be adopted that will achieve beneficial societal outcomes?; Is it prudent to develop race-related drugs and protocols for certain diseases? (*Id.*); and, Should one's genetic profile necessarily yield medical treatment as an exemplar of a race, as opposed to individualized treatment?

  Genomics can potentially eliminate and diffuse health disparities, or exacerbate such. Human populations are overlapping, indiscrete, and tend to share genetic variation irrespective of race and ethnicity. More from this "workshop seed" is to be published in the future.

- On October 27, 2004, the World Health Organization ("WHO") launched the World Alliance for Patient Safety ("Alliance") (http://www.who.int./mediacentre/news/release, last viewed on November 1, 2004). The Alliance marks the first time a coalition of global partners has come together in order to improve patient safety in hospitals and clinics. According to Sir Liam Donaldson, Chief Medical Officer of the United Kingdom and Alliance Chair, patient safety is a global problem; "First do no harm" will take on a global perspective under the Alliance. The United States Department of Health and Human Services ("DHHS") is a key member of the Alliance.

- The Office of Inspector General ("OIG"), within the DHHS, released its work plan for fiscal year 2005 on October 12, 2004 (http://www.oig.hhs.gov, last viewed on October 30, 2004). There are several focal points for the OIG, but one wrinkle that will definitely need ironing is a drafting snag in the Medicare Prescription Drug, Improvement and Modernization Act ("MMA") that prevents the Centers for Medicare and Medicaid Services ("CMS") from giving the OIG any of the $1 billion slated for MMA implementation. Some of the OIG work plan hot topics include: review of MMA-endorsed discount drug cards, including the CMS selection process for card sponsors; beneficiary notices regarding hospital lifetime reserve days; payment methods for resident training in non-hospital settings; and statutory safe harbor requirements for electronic drug prescriptions.

- California Governor Arnold Schwarzenegger signed Senate Bill 1262 into law on September 29, 2004. The bill, similar to Sarbanes-Oxley ("S-O"), enacts new corporate governance requirements for California nonprofit corporations that have both annual revenues exceeding $2 million and are required to register with the California Attorney's Office. Although the law becomes effective January 1, 2005, Governor Schwarzenegger has asked the California Legislature to revisit the legislation if it results in unnecessary expense to the nonprofit community.

  While several of the Bill 1262 provisions are stricter than their S-O counterpart, 1262 did preserve existing exemptions from the reporting requirements for various not-for-profit entities including hospitals, educational institutions, and religious organizations. Corporations that are affiliated with exempt organizations but are not in business for the purposes covered by the exemption, however, are subject to 1262. Thus, a hospital foundation for a hospital corporation will be covered by 1262, and the hospital will be exempt. Similar legislation has been proposed and/or introduced in several states, including New York.

- As this column was going to press, the pharmaceutical company, NitroMed, Inc. made history with its landmark development of the first drug to be marketed for a specific race.[1] The drug, known as BiDil, is a combination pill consisting of isosorbide dini-

trate and hydralazine. BiDil appears to dramatically increase the level of nitric oxide in black patients—an important element in the regulation of the heart. The clinical trial was so successful that researchers stopped it early in order for those on the placebo to benefit from BiDil. The randomly selected trial participants were categorized as having either New York Heart Association class III or class IV heart failure with dilated ventricles.[2]

When the clinical trial originally started, the two main pill components were given to trial participants separately. While white trial participants showed little or no improvement, black trial participants showed some improvement; thus, the decision to combine the two main pill components into one dosage.

Although the patent for BiDil allows it to be sold as a race-specific drug with some degree of exclusivity until 2020, BiDil will probably be utilized by other racial groups. NitroMed expects to have BiDil on the market by early 2005.

Endnotes

1. Anne L. Taylor, M.D. et al., *Combination of Isosorbide Dinitrate and Hydralazine in Blacks with Heart Failure*, 351 The New England Journal of Medicine 2049–57 (November 11, 2004).
2. *Id.*

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Regulatory Overview of New York State Commercial Health Maintenance Organizations

By Meredith L. Borden and Sean M. Nataro

I. Introduction

This article provides an overview of the issues that commercial health maintenance organizations ("HMOs") face in New York State when they begin to operate and provide health care services. Despite the breadth of HMO coverage in New York, it is difficult for insurers to initiate and properly maintain HMO operations largely due to the regulatory quagmire through which HMOs are governed. To simplify the maze of competing regulations, this article explains which agencies regulate and oversee commercial HMOs and commercial HMOs' most significant operational, financial and other requirements. Not included in this overview are the additional requirements for HMOs that exclusively participate in government programs such as Medicare risk contracting, Medicaid managed care or New York State's Child Health Plus program.

II. Regulatory Agencies and Regulatory Oversight

As explained below, both the New York State Department of Insurance ("DOI") and the New York State Department of Health ("DOH") oversee HMOs.

New York insurers have many options in how to cover enrollee health care service. For instance, insurers may underwrite contracts providing hospital, basic medical, major medical, Medicare Supplemental, dental and prescription drug benefits by organizing as a non-profit medical and dental indemnity, or health and hospital service corporations under Article 43 of the Insurance Law ("Article 43 Insurers").[1] Insurers may also underwrite accident and health insurance and be organized for profit under Article 42 of the New York Insurance Law (the "Insurance Law" or "INSL").[2] Alternatively, insurers may cover enrollee health care services by organizing as HMOs.

Irrespective of how an insurer is organized, no person, firm, association, corporation or joint-stock company can do any insurance business in New York State unless it has a license from DOI or is otherwise exempted from the licensing requirements.[3] An organization complying with the provisions of Article 44 of the New York Public Health Law (the "Public Health Law" or "PHL") is statutorily exempted from DOI licensing requirements and may operate without being licensed under the Insurance Law, although it must still comply with specific Insurance Law provisions.[4]

Article 44 of the Public Health Law regulates HMOs in New York State.[5] No person or group of persons may operate an HMO or issue a contract to an enrollee for membership in a comprehensive health services[6] plan in New York State without first obtaining a certificate of authority from the Commissioner of Health (the "Commissioner").[7] Thus, HMOs are statutorily exempted from DOI licensing requirements. It should be noted that as Article 43 Insurers are non-profit corporations, those that wish to be organized for pecuniary profit must be converted into another corporate form. Article 43 Insurers that do not wish to convert but desire for-profit operations can obtain a certificate of authority under Article 44 of the Public Health Law to do an HMO line of business which is also exempt from DOI licensing requirements.[8] The Public Health Law thus provides that DOH, not DOI, is responsible for overseeing the conduct of HMOs, regulating their contracts and authorizing them to conduct insurance line of businesses in New York State.[9]

Article 48 of the Insurance Law also provides that the Public Health Law oversees HMOs. Article 48 outlines operational requirements for all managed care health insurance contracts[10] delivered by New York State licensed insurers, such as grievance procedures, enrollee access to specialty care and health care professionals' application and termination procedures for contracting with managed care plans.[11] Article 48 specifically excludes from DOI's operational oversight of insurers' managed care health insurance contracts all New York insurers' HMO lines of business and HMOs certified under Article 44 of the Public Health Law or licensed under Article 43 of the Insurance Law and stipulates that the exempted corporations are subject to the provisions of Article 44 of the Public Health Law.[12] Therefore, both the Insurance and the Public Health Laws concur that the Public Health Law governs, regulates, and oversees New York HMOs.

The Superintendent of Insurance (the "Superintendent"), however, still has the power to promulgate regulations concerning HMOs and modify requirements applicable to HMO contracts with subscribers.[13] Article 44 of the Public Health Law also stipulates that the Commissioner must cooperate with the Superintendent and other state officials and agencies that establish standards and requirements concerning health care services' provision and financing to ensure necessary, equitable,

and consistent state supervision of all New York health care systems.[14]

HMOs and HMO lines of business (collectively, "HMOs") are therefore governed by Article 44 of the Public Health Law other than for a specific list of Insurance Law provisions with which HMOs must comply and to the extent the Superintendent does not promulgate regulations concerning them. To the extent the Superintendent promulgates regulations, DOH and DOI both have regulatory authority over commercial HMOs.[15] DOI has primary responsibility over HMOs' financial affairs and DOH has responsibility for HMOs' operations. Both DOH and DOI may audit and examine HMOs' records.[16]

The most significant operational requirements for HMOs are contained in Articles 44 and 49 of the Public Health Law and Part 98 of DOH regulations.[17] Significant portions of the Insurance Law and Part 52 of DOI regulations apply to HMOs' financial and other requirements.

DOH conducts annual on-site surveys of HMOs to measure their compliance with state statutes and regulations. HMOs' successful completion of these "Article 44" surveys is a requirement for HMOs to retain their certificates of authority.

III. Corporate Governance

An HMO's board of directors (the "Board") retains ultimate authority for the HMO's operations.[18] DOH regulations provide that the Board retains responsibility for a variety of functions including: quality assurance; utilization review; adopting budgets and financial records; ensuring the performance of the medical director, chief administrator and other senior management; disposing of assets; and marketing. Although the Board may enter into a management agreement with another entity to perform some of these functions, the agreement must receive DOH's prior written approval, and the Board must retain ultimate responsibility for critical functions.[19]

At least twenty percent of an HMO's Board must be comprised of HMO enrollees and at least one-third of the Board must be residents of New York State. Employees of health service providers or the HMO may not serve as enrollee representatives.[20]

IV. Financial Affairs

A. Financial Operations

DOI has primary responsibility for overseeing HMO's financial operations. Each HMO's line of business must be separately maintained from all other lines of business, and the HMO must maintain separate records, books, and accounts for HMO functions as compared to other functions.[21] All records pertaining to an HMO must be maintained in New York State.[22] DOH regulations also require that transactions between an HMO and its parent, affiliates, or subsidiaries must be fair and equitable and any charges or fees to the HMO for services performed must be reasonable.[23] Each entity in a corporate system must maintain books, accounts, and records that adequately reflect transactions between the entities.[24] The Commissioner's and the Superintendent's prior approval is required for transactions between the holding company entities and an HMO that involves ten percent or more of the HMO's Admitted Assets (see "Financial Reporting and Record Keeping" below). Prior notice must be provided for transactions involving five percent or more of the HMO's Admitted Assets.[25]

Each existing, certified operating HMO must maintain a contingent reserve fund that must be increased each year by at least one percent of the HMO's net premium income during the whole calendar year. Every new HMO must establish a reserve fund that is annually increased by at least five percent of the HMO's net annual premium income until the fund is at least equal to $50,000.[26]

HMOs initiating operations must deposit in escrow the greater of five percent of health care services' estimated annual expenditures or $100,000. The deposit may be used to offset the contingent reserve fund.[27]

B. Financial Reporting and Record Keeping

Although DOI is the primary overseer of HMOs' financial health, HMOs' specific financial requirements are found in DOH regulations.[28]

HMOs must file annual and quarterly financial statements with both DOI and DOH showing their financial condition.[29] The statements must include a balance sheet, an income statement, and enrollee population and service utilization analyses.[30]

Only certain assets may be considered in determining an HMO's financial condition. These include cash, investment held or acquired, declared and unpaid dividends on shares, and rent due or accrued on real property (collectively, the "Admitted Assets").[31] Certain assets are also specifically excluded from an HMO's financial condition determination, including an HMO's goodwill, trade names, prepaid or deferred charges for expenses, advances to officers (except policy loans), advances to employees, tangible personal property, fixtures, and printed matter.[32]

C. Financial Obligations of HMOs

The Superintendent assesses DOI's operating expenses for any fiscal year pro rata upon all New York

insurers in proportion to their gross direct premiums for insurance policies covering property or risks resident or located in the state, written or received during the preceding calendar year. Each insurer, inclduing HMOs, is required to make a partial quarterly payment of the assessed amount due.[33] The assessment's balance is paid upon a Superintendent determination of each insurer's actual amount due. Any overpayment of the annual assessment may be refunded or applied as a credit against the succeeding fiscal year's assessment.[34]

D. HMO Borrowings

An HMO may, without pledging any of its assets, receive advances or borrow funds to conduct its business, enable it to comply with any surplus requirement, make good any impairment or deficiency, defray reasonable organization expenses, provide any fund to be voluntarily contributed to surplus, or organize, acquire or invest in authorized subsidiaries.[35] An HMO may receive advances or borrow funds pursuant only to a Superintendent-approved written agreement that provides that the money borrowed or advanced and any interest thereon will be repaid only out of the HMO's free and divisible surplus.[36] Any sums an HMO is advanced or borrows may not be part of the HMO's legal liabilities.[37]

E. Financial Examination

The Superintendent will examine not less than once every three years each HMO's financial affairs.[38] The Commissioner may also examine such affairs at any time.[39] In connection with an examination, the Superintendent must have convenient access at all reasonable hours to an HMO's relevant documents, may conduct hearings and has the power to subpoena witnesses, compel their attendance, administer oaths, compel any person to subscribe to his or her testimony, and grant immunity.[40]

An HMO may be required to submit a special report to the Superintendent at the Superintendent's request in relation to its transactions or condition.[41] The Superintendent may additionally require the filing of quarterly statements. HMOs are responsible for all expenses incurred from an examination of their affairs.[42] The Superintendent may, upon a showing of good cause, remit such charges.[43]

The Superintendent may also order an independent management and financial audit of an HMO with a combined premium volume exceeding $2 billion annually to determine the viability of the HMO's products.[44] The audit's scope will include the HMO's financial and competitive position, corporate structure and governance, organization and management, strategic direction and rate adequacy, and the regulatory and New York State competitive environments.[45]

Alternatively, the Superintendent may require independent management and financial audits of an HMO whenever in the Superintendent's judgment the HMO's losses jeopardize its ability to provide meaningful coverage at affordable rates or when an audit would be necessary to protect enrollees' interests. The audit may include an investigation of the HMO's provision of benefits to senior citizens, individual, family, small group and small business enrollees in relation to the enrollees' needs. The audit may also include an evaluation of the HMO's management efficiency, particularly with respect to lines of business that are experiencing losses. The Superintendent may select the auditor whenever he or she requires an audit. Any costs DOI incurs from an audit are assessed on all domestic insurers in the same manner as provided for in section 332 of the Insurance Law (see "Financial Obligations of HMOs" above).[46]

Any audit's results will be provided to the audited HMO and each of its Board members. The Superintendent may direct the HMO to implement any recommendations resulting from the audit that the Superintendent finds necessary and reasonable.[47]

F. Claims Payment

HMOs must comply with New York State's "Prompt Payment Law" and pay claims or bills within 45 days of receipt.[48] If an HMO's obligation to pay a claim or make a payment is not reasonably clear, however, due to (1) a good-faith dispute regarding a person's eligibility for coverage, (2) another's liability for all or part of the claim, (3) the claim amount, (4) the contract's covered benefits or (5) the manner in which services were accessed or provided, the HMO must pay the undisputed portion of the claim.[49] Where a disputed claim or bill is not paid the HMO must provide written notice of the reason the claim or bill is not paid and explain what additional information is needed to pay the claim or bill. HMOs must pay the disputed portion within 45 days of receipt of the information requested or an appeal of a claim or bill for denied services.[50] HMOs are ultimately responsible for the prompt, fair, and equitable settlement of claims despite any contractual delegation of the claims payment process to independent practice associations.[51] HMOs are subject to fines and interest for failure to adjudicate claims within these time frames.[52]

HMOs are also subject to New York State's public goods and graduate medical education surcharges.[53] HMOs must reflect the methodology for financing these surcharges in their contracts and policies.[54]

Although regulations requiring DOH approval of HMO reimbursement to hospitals[55] have not been withdrawn, these regulations are no longer effective as of January 1, 1997 with the passage of the Health Care Reform Act.

V. Benefit Packages and Premiums

A. Enrollee Contracts

HMO enrollee contracts must comply with the offering, renewing, conversion, and termination provisions of section 4406 of the Public Health Law.

HMO enrollee contracts are regulated by DOI as if they were insurance subscriber contracts. They are therefore subject to DOI review and approval. All contracts must cover certain benefits ("mandated benefits"), make available and, if requested by the contract holder, cover certain other benefits (make available benefits), and include other provisions required in Article 43 of the Insurance Law.[56]

An HMO must establish written policies regarding enrollee rights under their contracts, including the right to:

- obtain complete, current information from a physician concerning a diagnosis, treatment, and prognosis;
- receive information from a physician necessary to give informed consent; and
- refuse treatment to the extent permitted by law and to be informed of the medical consequences of that action.[57]

Different regulations govern individual and group contracts. A group contract may be issued only to a collection of covered persons that conforms to the requirements of Insurance Law §§ 4235(c) and (d) and 4237(a)(3)(C).[58] Different regulations also govern small and large groups. DOI regulations define a small group as any group whose contract covers between two and fifty employees or members exclusive of spouses or dependents, including contracts for which the premiums are paid by a remitting agent for the group.[59] DOI regulations do not define a large group, but by implication it can be presumed that a large group is any group whose contract covers more than fifty employees or members exclusive of spouses and dependents.

Any individual or small group applying for individual or small group health insurance coverage must be accepted at all times for any hospital and/or medical coverage, including Medicare supplemental insurance, offered by an HMO to individuals or small groups.[60] Once accepted for coverage, an individual or small group cannot be terminated by the HMO due to claims experience.[61]

Every issued individual commercial insurance contract must be in writing and state its terms and conditions.[62] No individual contract may be for more than twelve months and may not provide that the contract's benefits start at a date later than one year from the contract's date.[63]

An HMO must issue to the group contract holder for delivery to each member of the insured group a copy of the contract or a certificate summarizing the essential features of the insurance coverage.[64]

B. Standard Individual Enrollment Direct Payment Contracts

HMOs must offer a standardized individual enrollee direct payment contract on an open enrollment basis.[65] The standardized individual enrollee direct payment contract must provide coverage for all health services that an enrolled population in an HMO might require in order to be maintained in good health and must be rendered without limitation as to time and cost.[66] No individual enrollee and no family unit may incur out-of-pocket costs in excess of $1,500 and $3,000, respectively, in any calendar year.[67]

HMOs must also offer to individuals a standardized individual enrollee direct payment contract on an open enrollment basis with an out-of-plan benefit system. The out-of-plan benefit system must either be provided by the HMO or through an accompanying insurance contract providing out-of-plan benefits offered by a licensed company.[68] Covered services for plans offering only in-plan benefits must be identical to the in-plan covered benefits of the standardized individual direct payment contracts that also cover out-of-plan benefits, except with respect to co-payments and co-insurance.[69]

No individual direct payment contract may exclude coverage of a health care service rendered or proposed to be rendered to an insured on the basis that the service is experimental or investigational, is rendered as part of a clinical trial or is a prescribed pharmaceutical product. Coverage of the patient costs of such services, however, must be recommended by an external appeal agent upon an external appeal.[70]

C. Standardized Qualifying Small Employer and Individual Contracts

The Health Care Reform Act of 2000 introduced the "Healthy New York" program to encourage qualifying small employers[71] to offer health insurance to their employees and cover uninsured employees whose employers do not provide group health insurance. HMOs must now offer qualifying group health insurance contracts[72] and qualifying individual[73] health insurance contracts.[74]

HMOs must obtain from the employer or individual applicant written certification of program eligibility both at the time of initial application and annually thereafter 90 days prior to the contract renewal date. HMOs may

require appropriate documentation to support the certification.[75] The Superintendent may require HMOs to give preference to qualifying small employers whose eligible employees have the lowest average salaries.[76]

Qualifying group health insurance contracts and qualifying individual health insurance contracts are required to provide in-plan benefits only, except for emergency care or where services are not available through a plan provider.[77] HMOs must offer the mandated benefits without changes or additions.[78]

The Superintendent established a "small employer stop loss fund" and a "qualifying individual stop loss fund" (the "Stop Loss Funds") from which HMOs may receive reimbursement for 90 percent of claims paid between $30,000 and $100,000 in a calendar year for any Healthy New York covered enrollee.[79] Claims are reported and funds distributed from the Stop Loss Funds on a calendar year basis. Claims are eligible for reimbursement only for the calendar year in which the claims are paid. Once claims paid on behalf of a covered enrollee reach or exceed $100,000 in a given calendar year, no further claims paid on behalf of the enrollee in that calendar year are eligible.[80] The Superintendent may require HMOs to submit claims data in connection with the reimbursement requests as he or she deems necessary to enable him or her to distribute monies and oversee the operation of the Stop Loss Funds. The Superintendent may require that the data be submitted on a per-member, aggregate, and/or categorical basis. Data must be reported separately for qualifying group and individual health insurance contracts.[81]

If the total requested reimbursement amount for a calendar year exceeds available funds, the Superintendent will provide for the pro-rata distribution of the available funds. Each HMO is eligible to receive only the proportionate amount of the available funds as the HMO's total eligible claims paid bears to the total eligible claims paid by all HMOs.[82] If available distribution funds exceed the total requested reimbursement amount, excess funds are carried forward and made available for distribution in the next calendar year.[83]

Upon the Superintendent's request, HMOs must furnish data in a Superintendent-prescribed form as the Superintendent deems necessary to oversee the Stop Loss Funds' operation. HMOs must also provide the Superintendent with Superintendent-prescribed monthly reports of the qualifying insurance contracts' total enrollment.[84]

The Superintendent estimates the per-member annual cost of total claims reimbursement from each Stop Loss Fund for qualifying insurance contracts.[85] The Superintendent also determines the total eligible enrollment under qualifying insurance contracts.[86] The Superintendent will suspend the enrollment of new employers under qualifying insurance contracts if he or she determines that the total enrollment reported by all HMOs exceeds the total eligible enrollment and thereby cause anticipated annual expenditures from the Stop Loss Fund to exceed the total funds available for distribution.[87] The Superintendent will notify HMOs of any enrollment suspensions as soon as practicable after receipt of all enrollment data. The Superintendent's suspension determination is made separately for the qualifying group and individual contracts.[88]

The suspension of issuance of qualifying insurance contracts to new qualifying small employers or new qualifying individuals does not preclude the addition of new employees of an employer already covered under a contract or new dependents of employees already covered under contracts, or the addition of new dependents to an existing qualifying individual health insurance contract.[89]

D. Point of Service Products

HMOs may provide a point of service ("POS") product if an insurance contract is issued and a separate contingent reserve fund is established and maintained.[90] Subject to certain exceptions, a POS product's out-of-plan benefits may not exceed ten percent of an HMO's total quarterly health care expenditures.[91] Enrollee indemnification of non-participating provider services may be subject to Superintendent-approved deductibles, co-payments and/or co-insurance.[92] An HMO offering a POS product must quarterly report to DOH and DOI non-participating provider services' percentage utilization.[93]

E. Child Enrollment and Family Coverage

1. Standardized Individual Direct Pay Contracts

No HMO may deny a child's enrollment under the child's parent's health coverage on the ground that the child was born out of wedlock, is not claimed as a dependent on the parent's federal income tax return, or does not reside with the parent or in the HMO's service area.[94] An HMO, for a child covered through a non-custodial parent's insurer, must (1) inform the custodial parent as necessary for the child to obtain benefits through the coverage, (2) permit the custodial parent or a health care provider with the custodial parent's approval to submit claims for covered services without the non-custodial parent's approval, and (3) pay claims directly to the custodial parent, the provider, or the social services district furnishing medical assistance to a child.[95]

An individual direct pay contract marked as a "family contract" may cover: a husband and wife; or husband, wife and their dependent child or children; or any

child not over 19 years old. An unmarried student at an accredited learning institution may be covered until he or she becomes 23 years old. A covered "dependent" also includes any other unmarried child who becomes incapable of self-sustaining employment due to mental illness, developmental disability, mental retardation, or physical handicap prior to attaining the age at which dependent coverage would otherwise terminate.[96]

All "family contracts" must also provide coverage of newborn infants, including newly born infants the insured adopted, from the moment of birth for injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities including premature birth.[97]

Under a "family contract," coverage of a dependent spouse or group member will not terminate when the dependent spouse becomes age-eligible to receive Medicare benefits so long as the contract remains in force and the dependent spouse does not claim any Medicare benefits.[98]

2. Standardized Qualifying Employee and Individual Contracts

A qualifying small employer may cover employee dependents. Any employee or dependent enrolled in Medicare is ineligible for coverage, unless required by federal law. Dependents of an employee who is enrolled in Medicare will be eligible for dependent coverage provided the dependent is not also enrolled in Medicare.[99]

F. Pre-Existing Condition Provisions

Enrollee individual or group contracts may include a pre-existing condition limitation, and all coverage under a Healthy New York qualifying insurance contract is subject to a pre-existing condition limitation.[100] All contracts that include a pre-existing condition provision must generally credit the time the covered person was previously covered under creditable coverage,[101] cannot exclude coverage for more than twelve months following the covered person's enrollment date,[102] and may relate only to a condition regardless of the condition's cause.[103] No pre-existing condition provision can, subject to certain exceptions, exclude coverage of (1) an individual who is covered under creditable coverage, (2) an adopted child or a child placed for adoption before turning 18 years old who is covered under creditable coverage, (3) pregnancy, or (4) an individual, and any dependent of such individual, who is eligible for a federal tax credit under the federal Trade Adjustment Assistance Reform Act of 2002.[104]

An HMO may elect to offer group contracts without a pre-existing condition provision and require that coverage will not become effective until after a specified affiliation period. The HMO is not required to provide health care services or benefits and no premium may be charged for any coverage during the affiliation period. Individual direct payment contracts, however, may not impose any pre-existing condition exclusions and they must comply with Insurance Law sections 4321 and 4322.[105]

No HMO may act as an administrator or claims paying agent, as opposed to an HMO, on behalf of a group that denies or limits benefits for a specific disease or condition or for a procedure or treatment unique to a specific disease or condition (a "Specific Disease or Condition") in a manner inconsistent with the Insurance Law had the group purchased insurance. HMOs are also prohibited from providing stop loss, catastrophic or reinsurance coverage to a group that denies or limits benefits for a Specific Disease or Condition in a manner inconsistent with the Insurance Law had the group purchased insurance. A limit, maximum, or other mechanism that controls total coverage without regard to a specific disease or condition is not one that denies or limits benefits for a Specific Disease or Condition.[106]

G. Coordination of Benefits

Group coverage through an HMO's plan[107] may include a coordination of benefits (COB) provision. Subject to certain exceptions, a plan that does not include a COB provision may not take another plan's benefits into account when it determines its benefits.[108] A group contract may not reduce benefits on the basis that another plan exists or that the person is or could have been covered under another plan, or a person has elected an option under another plan providing a lower level of benefits than another option which could have been elected.[109] No plan may contain a provision that its benefits to be "excess" or "always secondary" to another plan.[110]

A primary plan[111] must pay or provide its benefits as if a secondary plan[112] did not exist. A secondary plan may take the benefits of another plan into account only when it is secondary to that other plan.[113]

When there is a basis for a claim under more than one plan, a plan with a COB provision is a secondary plan and its benefits are determined after those of the other plan. If the other plan has a COB provision, however, the order of benefit payments is determined by the first of the following that applies:

1. The benefits of a plan that covers a person other than as a dependent are determined before those of a plan that covers the person as a dependent;

2. When a plan and another plan cover the same child as a dependent of different persons:

    a. the benefits of the plan of the parent whose birthday (determined by the month and day and not the year in which the parent was

born) falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but

b. if both parents have the same birthday, the benefits of the plan that covered the parent longer are determined before those of the plan that covered the other parent for a shorter period of time;

c. if the other plan has a rule based upon the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits;

3. If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

a. first, the custodial parent's plan;

b. then, the plan of the custodial parent's spouse;

c. finally, the non-custodial parent's plan; and

d. if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first;

4. The benefits of a plan that covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a plan that covers that person as a laid-off or retired employee (or as that employee's dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored;

5. If none of the above rules determines the order of benefits, the benefits of the plan that covered an employee, member, or subscriber longer are determined before those of the plan that covered that person for the shorter time.[114]

H. Rates

The Insurance Law governs commercial insurance contracts' rates.[115]

1. Rate Determinations

a. Standardized Individual Direct Pay Contracts

No individual or small group contract may be issued unless the contract is community rated.[116] The Superintendent will permit the use of separate community rates for reasonable geographic regions, which may include a single county. The separate community rate for an HMO's separate regional components must provide that each region component is geographically distinct and separate from every other regional component, and provide substantially the full range of basic health services to its members without extensive referral between HMO components or substantial utilization by any two regional components of the same facilities.[117] The Superintendent must approve the regions as part of the rate filing.[118]

An HMO's premium rates are subject to DOI review and approval.[119] The Superintendent may refuse approval if he or she finds that a premium schedule or, if appropriate, the rating formula from which premiums are determined, is excessive, inadequate or unfairly discriminatory.[120] The Superintendent may consider the HMO's financial condition in approving or disapproving any premium or rating formula.[121] Any approved premium schedule or rating formula must provide for necessary increases for the restoration of the HMO's statutorily prescribed reserve fund. The Superintendent may defer, reduce or reject a rate increase if he or she finds the HMO's senior level management executives' salary increases are excessive or unwarranted given the HMO's financial condition or overall performance.[122] Any billings to subscribers must be in accordance with an HMO's approved rate structure until the Superintendent reviews and approves a complete rate adjustment request.[123]

Prior to any DOI application for a change in premiums for individual direct pay contracts, an HMO must conduct a public hearing concerning the application's terms. Notice of the hearing must be published. A transcript of the hearing's testimony must be submitted together with a premium change application to the Superintendent. The Superintendent will render a written decision determining whether the application will become effective as filed or as modified, or will be disapproved. Complete rate adjustment requests must be filed at least 90 days prior to the requested effective date.[124]

Alternatively, an HMO that wants to modify premiums may submit an application to the Superintendent. The application will be deemed approved if (1) the contract form's anticipated incurred loss ratio is not less than 80 percent for individual direct payment contracts or 75 percent for small group and small group remittance contracts, (2) the loss ratio for any direct payment, group or group remittance contract is not more than 105 percent of the anticipated earned premium and (3) an American Academy of Actuaries member certifies that the HMO complies with these requirements.[125]

An HMO that elects to use the alternate rate approval method must return each calendar year, in the form of aggregate benefits incurred for each contract form, at least 80 percent for individual direct payment contracts or 75 percent for small group and small group remittance contracts but not more than 105 percent of the aggregate premiums earned for all contract forms. The HMO must annually report by May 1st the previous year's loss ratio for each contract form.[126]

Where a contract form's loss ratio fails to comply with the 80 percent or 75 percent minimum loss ratio requirement, an HMO must issue a dividend or credit against future premiums for all contract holders sufficient to ensure that the aggregate benefits incurred in the previous calendar year plus the amount of the dividends and credits equals no less than 80 percent or 75 percent, respectively, of the preceding year's aggregate premiums earned.[127] In each case where the loss ratio for a contract form fails to comply with the 105 percent maximum loss ratio requirement, an HMO must institute a premium rate increase sufficient to ensure that the preceding year's aggregate benefits incurred equals no more than 105 percent of the preceding year's contract form's aggregate premiums earned and the aggregate premium rate increase.[128]

An HMO may also, as an alternate means to establish rates, guarantee a rate based upon an approved rate at the effective date of the contract. To guarantee the rate, the HMO must obtain the Superintendent's approval for any contract, remitting agent agreement, or rider that limits the HMO to rate adjustment only on a policy anniversary date. Rates may be guaranteed by either (1) a rolling premium rate method, which established a scale of annual subscriber rates that quarterly or monthly varies, or (2) an annual level subscriber rate method, which permits an HMO to defer its right to a rate change until the next contract anniversary date using an appropriate estimated premium with a prospective or retrospective adjustment. A rolling rate will only be approved for a period not to exceed two years.[129]

b. Qualifying Small Employer and Qualifying Individual Contracts

A Healthy New York qualifying small employer must pay at least 50 percent of the premiums for covered employees. The employer premium contribution must be the same percentage for all covered employees.[130]

Premium rate calculations for Healthy New York qualifying insurance contracts are subject to the following:

- Coverage must be community-rated and include rate tiers for individuals, two adult families and at least one other family tier. The rate differences must be based upon the cost differences for the different family units, and the rate tiers must be uniformly applied. The rate tier structure for contracts issued to qualifying small employers and to qualifying individuals must be the same;
- If geographic rating areas are used, they must be reasonable and may include a single county. The geographic areas used must be the same for the contracts issued to qualifying small employers and to qualifying individuals. The Superintendent will not require the inclusion of any specific geographic region within the proposed community rated region selected by an HMO so long as the HMO's proposed regions do not contain configurations designed to avoid or segregate particular areas within a county covered by the HMO's community rates; and
- Claims experience under contracts issued to qualifying small employers and to qualifying individuals must be pooled for rate-setting purposes. The premium rates for qualifying group health insurance contracts and qualifying individual health insurance contracts must be the same.[131]

The premiums for qualifying group and individual insurance contracts must also factor in the availability of reimbursement from the Stop Loss Funds.[132]

c. POS Contracts

For HMOs writing POS products, the HMO's Board may adopt an experience-rated formula for use in rating the in-network component of a large group POS product, provided that the Superintendent-approved formula is consistent with the formula used in rating the out-of-network component. Additionally, an HMO with an approved experience-rated formula must establish a reserve for retrospective refunds based upon underwriting experience or a rate stabilization reserve.[133]

d. Experience-Based Contracts

Large group contracts may be experience-rated.[134] Large group contracts that provide for premium rate adjustments based upon the contract's experience must specify the term of the coverage, which cannot exceed three years. The contracts may provide that they will be automatically renewed at the termination of any period in the absence of one month's prior written notice by either party. If the contract is for a period of more than one year, an appropriate additional premium may be charged. Large group contracts may provide for a premium rate adjustment based upon the experience under the contract at the end of the first period of insurance or any renewal and any adjustment may be retroactive applied to the preceding period.[135]

2. Rate Filings

Rate filings for individual insurance and community rated contracts must include the following, among other things:

- the specific formulas and assumptions used in calculating gross premiums;
- the expected claim costs;
- identification of morbidity and mortality tables of experience studies used;
- published data of other insurers;
- the range of commission rates and other fees payable to agents, brokers, salespeople, and other persons except regularly salaried employees;
- identification of any occupational classification manual being submitted; and
- the expected loss ratio by policy duration.[136]

HMOs that wish to revise previously approved rates must file the following:

- information about claim or utilization frequencies, claim costs, and expenses shown for all contracts and riders for at least two years prior to the calendar year in which the new rates are effective;
- the same information as above projected for a period not more than two years beyond the effective date of the new rates;
- a summary of projected changes in claim or utilization frequency, average claim costs and expenses;
- the HMO's current financial condition and projected condition when the new rates will be in effect;
- the projected operating results or the period during which the new rates will be in effect; and
- a jurat subscribed by the HMO's president or chief executive officer, treasurer or chief financial officer, and the HMO's chief actuary.[137]

I. Contract Termination

Coverage terminations for individuals and small group contracts are based on different criteria.[138] All individual contracts must be automatically renewed from year to year unless the individual provides one month's prior written notice of his or her intent to terminate the contract.[139] No HMO may refuse to renew any individual contract because of the covered person's physical or mental condition or their health.[140] An HMO may, however, elect to terminate an individual contract's coverage if:

- the individual has failed to pay premiums or contributions in accordance with the contract's terms;
- the HMO has not received timely premium payments;
- the individual commits fraud or intentionally misrepresents a material fact under the contract's terms; or
- in the case of an HMO that offers health insurance in the market through a network plan, the individual no longer resides, lives, or works in the service area (or in an area for which the HMO is authorized to do business).[141]

Further, an individual contract may be terminated if an HMO (1) discontinues a class of contract, subject to certain restrictions, (2) withdraws from the individual direct payment market or (3) discontinues all individual hospital, surgical or medical expense insurance contracts for which the premiums are paid by a remitting agent of a group, in the small and/or the large group market in New York State, and withdraws from the small and/or the large group market in the state.[142] If an HMO discontinues a class of contract, it must act uniformly without regard to any health status-related factor of enrolled individuals and must offer individuals the option to purchase all other individual health insurance coverage currently being offered by the HMO in the market.[143] If the HMO withdraws from the individual direct payment market, it must provide the Superintendent with a written plan to minimize potential disruption in the marketplace caused by the withdrawal. The HMO may also not provide any hospital, surgical, or medical expense coverage in the individual direct payment market in the state for five years following the discontinuance of the last health insurance coverage not renewed.[144]

Every individual contract's termination notice must be in a form satisfactory to the Superintendent and include a statement of the conversion privileges, if any, upon termination.[145] In the event of an individual contract's termination, the HMO must return the premium's unearned portion.[146]

HMOs must renew or continue a group contract's coverage at the contract holder's option[147] unless:

- the contract holder fails to pay premiums or contributions in accordance with the contract's terms or the HMO has not received timely premium payments;
- the contract holder commits fraud or intentionally misrepresents a material fact under the contract's terms;

- the contract holder fails to comply with a material plan provision relating to employer contribution or group participation rules;
- the HMO ceases to offer group contracts in a market;
- the contract holder ceases to meet INSL § 4235's requirements for a group;
- a participating employer, labor union, association, or other entity ceases membership or participation in the group to which the contract is issued; or
- in the case of an HMO that offers a group contract in a market through a network plan, no enrollees in the plan live, reside, or work in the operating area of the HMO.[148]

Additionally, an HMO may non-renew or discontinue coverage of a group contract if it decides to discontinue offering a particular class of group contract of hospital, surgical, or medical expense insurance offered in the small or large group market or to discontinue offering all hospital, surgical, and medical expense coverage in the small and/or the large group market.[149] If the HMO elects to discontinue offering a particular class of group contract, it must notify each contract holder of the discontinuance and offer each contract holder the option to purchase all other hospital, surgical, and medical expense coverage currently being offered by the HMO to a group in the market. If the HMO elects to discontinue offering all coverage in one or both markets, the HMO must notify the Superintendent and each contract holder of the discontinuance and provide the Superintendent with a written plan to minimize potential disruption in the marketplace.[150]

VI. Provider Network

A. Network Composition and Provider Credentialing

HMOs must ensure enrollee access to care through written contracts with health care providers.[151] They must maintain a network adequate to provide all the services within their benefit packages. HMOs may not exclude any appropriately licensed providers as a class.[152] All participating providers must be licensed, registered, or certified under Title 8 of the Education Law.[153] HMOs must make available and disclose written application procedures and minimum qualification requirements for health care professionals to be considered by the HMOs.[154]

An HMO's network must allow enrollees the choice of three primary care providers and have adequate access to specialty providers. Additionally, the network must contain a sufficient number of geographically accessible participating providers and cannot exclude any appropriately licensed type of provider as a class. The network must provide access consistent with the Americans with Disabilities Act and meet the enrollee population's cultural and language needs.[155]

HMOs must provide standing referrals to specialists for ongoing treatment if the HMO or the primary care provider in consultation with the HMO's medical director believes such a referral is appropriate.[156] Enrollees with life-threatening or disabling or degenerative illnesses may be referred to specialists or specialty care centers for primary and specialty care.[157] Female enrollees do not need referrals from their primary care physicians for two visits per year for primary and preventive obstetrics and gynecologic care or any resulting treatment or from an acute gynecologic episode.[158]

Under certain circumstances, HMOs must allow enrollees to obtain treatment from non-participating providers. Example of such instances include when the HMO has no qualified provider within its network[159] or during a transitional period when either the enrollee's provider leaves the HMO's network or when the enrollee joins an HMO that does not have the enrollee's provider in its network.[160]

HMOs must annually report their network of participating providers to DOH.[161] DOH has created an electronic submission process, the Health Provider Network, through which the provider network is submitted to DOH for review.[162]

B. Provider Agreements

Both the Public Health Law and Regulations contain explicit requirements for agreements between an HMO and its participating providers. Most importantly, all provider agreements are subject to prior DOH approval.[163] DOH has published HMO and Independent Practice Association Provider Contract Guidelines (the "Guidelines") that include DOH required provisions in provider agreements.[164]

Provider agreements may not transfer impermissible levels of financial risk from HMOs to providers.[165] The level of acceptable financial risk depends on the type of provider, the method of payment and whether risk corridors or pools or stop-loss insurance is involved. The Guidelines detail these issues and require that risk arrangements be disclosed to and approved by DOH.

In addition to the Guidelines, DOH regulations provide that HMOs may not by contract or written policy or procedure prohibit or restrict any provider from (1) disclosing to any enrollee any information that the provider deems appropriate regarding a condition or course of treatment or the provisions of the HMO's products as they relate to the enrollee, (2) filing a complaint about the HMO's policies or practices that the provider believes may negatively impact on the quality

of or access to patient care or (3) advocating to the HMO on behalf of an enrollee for approval of coverage of a particular course of treatment.[166]

Provider agreements must also include provider compensation terms, which must include descriptions of the payment method, including any adjustments, the time period to calculate payment and adjustments, the records relied on to calculate payments and the process to resolve disputes over payments, and must specify the right of either party to seek resolution of the contract's payment terms through arbitration.[167]

The Commissioner may examine at any time the adequacy of an HMO's provider arrangements.[168]

C. Provider Termination

HMOs may not terminate a provider without providing statutory due process, except for terminations on the basis of imminent harm to patient care, a determination of fraud, or a final disciplinary action by a state licensing or other governmental agency that impairs the provider's ability to practice. No due process is required, however, where an HMO elects not to renew a provider agreement. HMOs may not terminate or fail to renew a provider agreement solely because the provider has filed a complaint or an appeal, advocated for an enrollee, or provided information or filed a report with a government body regarding the HMO's policies or practices.[169]

HMOs must make a written report to the appropriate professional disciplinary agency (usually the Education Department) within thirty days of a provider agreement's termination due to alleged mental or physical impairment, misconduct, patient safety or welfare, any termination to avoid disciplinary measures, or a termination on the basis of fraud or imminent harm to patient health.[170] HMOs must also report to the appropriate agency within thirty days of obtaining knowledge of any information that reasonably appears to show that a health professional is guilty of professional misconduct.[171] Any report or information furnished to a professional disciplinary agency is a confidential communication and will not be subject to inspection or disclosure.[172]

If a primary care provider leaves an HMO's network, the HMO must provide written notice to each enrollee who has chosen the provider as his or her primary care provider within fifteen days of the HMO becoming aware that the provider has left.[173] The HMO must permit an enrollee to continue an ongoing course of treatment with a provider that has left the network under certain circumstances.[174]

VII. Quality Assurance

A. Quality Assurance Program

HMOs must develop and implement Commissioner-approved, written quality assurance programs.[175] Such a program must include at least the following:

- a peer review committee;
- periodic written and oral reports by the committee to the Board;
- provider and staff participation;
- medical director supervision;
- regularly scheduled meetings;
- written minutes of committee meetings;
- defined methods for identifying problems from a variety of sources including chart review, member complaints, and utilization review; and
- adequate and documented evidence of timely follow-up recommendations and corrective action.[176]

In order to ensure the quality of services offered, the Commissioner will also examine not less than once every three years each HMO and all participating entities though which an HMO offers health services.[177]

B. Quality Assurance Reporting Requirements

Quality Assurance Reporting Recommendations ("QARR") is DOH's annual publication that summarizes the quality of care provided to New York HMO enrollees. QARR combines measures from the National Committee for Quality Assurance's ("NCQA") Health Plan Employer Data Information Set and DOH developed measures. When available, national averages from NCQA are also included for the commercial populations. QARR requires managed care plans to collect and submit data. Each HMO is audited on at least three quality measures and must show sufficient documentation (based on a random sample of charts) to verify that services were provided in order to pass the audit. An independent auditor, the Island Peer Review Organization, validates the data. If an HMO's rates have dropped or have remained low in past QARR reports, it must submit a corrective action plan to address the problems contributing to poor performance. DOH uses the plan as a reference point during its annual on-site visits.[178]

VIII. Utilization Review

HMOs must comply with all provisions of Article 49 of the Public Health Law regarding utilization review and external review.[179] Article 49 outlines the require-

ments and standards for all decisions by the HMO regarding the medical necessity of the treatment provided to enrollees, including which staff may make certain decisions and the time frames within which decisions must be made.[180]

Utilization review programs must adhere to certain standards. At a minimum, utilization review programs must:

- appoint a licensed physician as a medical director;
- develop written policies and procedures that govern all aspects of the review process and require a utilization review agent to maintain and make available to enrollees and providers the procedures;
- use written clinical review criteria developed pursuant to a utilization review plan;
- establish a process for rendering utilization review determinations;
- establish a written procedure to ensure that notice of an adverse determination includes specified provisions;
- establish appropriate policies and procedures to ensure all applicable federal and state confidentiality laws are followed; and
- establish a requirement that medically necessary emergency services are not subject to prior authorization, and reimbursement for emergency services cannot be denied on retrospective review.[181]

Utilization review may be conducted by administrative personnel, subject to certain limitations, an appropriately trained health care professional, and a clinical peer reviewer in the case of adverse determinations.[182]

A utilization review agent must make a utilization review determination involving health care services that have been delivered within 30 days of receipt of all necessary information.[183] An adverse determination's notice must be in writing and include the determination's reason, instructions on how to initiate standard and expedited appeals, and notice of the availability of the clinical review criteria used to render the determination.[184] An enrollee may appeal a utilization review agent's adverse determination[185] and has the right to an external appeal of a final adverse determination.[186]

Every utilization review agent who conducts utilization reviews must biennially register with the Commissioner.[187] HMOs licensed under Article 43 of the Insurance Law or certified under Article 44 of the Public Health Law are not required to register as a utilization review agent provided that the HMO otherwise provides the following information to the Commissioner:

- the utilization review plan;
- those circumstances, if any, under which utilization review may be delegated to a utilization review program;
- the provisions by which an enrollee, the enrollee's designee, or a health care provider may seek reconsideration of, or appeal from, the utilization review agent's adverse determinations;
- procedures by which a decision on a request for utilization review for services requiring preauthorization occurs in a timely manner;
- a description of an emergency care policy;
- a description of the personnel utilized to conduct utilization review;
- a description of the mechanisms employed to ensure that administrative personnel are appropriately trained and monitored;
- a description of the mechanisms employed to ensure that health care professionals conducting utilization review are appropriately licensed, registered, or certified and trained in the principles, procedures, and standards of the utilization review agent;
- a description of the mechanisms the utilization review agent employs to ensure that all affiliated contractors, subcontractors, subvendors, agents, and employees will adhere to statutorily prescribed standards; and
- a list of payors the utilization review agent performs utilization review for.[188]

Each utilization review agent must adhere to the utilization review program standards.[189]

IX. Enrollee Grievance and Dispute Resolution

A. Grievance Procedure

HMOs must establish a mechanism to address and resolve enrollee complaints and grievances.[190] They must disclose to enrollees the grievance procedure and related information in an enrollee handbook and at any time they deny access to a referral or determine that a requested benefit is not covered.[191] The enrollee grievance process notice must explain the process for filing a grievance, the time frames within which a grievance determination will be made, and an enrollee's right to designate a representative to file a grievance on the enrollee's behalf.[192] The grievance procedure must be reasonably accessible to enrollees that do not speak English.[193]

HMOs must respond in writing to enrollee grievances within fifteen business days of receipt.[194] All grievances must be resolved in no more than (i) 48 hours after the receipt of all necessary information when a delay would significantly increase the risk to an enrollee's health, (ii) 30 days after the receipt of all necessary information for referral requests or determinations concerning whether a requested benefit is covered and (iii) 45 days after the receipt of all necessary information in all other instances.[195]

B. Arbitration

An enrollee contract may permit enrollees to elect to have all claims for damages be subject to binding arbitration.[196] HMOs may provide Superintendent-approved arbitration election notices to enrollees and their covered adult family members that outline the enrollee's rights to arbitration and request that all claims arising under the enrollee contract will be subject to arbitration.[197] For new enrollees and their covered adult family members, HMOs may provide arbitration election notices detailing arbitration rights or an alternate notice that provides that the enrollees will be subject to arbitration unless a form is executed declining consent to arbitration of claims.[198] HMOs must notify at least annually persons who have agreed to arbitration that they may cancel their agreement to arbitrate and provide information as to how to cancel the arbitration agreement.[199] All health care providers who provide or receive compensation for health care services pursuant to an enrollee contract are bound by the arbitration agreement.[200]

Article 75-A of the Civil Practice Law and Rules ("CPLR") governs all arbitrations.[201] Arbitration's administrative expense is paid from the arbitration administration fund established under section 5603 of the Insurance Law.[202] A panel of three arbitrators hears all arbitrations.[203] One arbitrator is appointed to serve as the chairperson on a full-time basis.[204] The arbitration administrator forwards to each party in a dispute a list of candidates for the other two arbitrators. Each party may strike from the list any unacceptable name and must number the remaining names in order of preference. The arbitrator administrator selects the two remaining arbitrators as the first two mutually agreeable by both parties.[205] The arbitration panel will render its decision by majority vote within 30 days after the close of the hearing.[206] The panel may award costs and reasonable attorney's fees to a successful party if it finds that the unsuccessful party's action, claim, counter- or cross-claim or defense is frivolous.[207]

X. Marketing Materials

HMOs may distribute sales or marketing brochures describing its standardized coverage offered subject to Superintendent review.[208] An HMO's marketing materials must, however, be sufficiently clear to avoid deceptive or misleading information and may not disparage competitors.[209]

XI. Records

As stated above, both the Commissioner and the Superintendent may examine the records of HMOs. HMOs must also retain all records for a period of six years after filing of a relevant report with DOH.[210] This six-year limitation does not apply to cases involving fraud.

All enrollee medical records must be retained for six years after the date of service rendered to the enrollee or the HMO ceases operations. In the case of a minor, medical records must be retained for six years after majority.[211]

HMOs must retain records of all grievances and associated appeals for three years.[212]

XII. Disclosure of Information

HMOs must provide a variety of information to current and potential enrollees, such as descriptions of the HMO's utilization review program, grievance procedure, benefit package, provider reimbursement methodologies, and the mechanisms by which enrollees may participate in the development of the HMO's policies.[213] HMOs are also required upon request from an enrollee to provide information such as the names of the HMO's Board and copies of the most recent annual certified financial statement and the most recent individual, direct pay subscriber contracts.[214] An enrollee contract's terms control if there is any inconsistency between any separate written disclosure statement and the contract.[215]

HMOs are also required to comply with DOH regulations regarding advance directives.[216] These regulations require HMOs to provide enrollees with information regarding advance directives, including copies of New York State's health care proxy form.[217]

XIII. Annual Consumer Guide

HMOs must prepare, participate in and share the cost of the publication and dissemination of a consumer's shopping guide for standardized individual health plans and a separate consumer shopping guide for standardized qualifying individual health insurance contracts and standardized qualifying group health insurance contracts. The consumer's shopping guides are published annually and include the contact information for all HMOs offering coverage as well as a description of their plan design and premiums to facilitate consumer comparison.[218] HMOs must also include in their disclosures for the guides the number of enrollee grievances, the number of grievances where a determination

was reversed in whole or in part compared to the number of determinations that were upheld, the number of utilization review appeals, the number of adverse determinations that were reversed as compared to upheld, the percentage of board-certified physicians, primary care provider turnover rates, quality measures such as mammography screening and immunization rates, the methods used to compensate primary care physicians and other providers, and the results of a consumer satisfaction survey among enrollees.[219] HMOs must report the information to the Commissioner for inclusion in the consumer guides and not the Superintendent.[220]

XIV. Brokers and Agents

HMOs may use brokers and agents but must comply with the provisions of sections 2103, 2112, 2114, 2117, and 2123 of the Insurance Law and Part 98-1.11(o) of DOH regulations regarding agents' licensing and commissions.

A. Licensing of Insurance Agents

Every insurance agent must be licensed by the Superintendent. In order to obtain a license, an applicant must take a Superintendent-prescribed examination.[221] Different examinations are provided to individuals seeking to be licensed as an insurance agent with respect to accident and health insurance and HMO contracts. No individual may sit for an examination without first successfully completing a Superintendent-approved course of at least 40 hours covering the principal branches and contracts of life insurance, annuity contracts, disability insurance, accident and health insurance and related insurance. The Superintendent may approve the elimination of certain material from the agent's coursework (and subsequent reduction in class hours) if an HMO is not authorized to transact such kinds of insurance.[222]

An individual does not need to take a written exam if previously licensed for the same line or lines of authority in another state, provided that the applicant's home state grants non-resident licenses to New York residents on the same basis. The applicant also need not take any pre-licensing education.[223]

All licenses are for a two-year term and expire on June 30th of odd numbered years.[224] An annual fee of $20 is required as part of a license's maintenance.[225]

B. Certificates of Appointment

HMOs must file a Superintendent-prescribed certificate of appointment in order to appoint insurance agents to represent them.[226] Certificates of appointment are valid until terminated by the HMO, the license is suspended or revoked by the Superintendent, or the license expires and is not renewed.[227] An HMO must file a statement with the Superintendent upon an agent's termination of a certificate of appointment or the termination for cause of any business relationship with any insurance producer and provide a copy of the statement to the insurance agent.[228] An HMO that fails to report as required or that reports fraudulently, in bad faith, or through gross negligence may have its license or certificate of authority suspended or revoked and may be fined up to $5,000. In the absence of fraud, bad faith, or gross negligence, an HMO may not be subject to civil liability or a civil cause of action as a result of any statement or information submitted to the Superintendent.[229] Every statement is a privileged communication.[230]

Insurance agents appointed for an HMO may transact business for any of the HMO's subsidiaries or affiliates that are also licensed in New York State for the same line or lines of insurance without the HMO submitting additional appointments.[231] The HMO must provide the Superintendent with a certified copy of a resolution adopted by the Board of each of the relevant affiliates requesting the authority. The resolutions must also designate the primary HMO for which all of the company's agents must be appointed.[232]

C. Commissions and Compensation

HMOs may only pay insurance agents commissions or other compensation for soliciting, negotiating or selling any new HMO contract to HMO employees or organizations employed by HMOs who inspect, rate or classify risks, or supervise the training of licensed insurance producers and who do not individually sell, solicit or negotiate insurance.[233] The prohibition against other commissions excludes a referral to a licensed insurance agent or broker if the referral does not discuss specific insurance policy terms and conditions and the referral's compensation is not based upon the individual's insurance purchase.[234]

HMOs may only pay insurance brokers a commission per annum for or on account of the sale, solicitation or negotiation of or other services in connection with any insurance contract four percent of the HMO's approved premium for the contract sold.[235] An insurance broker may receive other compensation, however, from any insured or prospective insured if the compensation is based upon a written memorandum signed by the insured or prospective insured that specifies or clearly defines the amount or extent of the compensation. The insurance broker must retain a copy of the memorandum for at least three years after the services have been fully performed.[236]

D. Conduct of Agents

No HMO agent or representative authorized to transact HMO business and no other person, firm, association or corporation, may:

- issue or circulate any illustration, circular, statement, or memorandum misrepresenting the terms, benefits, or advantages of any HMO contract delivered in New York State;
- make any misleading estimate of the dividends or share of surplus or additional future amounts to be received on a contract or previously paid by the HMO on similar contracts;
- make any misleading representation or any misrepresentation about the HMO's financial condition or the HMO's reserves; or
- make any incomplete comparisons of HMO contracts for the purpose of inducing individuals to lapse, forfeit, or surrender any HMO contract.[237]

Any agent who violates any of these provisions and knowingly receives any compensation or commission for an HMO contract's sale that was induced by prohibited conduct is liable for a civil penalty equal to the received compensation or commission.[238] Any person induced to purchase an HMO contract may sue for and recover the penalty.[239] An agent engaging in also prohibited conduct is also liable for a civil penalty equal to any compensation or commission lost by any other agent as a result of the prohibited conduct. The agent who loses a commission or compensation may sue for and recover the penalty.[240]

E. Aiding Unlicensed or Unauthorized HMOs

No person may act as an agent for an HMO that is not licensed to do an HMO business in New York State; act as an insurance broker in soliciting, negotiating or in any way effectuating any HMO contract; or in any way aid any unlicensed HMO in effecting any HMO contract.[241] Any person who violates these rules is subject to a fine. This prohibition does not prevent an attorney from representing an unauthorized insurer in litigation or settlement of claims.[242]

XV. AIDS Testing and Confidentiality of HIV-Related Information

HMOs must comply with New York State's statutory safeguards regarding the confidentiality of AIDS and HIV information.[243] Generally, AIDS- and HIV-related information may not be released without the express consent of the individual to whom the information pertains.[244] Confidential HIV and AIDS information may be released to an HMO to reimburse a health care provider.[245] If confidential HIV and AIDS information is to be released to an HMO for reasons other than a provider's reimbursement (i.e., for a quality assurance study or for QARR), a dated and written authorization must be obtained.[246]

Endnotes

1. INSL §§ 4300 *et seq.*
2. INSL §§ 4200 *et seq*.
3. INSL § 1102(a).
4. INSL § 1109(a).
5. PHL §§ 4400 *et seq.*
6. "Comprehensive health services" means all those health services that an enrolled population might require in order to be maintained in good health and includes without limitation physician services (including consultant and referral services), in-patient and out-patient hospital services, diagnostic laboratory and therapeutic and diagnostic radiologic services, and emergency and preventive services. PHL § 4401(3).
7. PHL § 4402(1).
8. INSL § 7317.
9. PHL §§ 4403 and 4406.
10. A "managed care health insurance contract" requires that all covered medical or other health care services, other than emergency care services, be provided by or pursuant to a referral from a primary care physician and that an in-network health care provider render referred services. INSL § 4801(c).
11. INSL §§ 4800 *et seq.*
12. INSL § 4801.
13. INSL § 1109.
14. PHL § 4400.
15. INSL § 1109; *see generally* PHL §§ 4900 *et seq*. Although there is dual agency oversight of HMOs, what constitutes an HMO is not uniformly defined by both DOH and DOI. The Public Health Law defines an HMO as any natural or corporate person or group who enters into an arrangement, agreement, or plan to provide or offer a comprehensive health services plan. PHL § 4401(1). DOI regulations clarify this definition to include an organization or line of business of either an Article 43 Insurer that has received a certificate of authority from the Commissioner pursuant to Article 44 of the Public Health Law or an Article 43 Insurer that is qualified within the meaning of section 1310(c) of Title XIII of the Public Health Service Act. 11 N.Y.C.R.R. § 52.4(w). A Public Health Service Act "qualified health maintenance organization" is a public or private entity that is (1) organized under the laws of any state that provides or proposes to provide basic and supplemental health services to its members and (2) organized and operated in the manner prescribed by the Public Health Service Act. 42 U.S.C. § 300e-9(c); 42 U.S.C § 300e(a).
16. 10 N.Y.C.R.R. § 98-1.17(b); 10 N.Y.C.R.R. § 98-1.17(a).
17. DOH has proposed extensive revisions to Part 98 of DOH regulations. Some of the regulatory provisions identified herein may therefore be subject to change pending the revisions' final adoption.
18. 10 N.Y.C.R.R. § 98-1.11(g).
19. 10 N.Y.C.R.R. § 98-1.11(h).
20. 10 N.Y.C.R.R. § 98-1.11(f).
21. 10 N.Y.C.R.R. § 98-1.11(a).
22. *Id.*
23. *Id.*
24. 10 N.Y.C.R.R. § 98-1.10(b).
25. 10 N.Y.C.R.R. § 98-1.10(c); 10 N.Y.C.R.R. § 98-1.11(b).
26. 10 N.Y.C.R.R. § 98-1.11(d).

27. 10 N.Y.C.R.R. § 98-1.11(e).
28. 10 N.Y.C.R.R. § 98-1.11(d), (e).
29. PHL § 4408(5); 10 N.Y.C.R.R. § 98-1.16(a), (f).
30. PHL § 4403(5)(c); 10 N.Y.C.R.R. § 98-1.16(a).
31. INSL § 1301(a).
32. INSL § 1302(a).
33. INSL § 322(a).
34. INSL § 332(b).
35. INSL § 1307(a).
36. INSL § 1307(b).
37. INSL § 1037(c).
38. PHL § 4409(2); 10 N.Y.C.R.R. § 98-1.17(b).
39. 10 N.Y.C.R.R. § 98-1.17(b).
40. PHL § 4409(2); INSL §§ 304–306.
41. INSL § 308(a).
42. INSL § 313(a).
43. *Id*.
44. INSL § 4308(d).
45. *Id*.
46. INSL § 4308(e).
47. INSL § 4308(f).
48. INSL § 3224-a(a).
49. INSL § 3224-a(b).
50. INSL § 3224-a(b).
51. Circular Letter No. 12 (2000).
52. INSL § 3224-a(c); Circular Letter No. 6 (2000).
53. PHL § 2807.
54. INSL § 3236.
55. 10 N.Y.C.R.R. § 86.
56. PHL § 4406(1).
57. 10 N.Y.C.R.R. § 98-1.14(b).
58. INSL § 4305(a).
59. INSL § 4317(a).
60. *Id*.
61. *Id*.
62. INSL § 4306.
63. INSL § 4304(b)(1).
64. INSL § 4305(a).
65. INSL § 4321(a).
66. INSL § 4321(b); INSL § 4322(b).
67. INSL § 4321(b).
68. INSL § 4322(a).
69. INSL § 4321(b).
70. INSL § 4321(f).
71. A qualifying small employer is an employer that is either:
    1. An individual proprietor who is the only employee of the business:
        a. without health insurance that provides benefits on an expense reimbursed or prepaid basis in effect during the 12 months prior to a qualifying group health insurance contract application; and
        b. who resides in a household having a net household income at or below 208 percent of the non-farm federal poverty level or the gross equivalent of such net income; or
    2. An employer with:
        a. not more than fifty eligible employees;
        b. no group health insurance that provides benefits on an expense reimbursed or prepaid basis covering employees in effect during the 12 months prior to a qualifying group health insurance contract application; and
        c. at least 30 percent of its eligible employees receiving annual wages from the employer at a level equal to or less than $30,000.

    INSL § 4326(c)(1)(A)-(B). The Superintendent may adjust the 12-month periods to 18 months if the Superintendent determines that the period is insufficient to prevent inappropriate substitution of other health insurance contracts for qualifying group health insurance contracts. INSL § 4326(c)(1)(D).
72. A qualifying group health insurance contract is a group contract purchased from an HMO by a qualifying small employer that provides certain mandated benefits. The contract must insure not less than fifty percent of eligible employees. INSL § 4326(c)(2).
73. A qualifying individual is an employed person: (i) who does not have and has not had health insurance with benefits on an expense reimbursed or prepaid basis during the 12-month period prior to the individual's application for health insurance; (ii) whose employer does not provide group health insurance and has not provided group health insurance with benefits on an expense reimbursed or prepaid basis covering employees in effect during the 12-month period prior to the individual's application for health insurance; (iii) resides in a household having a net household income at or below 208 percent of the non-farm federal poverty level or the gross equivalent of such net income; and (iv) is ineligible for Medicare. INSL § 4326(c)(3)(A).
74. A qualifying individual health insurance contract is an individual contract issued directly to a qualifying individual that provides certain mandated benefits. At the option of the qualifying individual, the contract may include coverage for dependents of the qualifying individual. INSL § 4327(c)(4). INSL § 4326(b).
75. INSL § 4326(i).
76. INSL § 4326(j).
77. INSL § 4326(d).
78. INSL § 4326(h).
79. INSL § 4327(a), (b).
80. INSL § 4327(e).
81. INSL § 4327(f).
82. INSL § 4327(g)(1).
83. INSL § 4327(g)(2).
84. INSL § 4327(h).
85. INSL § 4327(i).
86. INSL § 4327(j). For qualifying group health insurance contracts, the total eligible enrollment is determined by dividing the total funds available for distribution from the small employer stop loss fund by the estimated per-member annual cost of total claims reimbursement from such fund. For qualifying individual health insurance contracts, the total eligible enrollment is determined by dividing the total funds available for distribution from the qualifying individual stop loss fund by the estimated per-member annual cost of total claims reimbursement from such fund. *Id.*

87. INSL § 4327(k).
88. INSL § 4327(l).
89. INSL § 4327(n), (o).
90. PHL § 4406(2).
91. PHL § 4406(2)(b)–(d).
92. PHL § 4406(2)(e).
93. PHL § 4408(6).
94. INSL § 2608-a(a).
95. INSL § 2608-a(b).
96. INSL § 4304(d)(1).
97. *Id*.
98. INSL § 4305(c)(2); INSL § 4304(d)(2).
99. INSL § 4326(l).
100. PHL § 4406(1); INSL § 4326(k).
101. "Creditable coverage" means coverage of an individual under any of the following: (1) a group health plan; (2) health insurance coverage; (3) Part A or B of title XVIII of the Social Security Act; (4) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928; (5) Chapter 55 of title 10, United States Code; (6) a medical care program of the Indian Health Service or of a tribal organization; (7) a state health benefits risk pool; (8) a health plan offered under chapter 89 of title 5, United States Code; (9) a public health plan; or (10) a health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. § 2504(e)). INSL § 4318(c).
102. "Enrollment date" means the first day of an individual's coverage under the contract or, if earlier, the first day of the waiting period that must pass with respect to an individual before the individual is eligible to be covered for benefits. INSL § 4318(b).
103. INSL § 4318(a) and (b).
104. INSL § 4318(b); INSL § 3232(b); 11 N.Y.C.R.R. § 52.20(b)(4).
105. PHL § 4406(1); 11 N.Y.C.R.R. § 52.20(b)(6).
106. INSL § 4320.
107. A "plan" is a form of coverage written on an expense-incurred basis with which coordination is allowed. The definition of "plan" does *not* include insurance contracts, direct-payment subscriber contracts, coverage through HMOs or coverage under other prepayment, group practice and individual practice plans. 11 N.Y.C.R.R. § 52.23(e).
108. 11 N.Y.C.R.R. § 52.23(b)-(e).
109. 11 N.Y.C.R.R. § 52.23(l).
110. 11 N.Y.C.R.R. § 52.23(m).
111. A "primary plan" does not consider any other plans when determining a person's coverage. A plan is a primary plan if either: (i) the plan has no order of benefit determination rules or it has rules that differ from those outlined above; or (ii) all plans that cover the person use the order of benefit determination rules outlined above and under those rules the plan determines its benefits first. 11 N.Y.C.R.R. § 52.23(g).
112. A "secondary plan" is not a primary plan. If a person is covered by more than one secondary plan, the order of benefit determination rules decide the order in which their benefits are determined in relation to each other. The benefits of each secondary plan may take into consideration the benefits of the primary plan(s) and the benefits of any other plan which has its benefits determined before those of that secondary plan. 11 N.Y.C.R.R. § 52.23(h).
113. 11 N.Y.C.R.R. § 52.23(n).
114. 11 N.Y.C.R.R. § 52.23(n)(3).
115. PHL § 4403(1)(h).
116. INSL § 4317(a); INSL § 3231. "Community rated" is a rating methodology in which the premium for all persons covered by a contract form is the same, based on the experience of the entire pool of risks covered by that contract form without regard to age, sex, health status or occupation. INSL § 4317(a).
117. 11 N.Y.C.R.R. § 52.42(c).
118. INSL § 4317(c).
119. INSL § 4317; INSL § 4308(b).
120. INSL § 4308(b).
121. *Id.*
122. *Id.*
123. Circular Letter No. 4 (1999).
124. INSL § 4308(c); Circular Letter No. 4 (1999).
125. INSL § 4308(g)(1); INSL § 4308(j).
126. INSL § 4308(h)(1); INSL § 4308(j).
127. INSL § 4308(h)(2); INSL § 4308(j).
128. INSL § 4308(h)(3).
129. 11 N.Y.C.R.R. § 52.42(b).
130. INSL § 4326(m).
131. INSL § 4326(n).
132. INSL § 4327(p).
133. Circular Letter No. 26 (2000).
134. INSL § 3231.
135. INSL § 4305(b).
136. 11 N.Y.C.R.R. § 52.40(d)(1).
137. 11 N.Y.C.R.R. § 52.40(d)(3).
138. INSL § 4317(a).
139. INSL § 4304(b)(2).
140. INSL § 4304(b)(3).
141. INSL § 4304(c)(A), (B), (D).
142. INSL § 4304(c)(C).
143. INSL § 4304(c)(C)(i).
144. INSL § 4304(c)(C)(ii).
145. INSL § 4304(c)(3).
146. INSL § 4304(c)(4).
147. INSL § 4305(j)(1).
148. INSL § 4305(j)(2).
149. INSL § 4305(j)(3).
150. *Id.*
151. 10 N.Y.C.R.R. § 98-1.13.
152. 10 N.Y.C.R.R. § 98-1.13(c).
153. PHL § 4406-d(9); 10 N.Y.C.R.R. § 98-1.12(h).
154. PHL § 4406-d(1).
155. PHL § 4403(5)(a)-(b).
156. PHL § 4403(6)(b).
157. PHL § 4402(b)(c) and (d).
158. PHL § 4406-b.
159. PHL § 4403(6)(a).
160. PHL § 4403(6)(e) and (f).
161. PHL § 4403(5)(c); 10 N.Y.C.R.R. § 98-1.16(a).

162. More information about the Health Provider Network is available at <http://commerce.health.state.ny.us/hpn>.
163. 10 N.Y.C.R.R. § 98-1.8(b).
164. More information about the Guidelines is available at <http://www.health.state.ny.us/nysdoh/mancare/hmoipa/guidelines.htm>.
165. PHL § 4403(1)(c) and 5(a); PHL § 4406-c(5-b).
166. PHL § 4406-c(2)-(4).
167. PHL § 4406-c(5-a).
168. 10 N.Y.C.R.R. § 98-1.17(a).
169. PHL § 4406-d(2), (3), (5).
170. PHL § 4405-b(1)(a).
171. PHL § 4405-b(1)(b).
172. PHL § 4405-b(3)(a).
173. PHL § 4408(4).
174. PHL § 4403(6)(e).
175. PHL § 4403(1)(f); 10 N.Y.C.R.R. § 98-1.12(a).
176. 10 N.Y.C.R.R. § 98-1.12(c)-(g).
177. PHL § 4409(1).
178. More information about QARR is available at <http://www.health.state.ny.us/nysdoh/eqarr/2003/about.htm>.
179. PHL § 4900.
180. PHL §§ 4900–4909.
181. PHL § 4902(1).
182. PHL § 4903(1).
183. PHL § 4903(4).
184. PHL § 4903(5).
185. PHL § 4904(1).
186. PHL § 4910.
187. PHL § 4901(1).
188. PHL § 4901(2), (5).
189. PHL § 4902(1).
190. PHL § 4403(1)(g); PHL § 4408-a(1).
191. PHL § 4408-a(2)(a); 10 N.Y.C.R.R. § 98-1.14(a).
192. PHL § 4408-a(2)(b).
193. PHL § 4408-a(2)(c).
194. PHL § 4408-a(4); 10 N.Y.C.R.R. § 98-1.14(d).
195. PHL § 4408-a(4).
196. PHL § 4406-a(1).
197. PHL § 4406-a(2)-(3).
198. PHL § 4406-a(3).
199. PHL § 4406-a(4).
200. PHL § 4406-a(6).
201. PHL § 4406-a(1).
202. CPLR 7553.
203. CPLR 7554(a).
204. CPLR 7554(a).
205. CPLR 7554(b).
206. CPLR 7563(b).
207. CPLR 7564(b).
208. INSL § 4323(b).
209. INSL § 4323(c).
210. 10 N.Y.C.R.R. § 98-1.17(d).
211. 10 N.Y.C.R.R. 98-1.12(j).
212. PHL § 4408-a(14); 10 N.Y.C.R.R. § 98-1.14(e).
213. PHL § 4408(1).
214. PHL § 4408(2).
215. PHL § 4408(1).
216. 10 N.Y.C.R.R. § 98-1.14(f).
217. 10 N.Y.C.R.R. § 700.5.
218. INSL § 4323(a); INSL § 210.
219. INSL § 210(b) and (c); Circular Letter No. 5 (1999).
220. INSL § 210(b)(10).
221. INSL § 2103(a), (b), (e).
222. INSL § 2103(f)(2)(A).
223. INSL § 2103(g)(11).
224. INSL § 2103(j)(2).
225. INSL § 2103(j)(9).
226. INSL § 2112(a).
227. INSL § 2112(c).
228. INSL § 2112(d).
229. INSL § 2112(g)(1).
230. INSL § 2112(d) and (e).
231. INSL § 2103(m).
232. *Id*.
233. INSL § 2114(a)(3).
234. INSL § 2114(a)(4) (to be repealed September 10, 2007).
235. 11 N.Y.C.R.R. § 52.42(e).
236. INSL § 2119(c).
237. INSL § 2123(a).
238. INSL § 2123(d).
239. *Id*.
240. *Id*.
241. INSL § 2117(a).
242. INSL § 2117(f).
243. PHL § 2780; 10 N.Y.C.R.R. § 63.1 and 2.
244. PHL § 2782; 10 N.Y.C.R.R. § 63.4.
245. PHL § 2782(i); 10 N.Y.C.R.R. § 63.5(9).
246. PHL § 2782(j); 10 N.Y.C.R.R. § 63.5(10).

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Mitigating the "HIPAA Scare": A Closer Look at Provider Disclosures to Patient Representatives Under the Health Insurance Portability and Accountability Act (HIPAA)

By Rob J. Senska III

Introduction

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pub. L. No. 104-191, represented the first comprehensive federal effort to ensure the security and privacy of sensitive and personal information contained within an individual's health records. HIPAA established a federal floor of safeguards to protect the confidentiality of this information. It explicitly governed those entities handling health information, or covered entities, which include health care clearinghouses, health plans, and health care providers (hospitals and practitioners for the purpose of this article).[1] In a nutshell, HIPAA created national standards to improve the efficiency and effectiveness of the health care system by facilitating the electronic exchange of data between health care entities while providing heightened protection for individually identifiable health information of patients.

"Neither HIPAA nor the Privacy Rule intended to hinder the easy exchange of information within the health care system which is essential for providers to render efficacious health care."

HIPAA specifically granted exclusive authority to the Secretary of the Department of Health and Human Services (DHHS) to promulgate regulations regarding the privacy and security of health information when Congress failed to enact further more comprehensive legislation by its self-imposed deadline of August 21, 1999.[2] These regulations are set forth at 45 C.F.R. Parts 160 and 164 and include the Standards for Privacy of Individually Identifiable Health Information, Security Standards for the Protection of Electronic Protected Health Information, and General Administrative Requirements. This article will focus on those regulations that have come to be collectively known as the Privacy Rule (hereinafter referred to as the Privacy Rule or the Rule).[3] This article does not address those regulatory provisions that are collectively known as the Security Rule which set forth security standards and implementation specifications for the protection of electronic protected health information (PHI). However, it is worth acknowledging that, while Security Rule compliance may presently seem to require the most attention given the imminence of its compliance deadlines, there remain numerous instances of non-compliance and uncertainty with the Privacy Rule that need addressing.

Neither HIPAA nor the Privacy Rule intended to hinder the easy exchange of information within the health care system which is essential for providers to render efficacious health care. In fact, the preamble of HIPAA dictates Congress' intent of making health data transmission more efficient, improving the continuity of health care insurance, combating waste and fraud in the health care arena, and generally simplifying the health care delivery process in order to ultimately improve both access to and quality of health care.[4] However, because providers fear violating HIPAA, instances in which they refrain from disclosing patient information to persons involved with the patient's care outside of the health care facility, such as family members or significant others (hereinafter referred to as "patient representatives"), have increased. Oftentimes, these communications with patient representatives are essential for providers to render effective and efficient high-quality health care. A complete understanding of the legislative intent, attainable through proper interpretation of the Privacy Rule and greater education of health care providers, should promote the privacy of health information and mitigate providers' fears, and thus militate against a dissuasion from engaging in meaningful communications with patient representatives.

HIPAA evolved from a portion of the proposed, but never enacted, 1993 Health Security Act entitled "Information Systems, Privacy, and Administrative Simplification," which largely sought to protect the privacy of health information.[5] Although this proposal never became law, the transfer and usage of individual medical information and privacy rights remained hot topics in the political arena. Due to the increased use of electronic medical records and increasingly complicated health delivery systems, Congress and DHHS remained intent on regulating the use of medical information to achieve administrative simplification of health care functions and to protect health information. Congress articulated the type of health information it was concerned about protecting when it defined health information as information relating to the mental or physical health of an individual, payment for the provision of health care, or provision of health care.[6]

HIPAA was a response to strong public sentiment, including the fear of identity theft and the use of sensitive health information to discriminate in the workplace. Congress was savvy about the modernization of health care claims processing and understood that the "pathway of a typical medical record [was] no longer confined within the control of the patient's personal physician" and that "a typical record may be handled by numerous individuals [in multiple organizations]."[7] HIPAA represented the codified culmination of public sentiment and astute political action aimed at allaying privacy fears.

In its effort to curb the public's privacy fears, Congress sought to achieve maximum security of health information without uprooting current state laws which adequately protected health information. This is why HIPAA is not intended to interfere with or preempt state laws that already adequately protect health information and establish sufficient safeguards for the transfer, storage, and protection of such data.[8] Where the state laws are not as stringent, however, HIPAA requires entities dealing with and handling personal health information to adopt the necessary physical, technical, and administrative safeguards to secure the confidentiality of that information.[9] This article does not elaborate on the preemption issue nor the complex interplay between HIPAA and state laws.

Congress also sought to ease the burden of implementing new privacy safeguards, because such implementation frequently translates into large capital investments, such as resource expenditures to procure and enhance information technology systems and furnish more intensive personnel training. In fact, even though the Privacy Rule set forth a multitude of new standards that health plans were required to meet, HIPAA provisions did not require full compliance for most health plans until April 14, 2003 and not until April 14, 2004 for smaller health plans.[10] This phase-in period demonstrated Congress' understanding of the magnitude and complexity of the legislation.

Additionally, Congress understood that HIPAA and the Privacy Rule should not deter providers from communicating with necessary parties to effectuate quality care. Nevertheless, the implementation has been, and continues to be, an onerous task, and some providers have become apprehensive about communicating with patient representatives. Providers' fears of civil or criminal penalty have stemmed from misinterpretation and misapplication of the Privacy Rule, two by-products of the health care industry's general lack of understanding about HIPAA. Given the complexity of the regulation, the confusion is justifiable. Also, given the fact that severe penalties may be imposed for persons violating the Privacy Rule, the fear is legitimate. In fact, the Office of Civil Rights (OCR), which administers and enforces the Privacy Rule, may impose civil penalties of up to $25,000 per annum and criminal penalties up to $250,000 and 10 years imprisonment on any person who violates HIPAA.[11]

Apprehension about committing a violation has caused providers to engage in behaviors that prevent the necessary sharing of information, which in turn adversely impacts health care delivery and quality. In reference to these negative behaviors and causal fears, health care administrators and lawyers have coined the term "HIPAA Scare." The HIPAA Scare has prompted some covered entities to engage in behaviors that thwart the ability of people to care for their loved ones. Providers, in some instances, have grown unnecessarily wary of sharing patient health information with patient representatives who are involved with the care of the patient outside of the facility. If providers possessed a more thorough understanding of the Privacy Rule, surely they would not fear sharing information with people intimately involved with and legitimately interested in the patient's care and overall health.

In many real-life scenarios, circumstances exist where communication with a patient's representative is inextricably linked to successful and complete care of that patient, both inside and outside of the health care facility setting. To illustrate this point, take the hypothetical case of a sick elderly person afflicted with a variety of physical impairments and infirmities. The elder lives alone, and relies heavily on her adult child to not only monitor her overall health, but also take her to and from physician appointments. The elder depends on her child to listen to and understand the physician-designed treatment plans and help her carry out those plans, which often include filling prescriptions, administering proper dosages, and scheduling further physician appointments.

As the patient representative, the elder's child essentially serves as an ad hoc nurse/physician outside of the medical facility and a case manager by coordinating the many aspects of the elder's care. The role of such a patient representative is undeniably essential to the health of the parent. It necessarily follows that physicians must be able to communicate freely and openly with such an individual in order to effectively coordinate the patient's care and ultimately render efficacious treatment, even if the patient has not directly authorized release of her health information to this individual.

To solve the problem of stymied communications between providers and patient representatives, the health care industry must overcome the HIPAA Scare and eliminate provider apprehensions and behaviors

detrimental to obtainment of the highest quality care. In order to do this, providers must continue to make efforts to better understand and properly apply the Privacy Rule. The industry must continue to take an active role in educating and properly training personnel to avoid the unintended negative effect of compromised patient care quality that results from severed communication lines. Undoubtedly, these efforts will persistently require a substantial amount of time and money, two resources already in short supply within the health care industry. Nevertheless, they are essential if HIPAA is to be properly integrated into any health care delivery paradigm.

This article concentrates generally on providing a summary and analysis of the elements of the Privacy Rule as a refresher for the more sophisticated audience and as a guide for health care providers so that they may improve their understanding, move past their hesitancies, and eliminate instances in which application of the Privacy Rule results in communication obstacles and becomes an impediment to patients receiving the highest quality health care practicable. The specific focus will be on identifying and overcoming barriers to disclosures by providers to those involved with the patient's care outside of the facility. For the purpose of this article, "providers" will consist of physicians and hospitals, and "individual" and "patient" will be used interchangeably. Patient representatives involved with the patient's care, but who are not health service providers, include all those parties that DHHS enumerated as potentially being involved with the patient's care and any other parties, not specified, that could reasonably fall within the ambit of the Rule.[12] For the ensuing discussion, and in most practical contexts, patient representatives include legally designated decision makers, family members, significant others, and friends. This article is divided into four Parts:

- Part I provides a basic understanding of the Privacy Rule and pertinent definitions thereunder.
- Part II delves into consents and authorizations under the Rule and highlights the salient differences between these two terms.
- Part III discusses exceptions to the Privacy Rule, or rather instances in which providers are permitted to use or disclose health information without patient authorization or consent apart from permissible disclosures for Treatment, Payment or Health Care Operations (collectively referred to as "TPO functions"). Permissible disclosures to patient representatives will be emphasized.
- Part IV touches elements of the first three parts as it raises a variety of issues that may cause providers to fear liability when disseminating a patient's health information to a patient representative. It offers plausible solutions, both in the form of clarification of the Privacy Rule and as suggestions for potential modifications, in an attempt to allay liability fears and thus curtail the HIPAA Scare. Section A of Part IV addresses specifically: (i) the knowledge requirement for patient revocations of prior authorizations, and (ii) incidental disclosures. Finally, Section B of Part IV concludes with a potential HIPAA Scare mitigating proposition which sets forth a unique interpretation of the Rule and is based on a careful analysis of DHHS language and rule-making history.

Through summary and analysis, this article aims to eradicate some common misconceptions and misinterpretations of the Privacy Rule so that providers can gain adequate confidence and comfort operating under the Rule and appropriately share information with persons interested in, and responsible for, patient care outside of the health care facility setting.

Part I: Understanding the Fundamentals of the Privacy Rule

While HIPAA's primary focus pertains to electronic exchanges of health information, the Privacy Rule applies to all Protected Health Information (PHI), which by definition includes all Individually Identifiable Health Information (IIHI) that is not explicitly excepted, regardless of the storage medium.[13] IIHI is information, including demographic information, that relates to the mental or physical health of a patient, or the provision of health care, and that identifies the individual, or for which there is a reasonable basis to believe that the information could identify the individual.[14] A "covered entity," which includes health plans, health care clearinghouses, and health care providers, may not use or disclose an individual's PHI, except as permitted or required by the Privacy Rule.[15] In general, the Privacy Rule prevents covered entities from disclosing PHI to others unauthorized by the statute without the written consent of the individual or an opportunity to formally object to the disclosure. There are no restrictions on the use or disclosure of information that is not PHI, such as de-identified health information.[16] The Privacy Rule defines "disclosure" as the release, transfer, provision of access to, or divulging of information outside the entity holding the information; it defines "use" as the sharing, employment, application, utilization, examination, or analysis of IIHI within the holding entity.[17]

The Privacy Rule has a limited application inasmuch as it only applies to covered entities. However, "business associates" may also be indirectly affected by the Privacy Rule. A business associate is a party, not directly regulated by the Rule, that performs some func-

tion or service for a covered entity and is bound by a contract (properly called a "business associate contract") to ensure it protects the PHI that it receives as part of the function or service it provides.[18] One example of a business associate is a firm that provides accounting services to a covered entity and, as part of its accounting function, must receive certain PHI. In such a case, the Rule mandates that the covered entity requires the business associate to enter into a business associate contract when providing such services.[19]

The Privacy Rule also explicitly defines the various covered entities that Congress envisioned it would regulate. Generally, a health plan is an "individual or group plan, whether private or governmental, that provides or pays for the cost of medical care."[20] This very broad definition includes such entities and programs as group and individual health plans, HMOs, Medicare, Medicaid, and employee welfare benefit plans. Moreover, a "health care clearinghouse" is a covered entity that processes or facilitates the processing of nonstandard data elements of health information into standard data elements.[21] Clearinghouses typically receive and aggregate data from various providers, health plans, or other clearinghouses and translate the data into an acceptable format for use by a receiving party.[22] Lastly, a "health care provider" is a provider of medical or health services or an entity that "furnishes, bills, or is paid for health care in the normal course of business."[23] However, only those providers who transmit any data in electronic format in connection with a standard HIPAA transaction are considered covered entities.[24] Once a provider transmits or stores any health information electronically, he becomes a covered entity, and all of the health information he uses or discloses becomes PHI under the Rule.[25] Again, for the purposes of this article, health care providers include health care practitioners, such as physicians, nurses, and hospitals.

Providers are permitted, but not mandated, to use or disclose PHI in order to carry out "treatment, payment, or health care operations" (commonly referred to as TPO functions) without a patient's authorization.[26] The definitions of TPO functions include most of the routine day-to-day activities of health care providers.[27] "Treatment" is defined as the provision, coordination, or management of health care and related services and includes coordination or management by a provider or a third party.[28] "Payment activities" include measures taken to obtain reimbursement for providing health care, to obtain premiums, or to determine or fulfill coverage responsibilities.[29] The term "health care operations" is defined very broadly and includes those activities undertaken by, or on behalf of, a covered entity for the purpose of carrying out administrative and management functions of the entity necessary for the support of treatment or payment.[30]

Generally, only the health care operations of a covered entity are covered by the Privacy Rule. Some entities, such as hybrid entities, may be simultaneously engaged in health care and non-health care functions. In such cases, only the hybrid entity's operations involving health care will be regulated by the Rule and its other functions will not be.[31] It is also possible that a single covered entity may perform multiple covered functions, each of which, while regulated by the Privacy Rule, may have separate compliance obligations. Such entities must comply with the Privacy Rule as it applies to each distinct covered function. The Privacy Rule requires that entities engaged in multiple covered functions and hybrid entities ensure separation between operations that use PHI and those that do not in order to prevent unlawful uses and disclosures of PHI, even amongst separate divisions of the same organization.[32]

As part of the Privacy Rule, DHHS also created the "minimum necessary" standard which mandates that a covered entity must limit its use or disclosure of PHI to that which is the minimum necessary to accomplish the intended purpose of the use, disclosure, or request.[33] The minimum necessary standard applies only to uses and disclosures of PHI for payment and health care operations.[34] The standard does not apply to disclosures to, or requests by, providers for treatment purposes so as not to overburden the delivery of health care services.[35] The standard is also inapplicable where a valid authorization has been obtained regarding the PHI, or where the use or disclosure is required by law or is made to the person who is identified by the PHI.[36] DHHS has left much discretion in the hands of health care covered entities to formulate policies and protocol establishing how minimum necessary is to be defined in cases where disclosures and uses are routine. Non-routine disclosures should still be reviewed on a case-by-case basis to ensure the information does not exceed the minimum necessary threshold.

Part II: Consents and Authorizations

Consents and authorizations are similar in that both documents permit providers to disclose PHI under specified circumstances, but neither obligates a provider to disclose the PHI at issue. In fact, unless an exception applies (such as permission to use PHI for TPO functions), a provider may use or disclose information only to the individual patient or pursuant to a patient's consent or authorization.[37] The documents differ since consents allow for the use or disclosure of PHI for TPO functions only, whereas authorizations must be obtained for the use or disclosure of PHI not otherwise permitted or required under the Rule. Furthermore, it is critical to note that even though the Privacy Rule originally required health care providers to obtain patient consent to carry out TPO functions, the final modifica-

tions to the Rule made obtaining patient consent optional because the consent requirement was found to be burdensome to providers and evoked negative reactions from the health care community.[38] Instead, in its current state, the Privacy Rule carves out an exception for TPO functions so that covered entities can use or disclose PHI for such purposes without patient consent or authorization.[39] A legally adequate consent will in no way mitigate against liability when a covered entity uses or discloses PHI for purposes other than TPO functions. In order to avoid violating the Rule in such a case, a specific exception must apply to the particular use or disclosure, or the entity must have first obtained a legally adequate patient authorization. As a practical matter, consents have become largely obsolete.

The Privacy Rule sets forth numerous technical requirements for a legally adequate or valid authorization. A valid authorization must be written in plain language.[40] It must be signed and dated by the patient, include a specific description of the information to be used or disclosed, specifically identify the persons authorized to make and receive the use or disclosure, specify a date or event which triggers the expiration of the authorization, and include revocation rights and instructions.[41] An expiration event must be related to the individual or the purpose of the use or disclosure.[42] If the authorization is to be signed by a patient representative, it must describe the representative's authority.[43] As long as the Privacy Rule's stipulated elements for a valid authorization are satisfied, there are no limits on the breadth or type of information that can be authorized for use or disclosure.[44]

A patient may authorize the use or disclosure of his or her information for any purpose, but typical uses include disclosures for research or marketing purposes. An individual may revoke an authorization at any time, provided the revocation is in writing, except (i) if the covered entity has taken action in reliance on the authorization, or (ii) if the authorization was obtained as a condition of obtaining insurance coverage and other applicable law provides the insurer that obtained the authorization with the right to contest a claim under the policy.[45] The latter exception has the practical effect of allowing insurers to obtain PHI during health insurance claim contestability periods under state law. In other words, in instances where a medical claim is being disputed by the insurer, the patient cannot revoke his authorization and thus prevent access to his information by the insurer until the dispute is resolved.

Generally, an authorization, other than an authorization for a use or disclosure of psychotherapy notes, may be combined with other authorizations.[46] However, authorizations may not be combined when the covered entity has conditioned the provision of treatment, payment, enrollment in the plan, or eligibility of benefits upon one of the authorizations.[47] Typically, a provider may not condition the provision of treatment to an individual on obtainment of an authorization.[48] The Rule sets forth a few exceptions to this general rule, including allowing the provision of research-related treatment to be conditioned on the provision of an authorization.[49] The Privacy Rule does not offer a sample form of an authorization since it is intended to be fluid enough to apply to many different circumstances.

Part III: Exceptions to the Rule: Permissible Disclosures Without Patient Consent or Authorization Apart from Those Made for TPO Functions

There are essentially four permissible disclosures contained in sections 164.510 and 164.512 of the Privacy Rule where a covered entity need not obtain a patient's consent or authorization to use or disclose PHI for purposes other than for TPO functions. First, a covered entity may, as part of its creation and maintenance of a facility directory, use or disclose certain limited general patient information.[50] Second, the Privacy Rule specifies that a covered entity may disclose PHI to the following patient representatives: family members, relatives, close personal friends of the patient, or any other person identified by the patient.[51] However, only that PHI which is directly relevant to such person's involvement with the patient's care or payment related to the patient's health care may be disclosed.[52] For example, a provider may disclose PHI to a patient representative who needs to know about a patient's ambulatory capabilities and medication treatment for the purpose of transporting him, or who is responsible for paying the patient's medical bill and wants to understand the services she is paying for. Third, a covered entity may disclose or use PHI to notify patient representatives of the patient's location, general condition, or death.[53] Finally, a covered entity may disclose PHI to authorized entities providing disaster relief and assistance in disasters, such as floods, fires, and terrorist attacks.[54]

Generally, the Privacy Rule requires that the patient be given prior notice and a reasonable opportunity to object or agree, both of which may be oral, for the above-mentioned exceptions.[55] However, where because of the individual's incapacity, opportunity to object cannot be practicably given, the covered entity may disclose PHI to those involved with the individual's care if, in the exercise of the covered entity's professional judgment, such disclosure is in the individual's best interest and is limited to that information which is relevant to the person's involvement in the individual's care.[56] Similarly, if because of incapacity the individual cannot be afforded the chance to object to the use of her PHI in the facility directory, the cov-

ered entity may use the information if (i) such use is consistent with any prior expressed preferences of the individual known to the entity and (ii) is consistent with the individual's best interest.[57] Also, the Rule does not require individual authorization for national priority uses and disclosures if the covered entity determines in its professional judgment this requirement would interfere with its ability to respond to emergency situations.[58]

All of the allowable uses and disclosures of PHI detailed in the Privacy Rule were designed to permit and promote key national health care priorities.[59] They were also created to obviate unnecessary hindrances in the transmission of PHI, which is essential to providing efficacious health care and facilitating the smooth operation of the health care system.[60] The remainder of this section, and article, focus generally on uses and disclosures to patient representatives other than for notification of a patient's location, general health, or death.

As previously noted, the Privacy Rule provides explicit guidance as to the types of persons DHHS reasonably foresaw as likely having involvement and interest in the care of a patient and to whom a provider could legally disclose PHI. In addition to those parties specifically addressed by 45 C.F.R. § 164.510(b)(1)(i) (2003), which again are family members, relatives, close personal friends of the patient, and any other persons identified by the patient, DHHS contemplated a list of other parties to whom a provider may be legally permitted to disclose PHI.[61] This list includes roommates, boyfriends, girlfriends, colleagues, neighbors, and domestic partners, but was only intended to be illustrative and is by no means all inclusive.[62]

DHHS was cautious to ensure that the Privacy Rule did not change the existing health care delivery practices with respect to: (1) involvement of other persons in patient treatment decisions and (2) informal information sharing among individuals involved in a patient's care.[63] These explicit precautions clearly indicate DHHS' understanding of the importance of providers being able to freely share information with patient representatives. The Rule simply imparts some additional considerations when disclosing PHI to patient representatives that, once providers have come to understand, should maximize privacy without interfering with the coordination of patient care inside and outside of the facility.

Evidenced by its intricate detail, the Rule imparts a careful balance between the patient's rights and need for privacy, and the patient representative's need for access to the patient's PHI in certain appropriate circumstances. Indeed, where a patient is available and has the capacity to make health care decisions, the covered entity must inform the patient and obtain authorization for PHI disclosures to a patient representative unless it can reasonably infer from the circumstances, and based on its professional judgment, that the patient does not object to the disclosure.[64] However, as previously noted, even if the patient is not present, it remains possible for the patient's representatives to receive the information they need in order to be adequately informed and to properly coordinate the patient's health care. If the patient is not present or he cannot practicably be afforded the opportunity to object—for example if he is incapacitated or in an emergency scenario—a provider may disclose PHI that is directly relevant to the patient representative's involvement with the patient's care.[65] The Rule conditions such a disclosure upon the provider exercising his professional judgment and deciding in accordance with the best interests of the patient.[66] It follows that in situations where a patient is unable to offer authorization, either formally in a written document or informally through a verbal communication, the provider may still convey the necessary information to the patient's representatives in order to keep them informed and coordinate care without fear of liability under the Privacy Rule.

Furthermore, the Privacy Rule directly addresses the necessity of patient representatives' involvement with the patient's care and their unavoidable handling of that individual's PHI. It allows a provider to use professional judgment and experience with common practice to make reasonable inferences about the patient's best interests. The Rule explicitly contemplates some common situations in which a provider's judgment to disseminate PHI to a patient representative would be reasonable, such as allowing the representative to pick up the patient's prescriptions, X-rays, or other similar forms of PHI.[67] Furthermore, the Privacy Rule does not require providers to verify the identity of a patient representative where the provider has reasonably inferred from the patient's actions that the patient representative is involved with the patient's care.[68] For example, a provider may discuss treatment with a patient representative when the patient has freely brought that person into the emergency room or doctor's office. On the other hand, however, a provider would not be allowed to disclose the details of a patient's medical history to a person who is simply picking the patient up from surgery.

The Privacy Rule affords providers broad discretion with respect to disclosures to patient representatives so long as providers make disclosures consistent with good health practice and ethics.[69] The Rule was not intended to thwart the lines of communication between providers and those caring for patients, but it does place the onus on the covered entity to make a case-by-case assessment using professional judgment, take rea-

sonable steps to protect PHI, and only disclose information to those involved with the patient's care if it is in the patient's best interest and directly relevant. Despite the overarching privacy thrust of the HIPAA regulations, a provider has a great deal of latitude when determining disclosures to patient representatives, and as long as such disclosures are made with reasonable professional judgment and in the patient's best interest, there should be no resulting liability.

Part IV: Providers Fearing Liability: Curbing the "HIPAA Scare"

A full understanding of the situations in which providers may disclose PHI to patient representatives should allay their fears of liability under the Rule and curtail the HIPAA Scare. While most of these situations have been addressed in the previous sections, there are some areas of concern under the Rule that necessitate a more in-depth analysis. Section A of this Part seeks to provide additional clarification about some areas that continue to promote the HIPAA Scare through a more detailed analysis and by offering suggestions for potential modifications to the Rule. Specifically, Section A discusses (i) the knowledge requirement for patient revocation of prior authorizations and (ii) incidental disclosures. Section B of this Part, as an alternative approach to mitigating the HIPAA Scare, contemplates a unique interpretation of the Privacy Rule; one that would consider provider disclosures of PHI to patient representatives to fall within the purview of TPO function permitted disclosures.

Section A: Mitigation of HIPAA Scare Through Analysis and Clarification of Problem Areas

i) Knowledge Requirement for Patient Revocation of Prior Authorizations

Let us recall that, under the Privacy Rule, a patient may revoke his authorization at any time.[70] However, it is not the actual revoking document itself that is important under the Rule, but the provider's knowledge of the revocation. If the event that triggers the expiration of the authorization, or "expiration event," is known by the covered entity to have transpired, the authorization is defective.[71] Also, if the covered entity knows the authorization has been revoked, it is defective.[72] The writing of a revocation may not always trigger the knowledge element of this provision. One can imagine a case where a provider is using or disclosing information in accordance with an authorization, and the patient has revoked the authorization without informing the provider. Clearly, the provider cannot be expected to know that the authorization has been revoked if not informed in some reasonably adequate manner. Conversely, however, providers must be aware that a written revocation is not necessary to meet the knowledge requirement of this provision.[73] In other words, if a patient makes it orally clear that he desires a revocation of his prior authorization then the provider has knowledge of the revocation and the authorization is invalid.[74]

The practical application of the current state of the Privacy Rule regarding the knowledge requirement becomes very confusing in cases where the provider is a large complex health care facility with numerous divisions. In such cases, there is a tremendous amount of administrative difficulty in revoking an authorization or making changes to the document. The diverse entity must make the changes according to the patient's requests and then inform all parties within the entity, such as employees, who deal directly with the patient or handle the patient's PHI, about the alterations. There is language in the Federal Register demonstrating that receipt of a request for an authorization change by one division or employee of a complex covered entity may not establish immediate knowledge of the change by all other divisions and employees of the company.[75] In fact, DHHS stated that "although an authorization must be revoked in writing, the covered entity may not always 'know' that an authorization has been revoked."[76]

DHHS could resolve this potential problem when the knowledge threshold is actually met by modifying the Privacy Rule. A suggested modification would involve infusing a temporal element into the knowledge standard which would be based proportionally on the size and complexity of the covered entity. For instance, a large internally-complex health care entity, such as an expansive tertiary care hospital, would be given more time than a smaller entity, such as a small group practice, to comply with a patient's requested changes in her authorization. In other words, the larger health care organization would have additional time in which to ensure every component and/or person within the company had actual knowledge of the authorization revocation. Clearly, in such instances, the Privacy Rule would have to mandate that the patient be informed before signing the authorization about the additional time a large complex health care entity is granted and the delay that might occur should the patient request a change in her authorization.

An alternative solution to this problem with determining when the Privacy Rule's knowledge threshold has been met is to modify the Rule to mandate a specified time period during which the patient cannot alter her authorization both after its creation and subsequent to any alterations. Such a solution would at least afford a set period of time during which larger covered enti-

ties could be certain changes to the authorization would not be made and, in the meantime, ensure that every division and employee handling the PHI is made aware of the authorization or its changes. This solution is lacking, as compared to the first, because it does not resolve the problem of making sure all company divisions and employees have knowledge of the authorization or change at the time it is made known by the patient. Furthermore, this second proposed solution differs from the first in that it is a more direct infringement on the patient's ability to make changes to her authorization and thus is a more blatant attack on the patient's ability to control her own PHI. Regardless, either proposed solution would have to require that the provider ensure the patient is fully informed about the time element which may impact either how long the provider has to implement the changes in the authorization or, alternatively, when the patient can actually request those changes.

ii) Incidental Disclosures

Another area of concern for many providers involves incidental disclosures. In other words, providers fear potential liability resulting from confidential conversations being overheard or from PHI being obtained by unauthorized parties from such sources as sign-in sheets, X-ray light boards, bedside charts, or empty prescription vials. In response to these fears, DHHS adopted, as part of its final modification to the Privacy Rule, a provision which explicitly permits certain incidental uses and disclosures that occur as a by-product of a use or disclosure otherwise permitted by the Privacy Rule.[77] In the context of our discussion, providers may fear unauthorized people hearing a confidential communication to a bona fide patient representative. Simply stated, so long as the provider applies reasonable safeguards consistent with 45 C.F.R. § 164.530(c) to protect the PHI, and is otherwise permitted to disclose to the patient representative, the provider is not in violation of the Rule. In fact, DHHS has clarified that the Privacy Rule is not intended to impede customary and necessary health care communications or practices, nor does it require providers to limit all risk of an incidental PHI use or disclosure. Furthermore, DHHS has made it clear that "the Privacy Rule must not impede essential health care communications and practices. Prohibiting all incidental uses and disclosures would have a chilling effect on important communications . . . and, therefore, would negatively affect individuals' access to quality health care."[78] Just as the Privacy Rule confers a great deal of discretion to providers in terms of deciding appropriate receivers of PHI, it also defers to providers the responsibility of protecting PHI from incidental disclosures to improper receivers of PHI.

Section B: Mitigating the HIPAA Scare by Considering Disclosures to Patient Representatives to Be Permissible TPO Function Disclosures

The HIPAA Scare could be mitigated greatly if provider disclosures to patient representatives were TPO function permitted disclosures. If we consider provider disclosures to patient representatives to be part of the coordination of a patient's care, and the definition of treatment includes such care coordination, then disclosures to patient representatives fall within the meaning of the definition of TPO functions. This argument is not only strong from a purely logical perspective, but can be construed from the current state of the Privacy Rule and garners strength from an analysis of the rule-making history. Theoretically, this unique interpretation of the law could be industry changing since it would mean providers' disclosures to patient representatives would be similar to other TPO function disclosures. As such, no authorization would be needed, and as our discussion in Part II pointed out, the minimum necessary standard would not be a concern because it does not apply to the treatment component of TPO functions. The resulting impact of this interpretation would be substantial and, as a practical matter, would afford providers much greater discretion when communicating with patient representatives.

In order to understand this proffered interpretation of the Privacy Rule, it is critical to look at the rule-making history and DHHS' choice of language throughout this history. In the proposed version of the Privacy Rule, DHHS defined "treatment" to include "the coordination of health care or other services among health care providers and third parties authorized by the health plan or the individual."[79] Under the proposed rule, it appears that DHHS intended for "treatment" to include only disclosures to third parties who were authorized by the health plan or the individual. Presumably, patient representatives would be included within the definition of third parties. Accordingly, a patient representative, as a type of third party, would have only been allowed to receive PHI disclosures from a provider pursuant to a valid authorization as discussed in Part II of this article. Therefore, if the proposed rule's language had remained unchanged and had been promulgated, it appears that an argument positing that treatment was intended to include coordination of care between a provider and a patient representative would not stand.

However, the language did change before the final version of the Privacy Rule was enacted. The language was modified so that now the definition of treatment includes both the coordination of health care or related

services by one or more health care providers,[80] and the "coordination" of the patient's health care "by a health care provider with a third party."[81] DHHS did not specifically exclude patient representatives as a potential third party and did not give any other guidance as to who was intended to be a third party. Therefore, it would seem a patient representative could be a "third party." Furthermore, since the proposed rule was modified so that language in the definition of treatment requiring an authorization for disclosures made to third parties was excerpted, and since "coordination of care" was not explicitly defined, it can be argued that DHHS implicitly intended to create an exception for disclosures made by providers to patient representatives. Clearly, this exception would only apply in situations where the patient representative is intimately involved with the patient's care and where the provider reasonably believes disclosures to this third party are essential to the coordination of care and thus the treatment of the patient.

There is additional language contained within the Federal Register that adds clout to this unique argument. DHHS declared, "Treatment refers to activities taken by the provider on behalf of a single patient. . . . Activities are considered treatment only if delivered by a health care provider or by a health care provider working with another party."[82] A patient representative is often "another party" who works with the providers to engage in treatment activities. DHHS obviously understood the need for a provider to work with other parties to effectively treat patients. As was the case in the previously discussed elder/adult-child hypothetical, in many instances a provider must work with a patient representative to effectively treat a patient.

Based on the current state of the Privacy Rule and a comparison between it and the proposed rule, it appears disclosures by providers to patient representatives, as coordination of care, could fall within the definition of treatment under TPO functions. However, a contradictory inference, which would militate toward making this argument relatively untenable, can be drawn from the fact that DHHS explicitly addressed an entire section of the Privacy Rule to regulating disclosures of PHI made by providers to those parties whom this article has referred to as patient representatives in situations other than for TPO functions. Nevertheless, DHHS does not make it clear that such an interpretation is erroneous, and the argument still stands, at a minimum, to add credence to this article's general thesis that the Privacy Rule, when properly understood, does not establish barriers to providers' communications with patient representatives.

Conclusion

If interpreted and applied correctly, the Privacy Rule should not interfere with a provider's ability to communicate with patient representatives who are necessary for efficacious care to be delivered to the patient. At the same time, proper application of the Rule should effectively achieve Congress' laudable goals of increasing the security of PHI and imparting precautionary standards for the safe transmission of this information in today's complicated and highly-technological health care delivery system. If providers are adequately educated and properly informed about the standards applicable to and limitations on disclosures to patient representatives, the health care delivery system should remain relatively unchanged in terms of ability to deliver effective and efficient care to the patient, and the HIPAA Scare will ultimately subside.

Endnotes

1. 45 C.F.R. § 160.103 (2003).
2. Health Insurance Accountability and Portability Act (HIPAA), Pub. L. No. 104-191 § 264 (1996).
3. 45 C.F.R Part 164 Subpart E (2003).
4. Health Insurance Accountability and Portability Act (HIPAA), Pub. L. No. 104-191, Preamble (1996).
5. Information Systems Privacy, and Administrative Simplification, S. 1779, 100th Cong. § 5101 *et seq.* (1993).
6. Health Insurance Accountability and Portability Act (HIPAA), Pub. L. No. 104-191 § 1171(4) (1996).
7. Proposed Rule on the Privacy of Individually Identifiable Health Information: Before the Senate Committee on Health, Education, Labor, and Pensions, 106th Cong. 2 (2002) (opening statement of Senator Jeffords, Chairman, Senate Committee on Health, Education, Labor, and Pensions).
8. Health Insurance Accountability and Portability Act (HIPAA), Pub. L. No. 104-191 § 264(c)(2) (1996).
9. 45 C.F.R. § 164.530(c) (2003).
10. Health Insurance Accountability and Portability Act (HIPAA), Pub. L. No 104-191 § 1175(b)(1)(A) and (B) (1996); *see also* 45 C.F.R. § 164.534.
11. Health Insurance Accountability and Portability Act (HIPAA), Pub. L. No. 104-191 §§ 1176, 1177 (1996).
12. *See* 65 Fed. Reg. 82500 (December 28, 2000) and 45 C.F.R. § 164.510(b)(1)(i) (2003) for those parties specifically enumerated by DHHS.
13. 45 C.F.R. § 160.103 (2003).
14. *Id.*
15. *Id.*
16. 45 C.F.R. §§ 164.502(d)(2), 164.514(a) and (b) (2003).
17. 45 C.F.R. § 160.103 (2003).
18. *Id.*
19. *Id.*
20. *Id.*

21. *Id.*
22. *Id.*
23. *Id.*
24. *Id. See also* 45 C.F.R. § 160.102(a)(3) (2003).
25. *Id.*
26. 45 C.F.R. § 164.502(a)(1) (2003).
27. 45 C.F.R. § 164.501 (2003).
28. *Id.*
29. *Id.*
30. *Id.*
31. 45 C.F.R. § 164.504(a) (2003).
32. 45 C.F.R. § 164.504(f) (2003).
33. 45 C.F.R. § 164.502(b) (2003).
34. *Id.*
35. 45 C.F.R. § 164.502(b)(2)(i) (2003).
36. 45 C.F.R. § 164.502(b)(2) (2003).
37. 45 C.F.R. § 164.502(a)(1) (2003).
38. 67 Fed. Reg. 14781 (March 27, 2002).
39. 45 C.F.R. § 164.502(a)(1)(ii) (2003).
40. 45 C.F.R. § 164.508(c)(3) (2003).
41. 45 C.F.R. § 164.508(c)(1) & (2) (2003).
42. 45 C.F.R. § 164.508(c)(1)(v) (2003).
43. 45 C.F.R. § 164.508(c)(1)(vi) (2003).
44. 65 Fed. Reg. 82517 (December 28, 2000).
45. 45 C.F.R. § 164.508(b)(5) (2003).
46. 45 C.F.R. §§ 164.508(b)(3) and 164.508 (b)(3)(iii) (2003).
47. 45 C.F.R. §§ 164.508(b)(3)(iii).
48. 45 C.F.R § 164.508(b)(4) (2003).
49. *Id.*
50. 45 C.F.R. § 164.510(a) (2003).
51. 45 C.F.R. § 154.510(b)(1)(i) (2003).
52. *Id.*
53. 45 C.F.R. § 154.510(b)(1)(ii) (2003).
54. 45 C.F.R. § 154.10(b)(4) (2003).
55. 45 C.F.R. § 154.510 (2003).
56. 45 C.F.R. § 154.510(b)(3) (2003).
57. 45 C.F.R. § 154.510(a)(3) (2003).
58. 45 C.F.R. § 164.510(b)(4) (2003); *see also* 65 Fed. Reg. 82524 (December 28, 2000).
59. 65 Fed. Reg. 82521 (December 28, 2000).
60. *Id.*
61. 65 Fed. Reg. 82522 (December 28, 2000).
62. *Id.*
63. *Id.*
64. 45 C.F.R. § 164.510(b)(2) (2003).
65. 45 C.F.R. § 164.510(b)(3) (2003).
66. *Id.*
67. 45 C.F.R. § 164.510(b)(3) (2003).
68. 65 Fed. Reg. 82523 (December 28, 2000).
69. *Id.*
70. 45 C.F.R. § 164.508(b)(5) (2003).
71. 45 C.F.R § 164.508(b)(2)(i) (2003).
72. 45 C.F.R. § 164.508(b)(2)(iii) (2003).
73. 65 Fed. Reg. 82515 (December 28, 2000).
74. *Id.*
75. *Id.*
76. *Id.*
77. 45 C.F.R. § 164.502(a)(1)(iii) (2003).
78. 67 Fed. Reg. 53194 (August 14, 2002).
79. 65 Fed. Reg. 82497 (December 28, 2000).
80. 45 C.F.R. § 164.501 (2003).
81. *Id. See also* 65 Fed. Reg. 82497 (December 28, 2000).
82. 65 Fed. Reg. 82497 (December 28, 2000).

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Collateral Estoppel and Professional Disciplinary Proceedings: Determinations in Related Proceedings May Be Binding in Professional Misconduct Hearings

By Barbara K. Hathaway

The outcome of other legal proceedings can have an impact on professional disciplinary proceedings against licensed health care professionals in a variety of ways. Physicians and other professionals can be found guilty of professional misconduct based on determinations in other proceedings, such as disciplinary proceedings in other states or administrative proceedings involving other regulations or laws. This permits the public agencies responsible for professional disciplinary proceedings to avoid using their scarce resources to re-try issues that the licensed professional has already had an opportunity to litigate, and thereby promotes the efficient and effective regulation of the professions. Parties to private civil actions, such as medical malpractice actions, may also attempt to rely upon the results of professional disciplinary proceedings. Accordingly, it is important that an attorney representing a health care professional in any legal matter consider the potential ramifications in future legal proceedings.

The Statutes Governing Professional Disciplinary Proceedings

Professional misconduct proceedings against physicians, physicians' assistants and specialists' assistants are handled by the state Department of Health's Board for Professional Medical Conduct ("BPMC"). Responsibility for regulating other professions, including dentistry, nursing, and pharmacy, resides in the state Education Department's Office for Professional Discipline ("OPD"). With some differences, the statutes governing both agencies provide that a licensee may be found guilty of professional misconduct based solely upon disciplinary action taken by a sister state's professional licensing agency, or a finding of guilt by an administrative tribunal or a criminal court. In such cases, the licensee is precluded from contesting his guilt, and is limited to presenting evidence relevant to the nature and severity of the penalty.

In certain situations, professional misconduct is defined by reference to the outcome of other proceedings. Specifically, Education Law § 6530(9)(a) states that a physician or physician's assistant is guilty of professional misconduct by being convicted of a crime under New York law, federal law, or the law of another jurisdiction, if the acts would constitute a crime under New York law. A professional misconduct charge may also be based on a finding of improper professional conduct by the professional disciplinary agency of another state, where the conduct upon which the finding is based would constitute professional misconduct under New York law.[1] With respect to physicians only, a number of actions by another state's disciplinary authority can result in a finding of professional misconduct in New York, including (1) having one's license to practice medicine revoked, suspended, or having other disciplinary action taken, (2) having a license application refused, revoked or suspended, or (3) voluntarily or otherwise surrendering one's license after disciplinary action is instituted, if the underlying conduct would be professional misconduct in New York.[2] Finally, one may also be found guilty of professional misconduct based on having been found guilty in an adjudicatory proceeding of violating a state or federal statute or regulation when the decision is final and no appeal is pending, or after resolution of the proceeding by stipulation or agreement, where the conduct would constitute professional misconduct under the laws of New York.[3]

Note that whether the determination is based upon a professional disciplinary proceeding in another state, a criminal proceeding or a proceeding involving violation of a statute or regulation, the elements of the offense must match up with the elements of a crime or professional misconduct in New York. Only subsection c, however, which deals with violations of statutes or regulations, requires that the determination be final and that no appeal be pending. In addition to section 6530(9), violation of certain other provisions of the Public Health Law ("PHL") also automatically constitutes professional misconduct. These include PHL § 2803-d involving patient abuse or neglect,[4] and willful violations of section 230(11), requiring licensees to report professional misconduct by other professionals.[5] Any willful or grossly negligent failure to comply with any substantial provisions of federal, state, or local law governing the practice of medicine is also automatically deemed to be professional misconduct.[6]

The provisions governing other professions, such as dentistry and nursing, are similar. Education Law § 6509(5) provides that one is guilty of professional misconduct if one is (1) convicted of a crime under New York or federal law, or the laws of another state where the conduct would be a crime in New York, (2) found guilty of improper professional practice by another state's professional disciplinary agency where the con-

duct would also be professional misconduct under New York law, or (3) having one's license revoked, suspended or other disciplinary action taken, or having one's license application refused, revoked or suspended, or voluntarily or otherwise surrendering one's license, after disciplinary action is instituted by another state, where the conduct would constitute professional misconduct in New York. Unlike section 6530(9)(c) (which governs physicians), section 6509 does not include a broad provision covering all statutory and regulatory violations, but includes violations of PHL Article 33, governing controlled substances.[7]

Accordingly, a licensee may be charged with and found guilty of professional misconduct for having one of the previously described determinations rendered against him or her in another proceeding. In such cases, a full hearing is not held, and the licensee has no opportunity to contest his or her guilt of the conduct at issue in the prior proceeding. Rather, evidence is limited to "evidence and testimony relating to the nature and severity of the penalty to be imposed upon the licensee."[8] PHL section 230(10)(p) also provides that, where the charges are based on a criminal conviction in another state, evidence may be offered to show that the conviction would not be a crime in New York. Thus, an attorney representing a health care professional in a criminal proceeding, a professional disciplinary proceeding in another state, or a civil or administrative proceeding involving any state or federal statute or regulation touching upon the practice of the profession, such as those governing the Medicaid and Medicare programs, or those concerning patient neglect or abuse, or controlled substances, must be conscious that any determination in that proceeding could potentially be used to establish professional misconduct. Although the criminal or administrative proceeding may be resolved by the payment of a fine or restitution, or some other penalty, the professional license may be in jeopardy through a subsequent professional disciplinary proceeding.

The Doctrine of Collateral Estoppel

These statutory provisions largely track the concepts of collateral estoppel. Indeed, even before the enactment of these statutes, courts used collateral estoppel to preclude licensees from re-litigating determinations made in prior proceedings, where the elements of the doctrine were satisfied. Under the New York law of collateral estoppel, more recently called issue preclusion, a prior determination is given conclusive effect in a subsequent proceeding where (1) the issue sought to be precluded is identical to a material issue necessarily decided in the prior proceeding, and (2) there was a full and fair opportunity to contest this issue in the prior proceeding. The proponent of issue preclusion must show the identity of the issues, whereas the opponent bears the burden of demonstrating the absence of a full and fair opportunity to litigate the issue.[9] In applying the professional disciplinary statutes expressly providing for expedited proceedings, courts have continued to draw upon the principles of collateral estoppel, noting that it is a flexible doctrine intended to produce justice and fairness. While the principles of efficiency and judicial economy underlying collateral estoppel often dictate that a licensee not be permitted to re-litigate the conduct involved in a prior proceeding, courts have also declined to give conclusive effect to the prior determination where the same issues were not actually litigated, the parties are not in privity, or other factors would render preclusion unfair.

Professional Disciplinary Actions of Other States

One common use of preclusion principles, and undoubtedly the area which has generated the most litigation, is the practice of affording reciprocal effect to the determinations of sister-state professional disciplinary agencies. Thus, if one is found guilty of professional misconduct in another state, that is sufficient to establish guilt in New York, so long as the conduct at issue would be professional misconduct under New York law. For physicians, under Education Law § 6530(9)(d), it is sufficient if any action is taken by the sister-state agency, including a temporary suspension or denial of a license application, even where there is no actual adjudication of guilt. Drawing on the principles of collateral estoppel, however, courts have declined to give conclusive effect to such sister-state determinations in certain instances. Courts have looked at such factors as the fairness and completeness of the proceedings in the other state (e.g., was a full hearing held), the wording of any stipulation or consent decree resolving the matter, and, in particular, whether any admissions were made or, by contrast, whether the licensee specifically denied any wrongdoing. The gravity of the conduct involved and the severity of the penalty imposed by the sister state in comparison to that imposed by New York also bear on the decision.

In *Halyalkar v. Board of Regents*,[10] the Court of Appeals refused to give preclusive effect to a prior New Jersey consent order. Petitioner, a physician, was charged with knowingly and willfully filing false certifications with insurance companies, attesting that he had performed medical examinations that he had not actually performed. On his attorney's advice, he settled the charges, agreeing to a three-month suspension of his license and restitution. The order was signed in the lawyer's office, and no hearing was held. The consent order contained no admission or adjudication of his guilt. Subsequently, the physician was also charged with professional misconduct in Pennsylvania based on the New Jersey suspension. In the Pennsylvania proceeding, petitioner, a recent immigrant, explained that he had signed the insurance forms at the request of a friend, and that he believed they were related to examinations that

he had indeed performed. He further stated that he settled the New Jersey charges simply to avoid the expense of contesting them, relying upon his attorney's advice that he would be subject to no further penalty. The Pennsylvania Hearing Examiner specifically found that his conduct did not rise to the level of willful misconduct, and he was given a private letter of reprimand.

New York then took action based upon the same conduct. Although the Hearing Committee declined to apply collateral estoppel to the prior determination, the Board of Regents disagreed, finding petitioner guilty of willfully and knowingly filing false medical reports, and suspending his license for one year. The Appellate Division, Third Department, found that the New Jersey determination was conclusive.

The Court of Appeals reversed. The Court found that because the issue of the willfulness of the physician's conduct was not actually litigated in the New Jersey proceeding, the "identicality of issue" element of collateral estoppel was absent. The Court concluded that, given the circumstances of the New Jersey matter, including the informality of signing the consent order in the lawyer's office, the lack of any admission of guilt, and the minimal penalty imposed, to give this determination "preclusive effect would, in our view, give it an effect neither justified by its language nor the circumstances surrounding its signing . . ."

In the years since *Halyalkar*, the courts have continued to draw upon the principles of collateral estoppel in applying the statutes that give conclusive effect to other determinations. Thus, there are two issues that must be addressed in determining whether a prior determination will be conclusive in a professional disciplinary proceeding. The first is, are the issues identical? This is embodied in the statutory requirement that the conduct underlying the sister-state action would, if committed in New York, constitute professional misconduct under New York law. As seen in *Halyalkar*, all of the elements of the offense in New York must have been actually litigated and decided.[11]

The second issue governing the preclusive effect of a prior determination is whether the licensee had a full and fair opportunity to litigate the matter. Here, the nature and extent of the procedures used in the other state will be important. When no hearing has been held and no findings made in the sister state, the courts have in some cases been reluctant to preclude a licensee from contesting the charges on the merits in New York. In *Becker v. DeBuono*,[12] the Third Department concluded that, "Inasmuch as no hearing was ever held in New Jersey and no findings of guilt were ever made, it would defy due process and the concept of fairness to use unsubstantiated allegations and inconclusive findings with the force of affirmative or offensive collateral estoppel effect against petitioner."

Nonetheless, that the charges in the other state were settled without a hearing does not preclude the determination from being dispositive in a New York professional disciplinary proceeding. Courts have recognized that waiving one's rights to contest the charges by entering into a settlement raises an inference that the charges are meritorious. Thus, in *Hatfield v. Dep't of Health*,[13] the court upheld the use of an Illinois stipulation of settlement, even where the stipulation specifically denied the allegations. The wording of the stipulation or consent order, however, is critical in such cases. *Khan v. New York State Dep't of Health*[14] vividly illustrates the importance of the language in the stipulation. Petitioner had entered into two consent agreements in Arizona. One, in which he stipulated to extensive factual findings, was properly given collateral estoppel effect. The other, however, was not preclusive, since it specifically stated that petitioner entered into the agreement "for the sole purpose of terminating the dispute" and provided that "nothing contained [therein] constitutes an admission . . ." In *Herberman v. Novello*,[15] the Third Department clarified the standard, stating that, "[i]t is only where the consent order specifically provides a disclaimer that nothing therein constitutes an admission of wrongdoing that preclusive effect will be denied." There need be no determination of wrongdoing or admission of guilt. Thus, while in earlier cases the courts appeared reluctant to give preclusive effect where there was no factual record either through a hearing or stipulations of fact,[16] this no longer appears necessary. So long as the elements of the offenses are the same, and there is no specific language denying that the settlement constitutes an admission, collateral estoppel will apply.[17]

As noted, in addition to guilty determinations and settlements, other actions by foreign disciplinary agencies can also be preclusive, such as denial of a license application or voluntary surrender of a license. In *Sternberg v. Administrative Review Board*,[18] the licensee surrendered his license in Florida. The court said that to prevent New York from considering the facts at issue in Florida "would be incongruous, for it would insulate from discipline in New York those who have managed, by the simple expedient of voluntarily sacrificing their licenses, to avoid a formal adjudication of guilt in another jurisdiction—the very concern Education Law § 6530(9)(d) was designed to meet."

In *Hason v. Dep't of Health*,[19] the court held that a physician was barred from contesting that he was impaired by a mental illness, based on California's denial of his application for a medical license on that ground. The California denial was based on a full evidentiary hearing at which petitioner was represented by counsel. The court specifically noted that finality was not required under Education Law § 6530(9)(d), and that "neither the fact that the California proceeding involved

a license denial as compared to the suspension of a license here, nor the fact that petitioner bore the burden of proof in the California proceeding but not in the New York proceeding precludes according collateral estoppel effect to the California determination."[20]

In conclusion, the statutes permitting the New York disciplinary agencies to rely upon the determinations of other states in expedited proceedings serve an important function, by preserving the scarce administrative resources available to discipline health care professionals who may be dangerous or dishonest. The agencies are spared the time and expense of having to prove the same facts at issue in the sister state, which may be especially difficult in these cases because the evidence and witnesses are likely to be located in the other state. While it is important that the licensees be afforded fair procedures, it is likewise important that they not be permitted to escape the consequences of their misconduct in other states by simply moving their practice to New York. It is also fair that settlements be binding since, as the Third Department has recognized, settling charges even without a specific admission often raises an inference that there was some merit to the allegations. Moreover, the licensee had an opportunity to contest the charges, but declined to do so. While in the early cases courts seemed persuaded by arguments that the licensee could not have anticipated that the determination in another state could have ramifications in New York, now that the criteria under which such determinations will be deemed conclusive have been increasingly clarified by the courts, this argument should lose its force. There is now every reason for the licensee to know that any determination, unless it is a settlement with a specific disclaimer, can be used to establish professional misconduct in New York, as long as the elements of the offense are the same as the New York professional misconduct charge.

Criminal and Administrative Violations

In addition to professional disciplinary determinations of other states, professional misconduct charges may be based upon criminal convictions—either under New York or federal law, or the laws of other states, if the elements of the offense would be a crime in New York. Charges may also be based upon violations of state or federal statutes or regulations, where the violation would be professional misconduct, but only after a final determination in an adjudicatory proceeding where there is no appeal pending. This provision is often used when a licensee has been found to have violated the rules and regulations governing the Medicaid and Medicare programs.[21] Charges have also been based on violation of Workers' Compensation Board rules,[22] and violation of PHL § 18, governing access to medical records.[23] There are also specific statutory provisions providing that violation of PHL Article 33, concerning controlled substances, constitutes professional misconduct.[24]

Courts have rejected arguments that, after being found guilty of one of the aforementioned violations, a licensee cannot be subjected to a professional disciplinary proceeding for the same conduct. They have reasoned that the purposes underlying professional disciplinary proceedings and the penalties available are sufficiently distinct.[25] Only in a professional misconduct proceeding can the state suspend or revoke a license, and the fines or other penalties available in other proceedings therefore cannot protect the public from the continued practice of a dangerous or unethical professional.

The prior determination, however, must include all the necessary elements to demonstrate that the conduct would constitute professional misconduct. Thus, in *Abraham v. Ambach*,[26] a Department of Social Services ("DSS") proceeding involving violations of the Medicaid rules did not establish professional misconduct, because nothing in the DSS record supported a finding that the conduct was willful, an element of the professional misconduct charge.

Prior Dismissals or Other Actions by the Disciplinary Agency

While state professional disciplinary agencies are often permitted to rely upon prior determinations to prove professional misconduct, licensees have not been similarly successful in relying upon past actions by the agencies to prevent professional disciplinary proceedings. Thus, an agency's prior dismissal of charges or a decision not to proceed during a previous investigation will not preclude the agency from later bringing charges based upon the same facts. This is consistent with the general principle that the government cannot be estopped from exercising its regulatory authority. This result also serves the public interest, as it permits the state to proceed against a licensee who may be a danger to the public health when, for a variety of reasons, charges may now be warranted although they could not have been effectively pursued previously. For example, additional facts could be discovered which make the case stronger or indicate a pattern of similar misconduct. In *Lombardo v. DeBuono*,[27] DOH was permitted to charge petitioner with misconduct based on the same facts it had previously investigated and dropped. The doctrine of res judicata, generally applicable to quasi-judicial administrative determinations, did not apply because the investigation was not adjudicative and thus was not quasi-judicial.

Similarly, in *Giffone v. DeBuono*,[28] DOH had initially investigated complaints by two patients, closing the investigations without bringing charges. Later, after additional patients came forward with similar complaints, petitioner was charged with professional misconduct based on those as well as the original complaints. The court held that BPMC was not precluded from

bringing charges, even in the absence of new evidence to support them. In *Ostrow v. Commissioner of Education*,[29] the court held that BPMC was not barred from bringing new charges after a prior statement of charges had been dismissed on procedural grounds. The first charges involved the same patient, but failed to specifically allege physical or sexual contact. The Board of Regents dismissed the matter without prejudice because the facts as stated in the charges failed to give the physician fair notice of the charges. Collateral estoppel did not bar the new charges, because the specific allegations of sexual contact had not been raised or determined in the first proceeding. The disciplinary agency also will not be barred from bringing charges of professional misconduct simply because it renewed a professional license after the alleged misconduct occurred.[30]

Dismissal of a proceeding involving a hospital or other third party also will not bar professional disciplinary charges against a licensee based on the same facts, due to the different focus of the proceedings. In *Heins v. Commissioner of Education*,[31] DOH initially brought a proceeding against a hospital, seeking to revoke the hospital's operating certificate, claiming that improper care had caused the deaths of two patients. The hearing officer dismissed the charges, finding that the Department had failed to prove that the deaths were preventable. Petitioner was then charged individually with professional misconduct, in connection with the same two patient deaths. The court held that the professional misconduct proceeding was not barred, because the issues were not the same. The issue in the professional disciplinary proceeding was whether the physician's care fell below the required standard of care, not whether the deaths were preventable. The court further reasoned that "the focus in the proceeding to revoke the hospital's operating certificate was the conduct of the agents of the hospital, including petitioner, while the focus of the disciplinary proceeding was the professional conduct of petitioner himself."

Reliance on Professional Disciplinary Determinations by Private Litigants

Private litigants, primarily patients in medical malpractice actions, have attempted to use guilty determinations in professional disciplinary proceedings offensively to prove their cases, while licensees have argued that dismissal of professional disciplinary cases should preclude private actions based on the same events. Due to the different nature of the proceedings and the lack of privity between the parties, courts have generally not accepted collateral estoppel arguments in such cases, although the Court of Appeals has left open the possibility that collateral estoppel may apply in appropriate situations.

In *David v. Biondo*,[32] the Court of Appeals held that the dismissal, after a hearing, of professional disciplinary charges did not preclude a subsequent civil action by the patient. The Court reasoned that the patient was not the real party in interest in the administrative proceeding, but testified simply as a fact witness. She did not control the proceedings and, indeed, had little input into how the matter was litigated. Thus, she did not have sufficient control or participation in the case to be in privity with OPD. As a policy matter, the Court was also concerned that patients would be deterred from reporting complaints to the professional disciplinary agencies, out of fear of jeopardizing their private civil cases.

In *Jeffreys v. Griffin*,[33] the roles were reversed. The physician had been found guilty of professional misconduct, and the patient invoked collateral estoppel in her civil action. In a case with a complicated procedural history, the Court held that a BPMC determination finding a physician guilty did not preclude him from contesting liability on the merits in a related private civil action. In *Jeffreys*, the physician's alleged sexual misconduct with the patient spawned criminal, civil and administrative proceedings. The physician was convicted in the criminal case, and BPMC also found him guilty of professional misconduct, aware that he had recently been convicted. The patient also won summary judgment in her civil action, based on the criminal conviction. However, the criminal conviction was then reversed on appeal, and the physician was retried and acquitted. Although the formal elements of the doctrine were satisfied, the Court of Appeals declined to apply collateral estoppel. The same issue had been decided in a quasi-judicial proceeding, and the parties were in privity. It was impossible to know, however, whether the BPMC hearing committee had been influenced by the criminal conviction. Given the physician's later acquittal at a retrial, fairness dictated permitting the physician to defend himself on the merits. These facts are obviously somewhat unusual.

The Third Department reached a similar result in *Stevenson v. Goomar*.[34] A patient argued that an administrative finding that a physician had committed professional misconduct should be binding in her medical malpractice action. Despite the elements of collateral estoppel being met, the court found that preclusion should not apply, primarily due to the different procedures governing the two proceedings. In the administrative proceeding, there was no discovery, the rules of evidence did not apply, there was no right to a jury, and the scope of judicial review in an Article 78 proceeding was extremely limited. By contrast, in a civil action the physician has a right to a trial before a jury in which the rules of evidence apply, extensive pre-trial discovery is available, and a fuller review is conducted on appeal. The court also noted that the physician had not chosen to liti-

gate the facts in the administrative forum. Thus, fundamental fairness dictated that preclusive effect not be given to the administrative determination.

The Court of Appeals has left open the possibility, however, that patients will be able to use favorable professional disciplinary determinations to establish their private medical malpractice claims, specifically stating that its decision in *David v. Biondo* "does not foreclose a plaintiff from invoking collateral estoppel when a Hearing Committee disciplines a physician." As opposed to the situation in *David*, where professional misconduct charges are dismissed but the patient is not the party who "lost," "when the physician loses in the Hearing Committee, assuming a full and fair opportunity to contest the identical issue, the physician has, indeed, had a day in court." These comments may indicate that the Court of Appeals does not agree with the Third Department's reasoning in its 1989 *Stevenson* decision that the less formal procedures in an administrative proceeding prevent it from being conclusive in a civil action. And, indeed, the general rule that determinations rendered in quasi-judicial administrative proceedings are entitled to preclusive effect would seem inconsistent with the rationale of *Stevenson*.

Conclusion

Because a wide range of administrative, civil, and criminal proceedings, as well as professional disciplinary cases in other states, can be used to conclusively establish professional misconduct, an attorney representing a licensed health care professional in such matters must be aware of the potential ramifications on the professional's ability to practice in New York. While private litigants have generally not been permitted to rely upon professional disciplinary determinations, the Court of Appeals has not ruled out the possibility that in an appropriate case, a patient may be able to use such a determination to prove his or her claims in a private action, such as a medical malpractice action. Although the use of collateral estoppel in all of these circumstances can conserve judicial and administrative resources and thus help overburdened administrative agencies to protect the public health, courts have also balanced these interests with concerns of fairness to all parties.

Endnotes

1. Education Law § 6530(9)(b).
2. Education Law § 6530(9)(d).
3. Education Law § 6530(9)(c).
4. Education Law § 6530(14).
5. Education Law § 6530(13).
6. Education Law § 6530(16).
7. Education Law § 6509(5)(c).
8. PHL § 230 (10)(p); Education Law § 6510(2)(d).
9. *Jeffreys v. Griffin*, 1 N.Y.3d 34, 39 (2003); *Ryan v. New York Tel. Co.*, 62 N.Y.2d 494 (1984); *Schwartz v. Public Administrator of County of Bronx,* 24 N.Y.2d 65 (1969).
10. 72 N.Y.2d 261 (1988).
11. *See also Dragan v. Commissioner of Education*, 142 A.D.2d 846 (3d Dep't 1988).
12. 239 A.D.2d 664 (3d Dep't 1997).
13. 245 A.D.2d 703 (3d Dep't 1997).
14. 274 A.D.2d 784 (3d Dep't 2000), *rev'd*, 96 N.Y.2d 879 (2001) (reversing on the ground that the Appellate Division improperly reached an unpreserved issue, because judicial review of Article 78 determinations are limited to issues of law).
15. 280 A.D.2d 814 (3d Dep't 2001).
16. *Compare Becker v. DeBuono*, 239 A.D.2d 664 (3d Dep't 1997) (no preclusion where the consent order contained no admission and stated that no findings of wrongdoing were being made) *with Ikramuddin v. DeBuono*, 256 A.D.2d 1039 (3d Dep't 1998) (collateral estoppel appropriate where the settlement occurred after a partial hearing was held, and petitioner stipulated to factual findings).
17. The Appellate Division recently reaffirmed this principle in *Ambrosio v. Dep't of Health*, 3 A.D.3d 706 (3d Dep't 2004) (physician's surrender of license in Nevada precluded review of the determination). The Court of Appeals has agreed to review this decision, which could, of course, significantly impact the law in this area.
18. 235 A.D.2d 945 (3d Dep't 1997).
19. 295 A.D.2d 818 (3d Dep't 2002).
20. *Id. See also Ricci v. Chassin,* 220 A.D.2d 828 (3d Dep't 1995) (California interim license suspension given preclusive effect).
21. *See Camperlengo v. Barell*, 78 N.Y.2d 674 (1991); *Choi v. State of New York*, 74 N.Y.2d 933 (1989).
22. *Willer v. New York State Bd. of Regents*, 126 A.D.2d 802 (3d Dep't 1987).
23. *Weg v. DeBuono*, 269 A.D.2d 683 (3d Dep't 2000).
24. Education Law §§ 6509(5)(c), 6530(9)(e).
25. *Weg v. DeBuono*, 269 A.D.2d 683 (3d Dep't 2000); *Abraham v. Ambach*, 135 A.D.2d 921 (3d Dep't 1987).
26. 135 A.D.2d 921 (3d Dep't 1987).
27. 233 A.D.2d 789 (3d Dep't 1996).
28. 263 A.D.2d 713 (3d Dep't 1999).
29. 187 A.D.2d 770 (3d Dep't 1992).
30. *Major v. Board of Regents*, 160 A.D.2d 1041 (3d Dep't 1990).
31. 111 A.D.2d 535 (3d Dep't 1985).
32. 92 N.Y.2d 318 (1998).
33. 1 N.Y.3d 34 (2003).
34. 148 A.D.2d 217 (3d Dep't 1989).

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"Who Plays and Who Pays"—Rationing or Rationalizing Health Care?

By Francesca Sommer

Introduction

With respect to health planning and resource allocation, there is one thing we do know—the growth in overall health care expenditures continues to outpace the growth of the national economy. Based on a recent release from the U.S. Department of Health and Human Services, in 2002, aggregate health care spending spiraled upward by 9.3%, the largest increase in the last 11 years. That means overall health care spending—$1.5 trillion last year—comprises approximately 15% of the gross domestic product.

Recently, the Centers for Medicare and Medicaid Services, National Health Statistics Group released its report on health care spending in 2002. In that report, they pointed to the spending trends and counter-trends, which will, out of necessity, "redesign" health care delivery. Health policy experts point to four key factors that will exert significant influence about how resource allocation and health care planning decisions will be made in the future:

- the availability of state-of-the-art (and costly) technology;
- skyrocketing prescription drug costs;
- the bubble of "baby-boomers" reaching Medicare eligibility; and
- growth in the Medicaid enrollment.

Fueling the health care debate is the very real possibility that our health care delivery system will crumble under its own weight, should the current pattern of resource consumption continue. In fact, a recent consumer poll indicated that worries about health care and rising costs zoomed to the top of the agenda, followed by concerns about the job market and economy.

Against this backdrop, a number of regulatory and insurance-driven initiatives to further control spending and improve quality of care have emerged. These include selective referrals, pay for performance, disease management, mandated regionalization of specialty services and expanded Certificate of Need programs.

These trends serve to highlight the potential implications for health care delivery over the next few years. Currently, the battle lines have been drawn around who gets to "play" in the health care market place, with the "players" being determined by who "pays" for those services.

As the influence of the insurance and managed care industry has grown, government's traditional control over health planning decisions has dwindled. In some states, government purview over health care planning has been entirely supplanted by the interests of private market-driven entities who control access to the market with their own non-statutory franchise approval process. While some parts of the country have allowed market forces to drive health planning and resource allocation, in New York State, a dual (and often competing) process exists, complicating how health care planning and franchise approval decisions are made.

How health care will be delivered, what services will be offered, and at what cost continues to dominate the national and state political debate. Lawmakers, representatives from business, the insurance industry, health care providers and consumer advocates are voicing their concerns about the future of health care—how to make the decision-making process more "rational," with the perhaps unattainable objective to curb spending and out-of-pocket costs without compromising access or quality.

Key policy questions emerging from the various forums include the following:

- What is the impact of having multiple groups, including government, and private interests continue to independently influence market configuration?
- What role, if any, should government and regulators play in health care planning decisions?
- Whether regulated or market-driven, should the health planning process attempt to control cost by controlling supply and consumption—including the closure of institutions?
- How should a planning process factor in current market trends, community need, public accountability, cost, quality and access to care?

An Environmental Scan—Where We Are Today

While national efforts to address health care delivery have focused primarily on Medicare and to a somewhat lesser extent, Medicaid, public program expenditures are one of the many factors that contribute to the growing sense of urgency. States and localities are also having their own "moment of truth" regarding how best to curb health care expenditures.

In New York State, Governor Pataki and the New York State Senate each convened special task forces to explore ways to control and reduce health care costs, and improve the efficiency of public programs, including Medicaid. Both the Senate Medicaid Task Force and the Governor's Health Care Reform Working Group reports detail recommendations for reforming long-term care, capacity and closure of existing institutions, easing the burden of Medicaid costs, and addressing prescription drug coverage, among many others.

Over the last decade, there is a growing sentiment that traditional government-regulated health planning models have not been able to keep pace with the tremendous changes in health care delivery. Health care planning—embodied in the provisions of the 1975 National Health Planning and Resources Development Act—has not yielded the anticipated goal of "rational" resource allocation and spending control. Nor has a solution to address the varying interests of business, insurers, consumers or providers yet taken shape. In every state, the regulated Certificate of Need (CON) process continues to be hotly debated. In 2002, lawmakers in over 20 states considered proposed legislation that ran the gamut from strengthening CON requirements to eliminating them entirely. While the American Health Planning Association (AHPA) indicated that the general trend over the last five years has been toward deregulation and relaxing of CON requirements, 36 states still maintain some level of formal CON process, almost three decades after the creation of the federal health planning program.

Despite the number of states maintaining a regulated health planning process, CON has neither stemmed competition, nor controlled cost. In an effort to level the playing field, a provision was included in the recently enacted Medicare Modernization Act of 2003, which places a moratorium on new specialty hospital development. While specialty hospital growth has garnered the same level of attention in New York, as it has in the rest of the country, the proliferation of freestanding entities has had a particularly serious impact on hospitals as the more profitable services continue to migrate from the acute care setting to ambulatory settings.

In fact, those most disaffected by the current CON process are those that are obligated to participate in it. Lengthy delays in the application review and approval process have increased project costs for the applicant, and have resulted in lost market share, since unregulated competitors have not been hampered by the same constraints as those that are obligated to seek state approval.

However, amidst the confusion about what to do about regulated health planning, insurers and business groups are coming together to look at ways to control premium increases, encourage operational efficiencies from providers, and reduce duplication of services. Jump-started by nationally driven quality initiatives, such as Leapfrog, a number of regional consortiums have sprung up across New York State to manage, or influence, health planning decisions in the private sector.

For example, groups like the Niagara Health Quality Coalition in Western New York, and the Community Technology Assessment Advisory Board in Rochester, have launched their own initiatives to assist in deciding "who will pay and who will play" in the health care arena. Comparisons of provider performance and clinical outcomes, especially for the more resource-intense services such as cardiac care and diagnostic imaging, have had an impact on resource allocation and utilization. Although contentious, research in which the quality of care has been correlated to hospital volume has contributed to the push by both private insurers and the state policy-making bodies to concentrate certain intensive or high-technology services in "centers of excellence," steering consumers to regional hubs. Over the last ten years, trauma and perinatal care have been "regionalized" into designated centers, with cardiac and stroke care following the same pattern of development.

Moreover, there has been a push by both private and consulting entities to expand interpretation of the volume-outcome relationships to conditions and procedures well beyond those where there is any scientific basis.

Some of these strategies can pose significant challenges for patients, public policy and health care organizations. In its 2002 report, *Interpreting the Volume—Outcome Relationship in the Context of Health Care Quality*, the Institute of Medicine cites seven practical and political barriers to selective referral, including:

- Access to Preferred Hospital in Rural Areas
- Accommodating Patient Preferences for Care Close to Home
- Ensuring Safe Patient Transfer
- Assuring Capacity at Preferred Hospitals
- Provider Acceptance of Proxies for Risk-Adjusted Outcome Measures of Quality
- Health Plan Opposition
- Possible Financial Dissolution of Hospitals

Private advisory boards have also formed to review and "approve" provider expansion efforts, especially

the acquisition of high-technology equipment like CT and PET scanners. It is interesting to note that while these health planning groups admit that their decisions are "non-binding" for providers, their recommendations clearly have an impact on subscriber utilization and provider payment. Notwithstanding the state's continuing role in regulated health planning and CON, some believe that these private groups are rapidly becoming the de facto decision makers in the health care planning process. The fact that there exist two distinct processes—one with statutory purview for health planning and the other with significant market clout—is causing considerable confusion for providers and consumers alike. Whatever health planning mechanism evolves as a result of the discussions presently occurring in various forums across the state, the impact of the decisions made by the state-regulated and market-driven decision-making models will affect everyone.

Trend Watch—Factors to Consider in the Health Planning Debate

New Technology, Heightened Competition and Consumer Demand

Unquestionably, advances in technology and pharmaceuticals have been significant drivers of resource consumption and spending. As a result, specialty services are now delivered in outpatient or office-based settings. The effect has been to provide greater choice for consumers, and at the same time, foster intense market competition between traditional providers and the new breed of physician-owned entities.

However, according to a 2003 study underwritten by Blue Cross and Blue Shield, the "if you build it, they will come" trend in the health care industry may be hitting a wall. The study concluded that the "unchecked appetite" for new and better technology has ignited consumer demand. The downstream effect on premium costs has caused those "who pay"—business interests and insurers—to sharpen their pencils. Hospitals and health systems will not be the only ones affected; free-standing providers and larger physician group practices will also face similar limitations on their expansion efforts.

The study also suggests that the haphazard way new technologies are adopted and deployed is reason enough to weigh their impact on cost and utilization through locally controlled planning processes like the ones in Buffalo, Rochester, and Syracuse.

Since private insurance covers over 70% of the population (U.S. Census Bureau, Historical Health Insurance Tables—October 2003), businesses are pushing back on rising premiums by ratcheting down employee benefits. Even well-insured consumers will assume greater out-of-pocket costs. In 2002, total consumer overall out-of-pocket spending rose by $12 billion, to $212 billion.

The trend toward market-driven health planning and franchise control will gain even greater momentum as insurers and business groups look for ways to influence costs by exerting greater control over franchise development.

The combined effect of the medical arms race between competitors and consumer demand for newer and better technology threatens the affordability of employer-sponsored health care benefits.

Private and Public Efforts to Shape Health Care Planning and Delivery

Of current interest are three related, but independent initiatives launched over the last year by the federal Centers for Medicare and Medicaid Services, the New York State Department of Health and private insurers, intended to broadly influence resource consumption and allocation. This is one trend in which public and private entities have adopted similar approaches to control the triad of cost, quality and access to care.

The three initiatives—"pay for performance," disease management, and the designation of specialty centers, or "centers of excellence"—operate under a similar set of objectives:

- Reduce excess capacity in a given market.
- Lower or control cost and consumption by steering patients to designated high-volume centers which have met certain performance and operational criteria.
- Raise the quality of care by rewarding or "paying" for improved performance on management of patient care, either through financial bonuses, selective contracting or the use of public report cards.

Unlike the traditional "command and control" regulatory models, where provider behavior was shaped by complaint investigation and surveillance, these recent initiatives are likely to have a more immediate impact on resource allocation and consumption.

On the positive side, these efforts have the potential to raise the threshold for quality of care and provide opportunities for health care organizations to distinguish themselves through service excellence.

Government, insurers, and private accrediting bodies have tended to leap on the bandwagon of specialty center designation without having a standard model for defining and evaluating the impact of these designations on cost, quality or access.

Institutions and providers with the ability to compete for these incentives have also embraced these initiatives with equal fervor. Those that cannot meet the criteria for these designations face not only the loss of that particular service to a competitor, but the loss of other services as well.

However, the halo effect created by specialty deeming, selective contracting, and other incentives can have a chilling effect on health care delivery at the local level. Consumers are steered to larger centers, often far from the community where they live, making access to care a challenge and increasing out-of-pocket costs. Providers, especially institutions like hospitals, find that the loss of volume has a deleterious impact on their ability to remain financially viable.

Health care organizations are already actively engaged in a variety of pay-for-performance initiatives that are written into their contracts with insurers, and include such things as target thresholds for disease management or process measures.

Disease management is also receiving renewed attention as a dual strategy for addressing escalating costs and improving quality. As previously noted, primary recommendations from the Senate Medicaid Reform Task Force contained several key recommendations for disease management demonstration models.

Although nursing homes and specialty hospitals have long engaged in addressing the needs of specialty populations, current disease management programs are focused on the long-term treatment of chronic diseases across the continuum, strategies to avoid preventable complications, and the use of expensive modalities of care.

In addition to creating financial incentives, insurers are also applying the concept of "centers of excellence" to entice hospital participation in cost reduction and quality improvement initiatives.

Theoretically, designated hospitals benefit by enhanced community reputation and increased patient volume.

As previously referenced, the state has had a long-standing position that is supportive of models for "centers of excellence" as evidenced by the strictly controlled cardiac surgery program, the recent re-definition of hospital maternity, newborn designation status, and the designation of trauma centers.

Moreover, the Department of Health has been piloting a system for designation of primary stroke centers in New York City that it plans to expand to upstate New York. It is also exploring a similar designation process for "centers of excellence" for cardiac care. The stroke initiative is modeled after the guidelines issued by the "Brain Attack Coalition," a collaboration of six leading national stroke-related health care associations. The goal of the national campaign is to promote the ultra-rapid triage, transport, evaluation, and treatment of suspected stroke patients to improve patient outcomes.

Early evidence also suggests that hospitals achieving the specialty stroke designation may find an influx of other patients as a result of "over-triaging" by emergency transport personnel. Conversely, hospitals without the stroke designation may experience a loss of patient flow beyond those patients with a stroke diagnosis as a consequence of over-triaging in the field.

Finally, many organizations are seeking certification in disease-specific categories from private accrediting organizations, particularly the Joint Commission on Accreditation of Healthcare Organizations. Reasons cited for seeking these designations include an interest in obtaining an objective, private evaluation of clinical programs, performance improvement activities, and as a strategy for market differentiation.

"Who Plays?"—How Resource Allocation Decisions Are Being Made

That regulated health planning has not lived up to its initial promise may be the one point on which providers, the insurance industry and business all agree. There is far less agreement on how future health care resource and spending decisions will be made and who will make them.

Over the last several years, business and insurance industry interests have joined forces in an effort to better control the flow of private health care dollars.

Even within regions, there has been significant competition between insurance entities, and a significant pushback from business interests who object to ever-escalating premiums to cover their employees. It is most likely that resource allocation—containing cost by controlling supply—will continue to be one of the driving forces behind efforts to re-invigorate regional or community "planning."

The momentum already established by regionally based, collaborative efforts among insurers, business groups, and other stakeholders to measure provider performance, evaluate expansion, and control cost will continue to drive the desire for a more relevant system of health planning. In an environment decidedly different from the '70s, in which national health planning predominated resource allocation, today government is not the driver of change.

Even though the state still has statutory authority over health planning, project review, and approval for regulated entities, the private market has seized a greater role in determining how health care will be delivered—and who delivers it.

While there are shortcomings inherent in a regulated planning model, the foundation of a government regulated planning model derives from its statutory charge to safeguard the public trust. Of concern is the state's continuing interest and legitimate role in access, cost, and quality of public programs such as Medicaid and Child Health Plus, among others. How will the state's interest fit into future health care resource allocation and delivery decision-making?

The existence of two health care planning models is a trend that places health care providers and the public in a vulnerable position, and one about which providers and consumers ought to be concerned. Consumers and providers are presented with both the opportunity and obligation to help shape the future.

Transcending Our Differences—Guiding Principles for Health Care Planning

While there is little consensus about the best model for health planning, one thing is certain—neither market competition nor regulation alone have been able to control costs or better allocate resources. This is what drives the overwhelming need to redesign the current approach to health planning.

In 1999, the AHPA Board of Directors adopted a mission statement, which articulated a fundamental or core set of principles for health care planning. They said,

> " . . . The mission of health planning is the development of comprehensive **community-oriented** health systems designed to assure **universal access** to **necessary** care of the **highest quality** and **most reasonable cost** possible . . . . The process must incorporate a **public** decision making, which is sensitive to concerns of **consumers, providers, payers** and the needs of **underserved populations,** and provides a broadly representative mechanism for **community need**, assessing capacity to meet those needs, **allocating resources and resolving conflicts** in order to assure accountability and equity in the design and direction of the future healthcare system. . . ."

In addition, they highlight the following elements which have emerged from the many national and state discussions on health planning, and which can serve as building blocks in a strategic planning process:

- Community mission and collaboration among all stakeholders in a public decision-making process;
- Equitable access for consumers to care, including special, high-risk or uninsured populations;
- Public accountability for resource allocation and spending;
- Ability to measure community need, provider performance, and quality outcomes; and
- Responsiveness and recognition to marketplace factors affecting how health care is delivered.

This then can serve as a starting point for our own deliberations on how to create an intelligent and equitable health planning model that coalesces the best and most current thinking, and promote a more solid foundation for health planning and decision making in the future.

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New York Medicaid Reimbursement Guide: 2005 Update

By Eugene M. Laks

The following are excerpts from the upcoming 2005 Update to the New York Medicaid Reimbursement Guide *published by the Healthcare Association of New York State. This preview is based on legislation and regulations adopted as of October 15, 2004. The final 2005* Update *will reflect developments through December 31, 2004. The* New York Medicaid Reimbursement Guide *is written by Eugene M. Laks.*

Volume I, Hospital and Clinic Services, contains chapters on Inpatient Hospital Services, Hospital Emergency Services, Hospital Outpatient Department Services, Diagnostic and Treatment Center Services, and Ambulatory Surgical Services. Volume II, Continuing Care, contains chapters on Nursing Home Services, Adult Day Services, and Home Care Services. Volume III, Mental Hygiene Law Services, contains chapters on Mental Retardation and Developmental Disabilities Services, Mental Health Services, and Alcoholism and Substance Abuse Services. Volume IV, Practitioners and Suppliers, contains chapters on Health Care Practitioners and Health Care Suppliers and Vendors. Each volume also contains chapters on an Overview, General Medicaid Provisions, Medicaid Managed Care Programs, and Audits and Recoveries.

CHAPTER 1

Overview

General

For New York State, the federal medical assistance percentage (FMAP) for Medicaid (federal reimbursement to the state for a share of Medicaid expenditures) has been generally 50%. A temporary increase in the Medicaid FMAP of 2.95% was provided for the 15-month period April 2003 through June 2004,[1] generating over $1 billion in additional federal funds for New York.

Provider Medicaid Claims

States will be required to estimate improper payments in the Medicaid program and report those estimates to Congress. Reports may be required on state actions to reduce erroneous payments.[2]

New York State Medicaid Management Information System (MMIS)

New York State has entered into a multi-year contract with Computer Sciences Corporation to modernize and replace the MMIS. The new system is called eMedNY. The Electronic Provider Assisted Claim Entry System (ePACES) component of this new system became effective in 2003 providing for electronic submission of HIPAA-compliant Medicaid claims, Medicaid patient eligibility verification, Medicaid service authorizations, and related transactions. After December 29, 2004, only HIPAA-compliant claim forms will be processed.

Implementation of eMedNY Phase II is scheduled for March 2005. This will replace MMIS and provide various system enhancements.

CHAPTER 2

Inpatient Hospital Reimbursement

General

The NYPHRM Medicaid rate setting system under the Health Care Reform Act has been extended to July 1, 2005.[3] This system is based generally on per-case Medicaid reimbursement rates based on assignment of patients upon discharge to diagnosis-related groups and per-diem payments for hospital exempt units. State-operated pools of funds allocated for indigent care, health care initiatives, tobacco control and insurance initiatives, and graduate medical education also are continued. The allocations of pool funds to various programs have been adjusted and allocations provided for new initiatives.[4]

The DRGs, service intensity weights, and length-of-stay trim points for calculating outlier payments have been updated for 2003, 2004, and 2005, respectively.[5]

Medicaid Rate Enhancements for Graduate Medical Education Costs

Enhanced Medicaid payment rates are authorized effective April 1, 2004 for each non-public teaching hospital based on the difference between the amount received by the hospital in 2003 Medicaid rates of payment, including exempt unit rates of payment, for direct and indirect graduate medical education costs and the amount the hospital would have received if payment rates were calculated based on actual 2001 direct costs and a revised 2001 indirect costs formula methodology. The enhancement amount is limited to 75% of the hospital's 2002 Medicaid payments for direct and indirect graduate medical education costs and in the aggregate is limited to the Medicare upper payment limit for non-public hospitals.[6]

The payment rate increase for a rate period is based on the enhancement amount and two year old Medicaid utilization data for the hospital. The Medicaid rate increase applies to inpatient rates of payment, excluding exempt unit rates of payment, but including the Medicaid graduate medical education payments made to hospitals per discharge for services provided to Medicaid managed care patients.

Funds are reserved within the tobacco control and insurance initiatives pool for non-Medicaid grants to compensate hospitals for lost revenue where the Medicaid graduate medical education rate enhancements result in the hospital exceeding its disproportionate share payment limit for distributions from the indigent care pool for a year.[7]

Professional Education Pool

Beginning April 1, 2004, the amount calculated as due to a teaching hospital from the Professional Education Pool for graduate medical education costs of non-Medicare, non-Medicaid patients enrolled in managed care programs is reduced by the amount of the enhanced Medicaid payment amount for the hospital for graduate medical education costs.[8] The annual covered lives assessments and payor surcharges used to fund this pool are correspondingly reduced.[9]

New York Surcharges on Payor Payments

Provider-Specific Taxes

Surcharges continue to apply to non-Medicare payments for hospital inpatient and outpatient services, payments to ambulatory surgery centers, and payments to comprehensive diagnostic and treatment centers. These surcharges provide funds for the annual indigent care pools and health care initiative pools. Effective July 1, 2003, the surcharge on Medicaid payments (including Medicaid managed care payments) is increased from 5.98% to 6.47%, and the surcharge on other non-Medicare payments is increased from 8.18% to 8.85%. The additional surcharge that is applied to payors that do not elect to pay the surcharge directly to the state (rather than to the health care provider) is increased from 24% to 25.97%.[10] The surcharges are paid to the state Department of Health and applied to fund state-operated pools.

Hospital Indigent Care Pool

Originally to be effective July 1, 2003 and then deferred to January 1, 2004, losses from outpatient services considered in determining a hospital's share of indigent care pool funds include losses from hospital-controlled diagnostic and treatment centers.[11]

Additional Medicaid Disproportionate Share Payments to Public Hospitals

For April 1, 2003 through March 31, 2005, the hospital-specific caps on the amount of Medicaid disproportionate share payments that may be paid to public hospitals are increased under federal law from 100% to 175% of the uncompensated care costs of services provided to Medicaid and uninsured patients. New York increased its Medicaid supplementary payment program to public hospitals accordingly.[12]

The New York State requirements for recycling 40% of the funds from such programs from the counties and the City of New York to the state were terminated January 31, 2004.[13] The Commissioner of Health has been vested with authority to increase local shares of Medicaid expenditures up to specified dollar amounts.[14]

Pool Funding

Federal funds available through the Community Health Care Conversion Demonstration Project under the three-year extension of New York's section 1115 Medicaid managed care waiver from April 1, 2003 through March 31, 2006 are allocated to the state-operated pools for funding professional education (graduate medical education), health facility restructuring, and health workforce retraining, recruitment, and retention costs.[15] For the first year, $250 million is provided; for the second year, $100 million is provided.

Funds from the conversion of Empire Blue Cross and Blue Shield to a for-profit corporation allocated to the Tobacco Control and Insurance Initiatives Pool remain in escrow as litigation concerning the conversion remains pending.

An amnesty from the imposition of penalties and interest was provided for all delinquent payments due to the pools that were paid by December 31, 2003.[16]

CHAPTER 5

Diagnostic and Treatment Center Services

General

The freeze on the operating cost component of diagnostic and treatment center Medicaid reimbursement rates, applicable for clinics that do not have a specialty rate, has been extended through September 30, 2005.[17]

Indigent Care Program

Funds are allocated from the Health Care Initiatives Pools for Medicaid rate adjustments to offset a portion of the costs of uncompensated (charity) care for voluntary non-profit and publicly sponsored diagnostic and treat-

ment centers that provide a comprehensive range of primary health care services. These funds had been allocated among various categories of providers for distribution to eligible providers based on specific percentages. Beginning July 1, 2003, specific dollar amounts are provided for each category and Medicaid rate adjustments are calculated for eligible providers.[18] Originally to begin July 1, 2003 and deferred until January 1, 2004, losses from hospital-controlled diagnostic and treatment centers will be considered in the distribution of funds from the hospital indigent care pool rather than from the diagnostic and treatment center uncompensated care funds.[19]

Federally Qualified Health Centers, Look-Alikes, and Rural Health Clinics

In lieu of the Medicaid reimbursement rate freeze for diagnostic and treatment centers, New York State will pay these providers an all-inclusive per threshold visit Medicaid reimbursement rate calculated based on the facility's allowable cost per visit, subject to peer group ceilings, based on the average of facility cost data for 1999 and 2000 used as base years.[20] Look-Alikes are providers that are not receiving federal grants but have been determined by the Secretary of the federal Department of Health and Human Services to meet the requirements for receiving a grant as a federally qualified health center.

Medicaid rates based on this methodology have been issued in 2004 and, as required by federal law,[21] retroactive to 2001. The supplementary increases in Medicaid rates provided by the state for the purpose of recruitment and retention of workers are added to these payment rates.

Beginning October 1, 2002 and thereafter, the operating cost component of these prospective payment system rates is increased annually by the Medicare Economic Index. Capital costs may be increased on an appeal basis.

Providers reimbursed under the Products of Ambulatory Care (PACs) reimbursement rates system have the option of continuing under the PACs payment system or converting to the new cost basis rate system.[22]

Federally Qualified Health Centers—Social Work Services

Patient visits to a diagnostic and treatment center solely for pharmacy, nutrition, medical social services, respiratory therapy, or recreation therapy are not considered billable threshold visits. However, effective November 2003, individual psychotherapy services provided in Federally Qualified Health Centers, Look-Alikes, and Rural Health Clinics by a social worker are billable visits.[23] This does not apply to clinics licensed and reimbursed pursuant to the Mental Hygiene Law which are regulated by separate billing rules and which also allow for billing for group psychotherapy services.

Medicaid Wrap-Around Payments

For Federally Qualified Health Centers, Look-Alikes, and Rural Health Clinics participating in Medicaid managed care panels of providers, the Department of Health provides a supplementary Medicaid payment of 100% of the difference between what the provider would have received under the Medicaid fee-for-service system and the reimbursement received from Medicaid managed care organizations. This wrap-around payment is required under federal law. These payments have been calculated retroactive to 2001.

For comprehensive diagnostic and treatment centers that are not Federally Qualified Health Centers, Look-Alikes or Rural Health Clinics, a supplementary Medicaid payment is made in accordance with the Partnership Plan § 1115 Medicaid managed care waiver of part of the difference between the Medicaid fee-for-service reimbursement and reimbursement from Medicaid managed care organizations. The payment is 90% of the difference during the first year of Medicaid managed care implementation in the area and 50% of the difference thereafter.

Provider-Specific Taxes

Surcharges on non-Medicare payments to comprehensive diagnostic and treatment centers are increased effective July 1, 2003 from 5.98% to 6.47% on Medicaid payments (including Medicaid managed care payments) and from 8.18% to 8.85% on other non-Medicare payments. The additional surcharge that is applied to payors that do not elect to pay the surcharge directly to the state (rather than to the health care provider) is increased from 24% to 25.97%.[24] The surcharges are paid to the state Department of Health and applied to fund state-operated pools.

Methadone Maintenance Treatment Services

Effective April 1, 2004, Medicaid reimbursement for methadone maintenance treatment services provided by a diagnostic and treatment center will equal the weekly payment amount made to hospital outpatient departments for such services.[25]

CHAPTER 6

Ambulatory Surgical Services

Reimbursement Rates

Medicaid reimbursement rates for ambulatory surgical services in effect on March 31, 2003 will continue in effect through September 30, 2005.[26]

Provider-Specific Taxes

Surcharges on non-Medicare payments for ambulatory surgical services are increased effective July 1, 2003 from 5.98% to 6.47% on Medicaid payments (including Medicaid managed care payments) and from 8.18% to 8.85% on other non-Medicare payments. The additional surcharge that is applied to payors that do not elect to pay the surcharge directly to the state (rather than to the health care provider) is increased from 24% to 25.97%.[27] The surcharges are paid to the state Department of Health and applied to fund state-operated pools.

CHAPTER 7

Nursing Home Services

Nursing Home Reimbursement Rates

A challenge brought by the New York Association of Homes and Services for the Aging, Inc. and several nursing homes to various Medicaid nursing home reimbursement cost containment statutory provisions was dismissed by the U.S. District Court for the Northern District of New York. The court held that retroactive relief was barred by the Eleventh Amendment immunity of the state and further held the plaintiffs lacked any federally enforceable rights under applicable federal laws and regulations to challenge the Medicaid reimbursement rate provisions.[28]

Assessment on Nursing Home Gross Receipts

The state assessment on nursing home gross receipts that was scheduled to be reduced from 5% to 2.5% April 1, 2004 and expire April 1, 2005 was continued at 5% through March 31, 2006.[29] The assessment is paid by or on behalf of the nursing home to the Commissioner of Health for deposit to the state General Fund. The assessment continues to be a reimbursable provider cost reflected in an increase in nursing home Medicaid reimbursement rates. Thus, the financial impact of the assessment on a nursing home is mitigated to the extent the nursing home's patient mix is composed of Medicaid patients.

Waiver of Interest and Penalties

To avoid paying interest and penalties on assessments for the period between January 1, 2003 and June 30, 2004, nursing homes must pay the gross receipts assessments before February 15, 2005. For unpaid assessments due for periods prior to January 1, 2003, a 50% abatement in interest and penalties is provided.[30]

Capital Costs—AIDS Facilities

Each AIDS nursing home or nursing home with a discrete AIDS unit whose construction was financed by Public Authority bonds must refinance its capital mortgage unless excused for economic reasons by the state Department of Health. Medicaid reimbursement for interest expenses will be adjusted to reflect the lower interest rate that is paid under the refinancing or would be paid if the provider refinanced.[31]

Regional Direct and Indirect Price Adjustment Factors

Effective April 1, 2004, an additional basis is provided for the calculation of the regional direct and indirect price adjustment factors and corridors applied in the determination of nursing home Medicaid reimbursement rates to account for regional differences in employee wage rates. In addition to existing options, 2001 financial and statistical data may be used, whichever approach results in the highest reimbursement rate.[32] However, the annualized statewide increase based on use of 2001 data and statistics cannot exceed a state share of $22 million.

Financially Disadvantaged Nursing Homes

A formula methodology is established for allocation of funds for Medicaid rate increases among qualifying nursing homes related to facility negative operating margins over a three-year period.[33] This approach converts a program originally established as a grant program to a Medicaid rate adjustment program, subject to approval of federal financial participation, beginning July 1, 2004.

Additional Medicaid Payments to County Nursing Homes

Additional Medicaid payments to county and public benefit corporation operated nursing homes are made based on the federal upper payment limit for the class of providers. The state requirements for recycling 40% of the funds from this program from the counties and the City of New York to the state were terminated January 31, 2004.[34] The Commissioner of Health has been vested with authority to increase local shares of Medicaid expenditures up to specified amounts.[35]

CHAPTER 9

Home Care Services

Certified Home Health Agency Bad Debt and Charity Care

The 2004-2005 state budget continues to provide for an additional $4.25 million in Medicaid funding ($1.7 million state share) for bad debt and charity care allowances for public certified home health agencies.[36]

Personal Care and Home Health Aide Services

Effective August 1, 2004, the following Office of Mental Retardation and Developmental Disabilities licensed providers became responsible for all personal care and home health aide services provided to program participants:

- intermediate care facilities
- day treatment and day habilitation programs
- supervised community residences
- supervised individual residential alternatives

Personal care or home health services for such program participants cannot be separately billed to Medicaid.[37]

District-Specific Savings Targets

The methodology for determining local social services district-specific Medicaid expenditure savings targets for home health care and personal care services is continued through March 31, 2006 and the aggregate annual statewide state-share Medicaid savings amount compared to the base year is increased from $33.5 million to $44 million.[38]

Long-Term Care Demonstration Projects

The Commissioner of Health is authorized to approve two projects to encourage community-based care and smaller residential health care models, in lieu of nursing home beds, for the delivery of services. A Community-Based Care Demonstration Project and a Residential Health Care Demonstration Project are authorized.[39] The Commission of Health may apply for any necessary federal waivers. In addition to Medicaid reimbursement for covered services, grant funding is provided.[40]

Chapter 10

Mental Retardation and Developmental Disabilities Services

Home and Community-Based Services Waivers

The Commissioner of Health is authorized to apply for a home and community-based waiver to consolidate the current care at home model waiver programs. This waiver would continue to be administered by the Office of Mental Retardation and Development Disabilities. Consolidation removes the caps on the numbers of program participants and simplifies administration. The waiver would continue to be designed to preserve family settings as a residential option for children under 18 with developmental disabilities who also have complex health care needs.[41]

Chapter 11

Mental Health Services

Hospital Outpatient Mental Health Departments

The authority to establish Medicaid reimbursement rates for hospital outpatient mental health departments dually licensed by the Department of Health and the Office of Mental Health had been transferred to the Commissioner of Mental Health in 1993. However, the rates have remained frozen, for both operating and capital costs, at 1993 rates. For 2004, payment rates will be updated based upon 2002 data and statistics, provided that the rate for any hospital shall be no less than 50% of the prior rate.[42] Beginning in 2004, all hospital outpatient mental health department rates must be, and all such prior rates are deemed to have been, certified by the Commissioner of Mental Health.[43]

Personalized Recovery Oriented Services (PROS)

The Office of Mental Health is continuing to develop a new comprehensive recovery-oriented program model for delivery of outpatient mental health services for individuals with severe and persistent mental illness, Personalized Recovery Oriented Services (PROS). Under the PROS program, providers would be licensed to provide community rehabilitation and support services, intensive rehabilitation, vocational support, and clinic treatment under an individualized service plan. Under this approach, rehabilitation programs would participate in the Medicaid program. A Medicaid reimbursement methodology is being developed for this service model. Various current categories of licensure for mental health outpatient services would convert to new licensure categories.

Chapter 12

Alcoholism and Substance Abuse Services

Chemical Dependence Services

Inpatient Medically Supervised Withdrawal Services

Providers of alcohol primary care detoxification services that convert to licensure as inpatient medically supervised withdrawal services providers by January 2005 are eligible to receive the higher of their former Medicaid reimbursement rate or the new Medicaid alcohol primary care detoxification fee until at least April 1, 2006.[44] A provider-specific fee transition plan must be submitted.

CHAPTER 15

General Medicaid Provisions

Medicare Cross-Over Patients

Medicare Deductibles and Coinsurance

Effective July 1, 2003, Medicaid payments for Medicare deductible and coinsurance amounts for Medicare Part B covered services where Medicaid fees are lower than the Medicare fees are limited to: 100% of the Medicare deductible amount; and 20% of the Medicare coinsurance amounts, except for ambulance services, psychologist services, facilities operating under the Mental Hygiene Law, hospital outpatient departments, and licensed freestanding clinics for which Medicaid continues to pay the Medicare coinsurance amounts in full.[45]

For clinic services licensed both by the Department of Health and the Office of Mental Retardation and Developmental Disabilities provided to Medicare cross-over patients who are also diagnosed with a disability, a provider will receive not less than the established Medicaid rate less the Medicare payment.[46] For preferred primary care clinic providers reimbursed using the products of ambulatory care reimbursement methodology, the Medicaid rates applicable for services provided to Medicare cross-over patients exclude the ancillary portion, which must be billed separately to Medicare and Medicaid.

Disease Management Demonstration Programs

The Commissioner of Health is authorized to establish up to six disease management demonstration programs for dual-eligible persons with chronic diseases who are high-cost users of Medicaid services and not enrolled in Medicaid managed care programs. Providers will receive capitation payments per enrollee per month for Medicaid services, limited to 95% of the estimated fee-for-service payment amounts for such enrollees.[47]

CHAPTER 16

Medicaid Managed Care Programs

Partnership Plan

New York's mandatory Medicaid managed care waiver under section 1115 of the Social Security Act was extended for an additional three years, for the period April 1, 2003 through March 31, 2006. Under this extension, additional federal funding of $250 million for the first year and $100 million for the second year is provided for New York's Community Health Care Conversion Demonstration Project. However, these federal funds are now dedicated to New York's programs that provide funding for graduate medical education, health facility restructuring, and health workforce retraining, recruitment, and retention.[48]

Special Needs Plans

The statutory authority to establish Medicaid managed care Comprehensive HIV Special Needs Plans, as authorized under the Medicaid managed care section 1115 waiver, was extended through March 31, 2006.[49] Plans became operational in New York City in 2003.

Medicaid Wrap-Around Payments

For Federally Qualified Health Centers, Look-Alikes, and Rural Health Clinics participating in Medicaid managed care panels of providers, retroactive to 2001 as required by federal law,[50] the Department of Health provides a supplementary Medicaid payment of 100% of the difference between what the provider would have received under the Medicaid fee-for-service system and the reimbursement received from Medicaid managed care organizations.

For comprehensive diagnostic and treatment centers that are not Federally Qualified Health Centers, Look-Alikes, or Rural Health Clinics, a supplementary Medicaid payment is made in accordance with the Partnership Plan § 1115 Medicaid managed care waiver of part of the difference between the Medicaid fee-for-service reimbursement and reimbursement from Medicaid managed care organizations. The payment is 90% of the difference during the first year of Medicaid managed care implementation in the area and 50% of the difference thereafter.

Diagnostic and Treatment Center Transition Funds

In 2003, an amount of $4.9 million was authorized initially for the October through December 2003 period for diagnostic and treatment centers transitioning into the Medicaid managed care program with an additional $112,000 for university or dental school operated dental clinics.[51] Further amounts of $4.9 million and $112,000 also were authorized for such period.[52]

Dental Services

For Medicaid managed care plans covering dental services, dental clinic services provided by a diagnostic and treatment center affiliated with a dental school are carved out from the Medicaid managed care rates and would be provided on a Medicaid fee-for-service basis.[53]

Prescription Drugs

The Commissioner of Health is authorized to conduct a demonstration program that would include prescription drugs in the Medicaid managed care benefit package and capitation rates for persons dually eligible under the Medicaid and Medicare programs that voluntarily elect to enroll in the demonstration.[54]

CHAPTER 18

Audits and Recoveries

The Department of Health audit protocols were revised in 2004 to include verification of documentation issues through independent sources; and an evaluation of medical necessity and/or quality, where indicated.[55]

Endnotes

1. *See* Jobs and Growth Tax Relief Reconciliation Act of 2003, Pub. L No. 108-27, Title IV, § 401(a).
2. *See* Improper Payments Information Act of 2002, Pub. L. No. 107-300; 69 Fed. Reg. 52620 (2004) (proposed regulations).
3. *See* 2003 N.Y. Laws Ch. 62, Part A3, §§ 1, 2.
4. *See* 2003 N.Y. Laws Ch. 62, Part A3, Ch. 63, Part M1, Ch. 686, Part H; 2004 N.Y. Laws Ch. 58, Part B, §§ 12-16, 22, 26, Part C, §§ 1, 23, 25, Part D, § 4.
5. *See* N.Y. Comp. Codes R. & Regs. tit. 10, §§ 86-1.62, 1.63 (2003) as amended, filed Sept. 21, 2004 (hereinafter "N.Y.C.R.R."), [2004] 40 N.Y. St. Reg. 9.
6. *See* N.Y. Pub. Health Law § 2807-c(25)(d) as added by 2004 N.Y. Laws Ch. 58, Part B, § 7.
7. *See id.* § 2807-e(25)(e).
8. *See id.* § 2807-m(3)(e) as added by 2004 N.Y. Laws Ch. 58, Part B, § 8.
9. *See id.* § 2807-s(7)(a)(vii) as added by 2004 N.Y. Laws Ch. 58, Part B, § 9.
10. *See id.* § 2807-j(2) (McKinney Supp. 2004).
11. *See id.* § 2807-k(1)(f) as amended by 2004 N.Y. Laws Ch. 80, § 1.
12. *See* 1996 N.Y. Laws Ch. 474, § 212(1)(b) as added by 2003 N.Y. Laws Ch. 62, Part Z2, § 9.
13. *See* 1996 N.Y. Laws Ch. 474, § 217 as amended by 2004 N.Y. Laws Ch. 15, § 2.
14. *See* 2004 N.Y. Laws Ch. 15, § 7, Ch. 120, Part A, § 1.
15. *See* 2003 N.Y. Laws Ch. 62, Part A3, § 18.
16. *See id.* § 27.
17. *See* 1995 N.Y. Laws Ch. 81, § 4 as amended by 2003 N.Y. Laws Ch. 62, Part Z2, § 15.
18. *See* N.Y. Pub. Health Law § 2807-p (McKinney Supp. 2004).
19. *See id.* § 2807-p(2) as amended by 2004 N.Y. Laws Ch. 80, § 3.
20. *See id.* § 2807(8) (McKinney Supp. 2004).
21. *See* Soc. Sec. Act § 1902(bb), 42 U.S.C.S. § 1396a(bb) (Law. Co-op. Supp. 2003).
22. *See* N. Y. Pub. Health Law § 2807(8)(e) as added by 2003 N.Y. Laws Ch. 611.
23. *See* 10 N.Y.C.R.R. § 86-4.9 (2004).
24. *See* N.Y. Pub. Health Law § 2807-j(2) (McKinney Supp. 2004).
25. *See* 2004 N.Y. Laws Ch. 58, Part G, § 1.
26. *See* 2003 N.Y. Laws Ch. 62, Part Z2, § 17.
27. *See* N.Y. Pub. Health Law § 2807-j(2) (McKinney Supp. 2004).
28. *See In Re NYAHSA Litigation*, 318 F. Supp. 2d 30 (N.D.N.Y. 2004); 2004 U.S. Dist. Lexis 9108.
29. *See* N.Y. Pub. Health Law § 2809(d)(2)(b)(vi) as amended by 2004 N.Y. Laws Ch. 58, Part C, § 6.
30. *See* 2004 N.Y. Laws Ch. 58, Part C, § 29.
31. *See* 2004 N.Y. Laws Ch. 58, Part C, § 7.
32. *See* N.Y. Pub. Health Law § 2808(17) as amended by 2004 N.Y. Laws Ch. 58, Part C, § 24.
33. *See id.* § 2808(19) as amended by 2004 N.Y. Laws Ch. 58, Part C, § 26 and (21) as added by 2004 N.Y. Laws Ch. 58, Part C, § 27.
34. *See* 1996 N.Y. Laws Ch. 474, § 222 as amended by 2004 N.Y. Laws Ch. 15, § 3.
35. *See* 2004 N.Y. Laws Ch. 15, § 7, Ch. 120, Part A, § 1.
36. *See* 2004 N.Y. Laws Ch. 58, Part H, § 11.
37. *See* [2004] 6 New York State Department of Health Medicaid Update (June 2004).
38. *See* 1997 N.Y. Laws Ch. 433, § 36 as amended by 2004 N.Y. Laws Ch. 58, Part C, § 8.
39. *See* N.Y. Pub. Health Law § 2807-x as added by 2004 N.Y. Laws Ch. 58, Part D, § 6.
40. *See id.* § 2807-v(1)(tt) as added by 2004 N.Y. Laws Ch. 58, Part D, § 5.
41. *See* N.Y. Soc. Serv. Law § 366(7) as amended by 2004 N.Y. Laws Ch. 324.
42. *See* 2004 N.Y. Laws Ch. 58, Part F, § 1.
43. *See id.* § 2.
44. *See* 2004 N.Y. Laws Ch. 59, Part G, § 2 as amended by 2004 N.Y. Laws Ch. 59, Part GG, § 1.
45. *See* N.Y. Soc. Serv. Law § 367-a(1)(d) (McKinney Supp. 2004).
46. *See id.* § 367-a(1)(e).
47. *See* N.Y. Pub. Health Law § 2111 as added by 2004 N.Y. Laws Ch. 58, Part C, § 21.
48. *See* 2003 N.Y. Laws Ch. 62, Part O2, § 44.
49. *See* N.Y. Pub. Health Law § 4403-c (McKinney Supp. 2004).
50. *See* Soc. Sec. Act § 1902(bb), 42 U.S.C.S. § 1396 a(bb) (Law. Co-op. Supp. 2003).
51. *See* N.Y. Soc. Serv. Law § 364-j-2 (McKinney Supp. 2004).
52. *See id.* as amended by 2004 N.Y. Laws Ch. 15.
53. *See id.* § 364-j(4)(a)(iii)(D) as added by 2003 N.Y. Laws Ch. 697.
54. *See id.* § 367-i as amended by Ch. 58, Part C, § 18.
55. *See* [2004] 3 New York State Department of Health Medicaid Update (March 2004).

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Wouldn't It Be Nice—Utilization Review Determinations, External Appeals and the Benefits of Being a Provider Covered by the NYS Access to End of Life Care Law

By Kathleen Duffett, R.N., J.D.

"Wouldn't it be nice if we could get paid
After all the work we've done was through?
And wouldn't it be nice not to have to argue
With the plan about the good care we provided to you?

I know this law will make it so much better—
For us to say "You're admitted!" and can stay—forever(?)
Oh wouldn't it be nice?"

(Sung to the tune of the Beach Boys "Wouldn't It Be Nice")

Payment for services—whether prompt or otherwise—has been and remains a major issue for health care providers, both individual and institutional. This is especially so when the payor is a managed care plan. Over the past several years, New York State has taken a number of different measures, both direct and indirect, to ensure that providers get paid for the services they provide to members of managed care organizations ("MCOs"). This article will give a history of managed care regulation in NYS related to utilization review and will discuss in detail New York State's Access to End of Life Care Law, a unique piece of health care legislation.

First Step: The 1996 Managed Care Reform Act

In 1996, New York State passed the Managed Care Reform Act,[1] which created a statutory framework for utilization review ("UR") decision making. UR decision making involves approving or denying a request for a treatment or health care service based on a determination of the medical necessity of that treatment or service.[2] UR decisions were characterized under the Act as prospective (a.k.a., preauthorized), concurrent or retrospective. Under the Act, health plans[3] that performed UR were required to make their determination within a specific time frame.[4] If the health plan denied the request, an adverse determination letter had to be provided, which had to include the specific clinical reason for the denial, the availability of the clinical review criteria relied upon to make the determination and the member's (and, in retrospective review cases, the provider's) appeal rights within the health plan.[5] Failure to make the determination within the required time frame was deemed a denial under the law, which could be appealed to the health plan. Like denials, appeals had to be carried out within a specific time frame.[6] If the health plan denied the appeal, another adverse determination letter had to be provided.

The Act benefited providers in that it compelled HMOs and other insurers to make UR decisions in a timely manner which , as a practical matter, gave providers a more concrete framework for initiating UR requests and tracking UR decisions. It also gave all providers (i.e., participating and non-participating providers) a statutory right to appeal retrospective review denials. However, it was lacking in certain significant respects, which led to its amendment in 1998.

When at First You Don't Succeed: The 1998 NYS External Appeal Law

The 1996 Managed Care Act did not remedy all the perceived problems with HMOs and other insurers conducting UR. Providers and members continued to complain that their appeal rights were essentially illusory as the appeal was heard by the same organization that issued the denial, namely, the member's health plan. Consequently, the 1998 NYS External Appeal Law was enacted.[7] Effective as of July 1, 1999, the External Appeal Law provided members and, in some cases, providers, with the right to appeal a denial by a health plan to an independent third party after the member or provider completed at least one level of internal appeal through the member's health plan. The Department of Insurance was charged with the responsibility for managing the External Appeal Program and for contracting with external agents to perform the medical necessity reviews.[8]

Although quite beneficial to consumers, the External Appeal Law resulted in a limited benefit for most providers. This was so because the External Appeal Law limited a provider's independent right to external appeal to decisions involving retrospective review, i.e., cases in which the health plan initiated UR after the services had been rendered in their entirety.[9] As a practical matter for acute care inpatient facilities, most health plans initiated UR some time *during* the patient's inpatient stay, thus making such reviews concurrent. Under the statute, providers did not have an express, independent right to initiate an external appeal for concurrent review denials. However, members or their designees had the right to appeal a denial regardless of the type of review on which it was based. Consequently, if a member appointed an acute care facility as the member's designee, then the facility would stand in the shoes of the member and could initiate an external appeal of a concurrent review denial on the member's behalf, right? Not exactly.

In the regulations implementing the 1998 External Appeal Law, the Departments of Health and Insurance

defined "designee" as "for the purpose of requesting an external appeal, [a designee is] a person authorized in writing by an insured to assist such insured in obtaining access to health care services. If the insured has already received health care services, a designee shall not be authorized for the purpose of requesting an external appeal."[10] Since most acute care facilities were not notified of the concurrent review denial until after the patient had received the services, the regulatory definition precluded the member from appointing the facility as the member's designee. As evidenced in their first annual report regarding the External Appeal Program, the Departments of Health and Insurance made quite clear their position on this, stating, "[The External Appeal Program] was not intended to permit disputes between providers and health plans that were not based upon a retrospective adverse determination to be subject to the external appeal process. A definition of designee was added to the regulations to ensure that a designee would have to act on behalf of a patient and could not use the external appeal process as a mechanism to arbitrate payment disputes that would not otherwise be eligible for external appeal."[11] This did not sit well with the provider community, which decided to take action.

When You Just Can't Take No for an Answer: *HANYS v. Serio*

In November 2001, the Healthcare Association of New York State ("HANYS") and other interested parties sued the state Departments of Health and Insurance, objecting to their restrictive interpretation and implementation of Article 49 of the Insurance and Public Health Laws. Specifically, the lawsuit challenged the Departments' authority to promulgate the following definitions of "designee" and "retrospective adverse determination":

> **Designee**—means, for the purpose of requesting an external appeal, a person authorized in writing by an insured to assist such insured in obtaining access to health care services. If the insured has already received health care services, a designee shall not be authorized for the purpose of requesting an external appeal.[12]
>
> **Retrospective adverse determination**—means a determination for which utilization review was initiated after health care services have been provided. Retrospective adverse determination does not mean an initial determination involving continued or extended healthcare services, or additional services for an insured undergoing a course of continued treatment prescribed by a health care provider pursuant to Section 4903(c) of the Insurance Law.[13]

The Supreme Court, Albany County, decided the case in February 2002. The court upheld the Departments' authority to promulgate the definition of retrospective adverse determination but it struck down the Departments' definition of designee. In doing so, the court stated, "the Court cannot state a rational basis exists for the [Departments'] definition of "designee" . . . This definition appears to be drafted solely to restrict the right of an enrollee to appoint a designee . . . The Court finds this restriction to both materially change and in direct contradiction of the law as written and must be invalidated."[14]

By striking down the definition of designee, the court effectively allowed a patient to designate a hospital as his or her representative to appeal inpatient services denied by a health plan as a result of concurrent utilization review. Thus, if a hospital obtained an appointment as a designee, the hospital would have access to the External Appeal Program in the event the health plan denied the first level appeal. This would be so because the statute authorizes enrollees or their authorized representatives to appeal all final adverse determinations, regardless of whether the underlying review was concurrent or retrospective.

Although viewed as a victory for providers when it was issued, the tangible benefits of the *HANYS v. Serio* decision remain to be seen. For the past two years, HANYS has worked with outside counsel to develop forms and other materials to facilitate the appointment of hospitals as designees. Anecdotally, it appears that most facilities have not attempted to utilize the *HANYS v. Serio* decision to pursue appeals of medical necessity denials.

Some Guys Have All the Luck: The Benefits of Being a Provider Covered by the NYS Access to End of Life Care Law

As discussed above, New York State law provides a framework for turnaround times regarding UR decisions. This helps members and providers in that it establishes bright-line rules for the timely processing of UR requests. However, a provider's right to effectively and efficiently appeal denials of UR decisions, particularly concurrent review denials, is hamstrung by regulatory issues (such as the definition of retrospective adverse determination) and operational issues (such as how and when to ask a patient to appoint a facility as his or her designee for the purpose of pursuing appeals). But not all providers suffer from this burden. In fact, there is one class of provider that receives special treatment under New York State law: acute care facilities licensed pursuant to Article 28 of the Public Health Law specializing in the treatment of terminally ill patients. Calvary Hospital in the Bronx, New York, appears to be the primary (if not the only) beneficiary of the Access to End of Life Care Law.[15]

Sponsored by Senator Hannon and enacted into law in 1999,[16] the Access to End of Life Care Law[17] essentially guarantees admission to a facility such as Calvary if the patient's medical condition meets certain requirements. As a result of its amendment in 2000,[18] the statute also dictates how much such a facility will be paid for the admission. Perhaps most interestingly, the Access to End of Life Care Law controverts the usual practice under the External Appeal Law in that it requires the health plan, not the member, to initiate an expedited external appeal if the health plan disagrees with the decision to admit (or to continue services).

Specifically, the Access to End of Life Care Law requires that health plans "shall provide an enrollee diagnosed with advanced cancer (with no hope of reversal of primary disease and fewer than sixty days to live, as certified by the patient's attending health care practitioner) with coverage for acute care services at an acute care facility licensed pursuant to article twenty-eight of this chapter specializing in the treatment of terminally ill patients, if the patient's attending health care practitioner, in consultation with the medical director of the facility, determines that the enrollee's care would appropriately be provided by the facility."[19] If the health plan disagrees with this determination, it cannot deny the admission. Rather, it must initiate an expedited external appeal with the Department of Insurance.[20] If the health plan does not initiate an expedited external appeal, it is required to reimburse Calvary for services provided subject to the reimbursement requirements of the statute and other limitations otherwise applicable under the enrollee's contract.[21] Significantly, the statute mandates with specificity how Calvary should be reimbursed if it is not a participating provider in the member's health plan network.[22]

Conclusion

Payment for services rendered remains an ongoing struggle for health care providers, particularly acute care facilities. Although the law provides some rights with regard to UR turnaround times and external appeal rights, most providers feel that these rights are weak at best. Some providers, such as Calvary Hospital, have been fortunate enough to convince the New York State legislature to pass a law that basically guarantees admissions and payment (subject to certain conditions). Hope for other providers may come in the form of Assembly Bill A.6844-A and Senate Bill S.5744-A, which, among other things, redefine the definition of "retrospective adverse determination" in a way that is much more favorable to inpatient facilities and strengthen a provider's right to receive payment for services that were preauthorized.[23] Lest providers become too hopeful, it should be noted that these bills have been making the rounds since 1999 and have yet to be made into law. Could it be possible that Nietzche was thinking of health care providers when he said, "That which does not kill us makes us stronger"?

Endnotes

1. Chapter 705 of the Laws of 1996.
2. *See, e.g.*, N.Y.S. Public Health Law § 4900(8) ("PHL").
3. "Health plans" as used in this article includes HMOs and any other health insurers that conduct utilization review.
4. PHL § 4903(2-4).
5. PHL § 4903(5).
6. PHL § 4904(2-3).
7. Chapter 586 of the Laws of 1998.
8. *See generally* N.Y. Comp. Codes R. & Regs. tit. 11, §§ 410 *et seq.* ("N.Y.C.R.R.").
9. See definition of "retrospective adverse determination" at 10 N.Y.C.R.R. § 98-2.2(h) and 11 N.Y.C.R.R. § 410.2(i).
10. *See* 11 N.Y.C.R.R. § 410.2(d). The N.Y.S. DOH implementing regulations define designee the same way. *See* 10 N.Y.C.R.R. § 98-2.2(c).
11. *See* N.Y.S. DOI and DOH External Appeal Program Annual Report, July 1, 1999-June 30, 2000, *available at* http://www.ins.state.ny.us/acrobat/extapp.pdf.
12. See the Department of Insurance regulations at 11 N.Y.C.R.R. § 410.2(d). The Department of Health's regulation reads the same except that it substitutes "enrollee" for "insured" (*see* 10 N.Y.C.R.R. § 98-2.2(c)).
13. See the Department of Insurance regulations at 11 N.Y.C.R.R. § 410.2(i). The Department of Health's regulation reads the same except that it substitutes "enrollee" for "insured" and makes reference to the Public Health Law rather than the Insurance Law (*see* 10 N.Y.C.R.R. § 98-2.2(h)).
14. *Healthcare Association of New York State v. Gregory V. Serio*, Decision and Order, Index No. 3133-01, RJI No. 0101ST857 (Sup. Ct., Albany Co., Feb. 8, 2002).
15. PHL § 4406-e (McKinney's 2002); NYS Insurance Law § 4805 McKinney's 2000, Supp. 2004).
16. Chapter 559 of the Laws of 1999.
17. PHL 4406-e applies only to members of HMOs that are certified under Article 44 of the Public Health Law or are licensed under Article 43 of the Insurance Law. Access to end-of-life care obligations for all other types of health insurers are governed by section 4805 of the Insurance Law. It should be noted that neither law applies to Medicare members as federal preemption precludes such application.
18. Chapter 572 of the Laws of 2000.
19. PHL § 4406-e(2); N.Y.S. Insurance Law § 4805(a).
20. PHL § 4406-e(3); N.Y.S. Insurance Law § 4805(b).
21. PHL § 4406-e(4); N.Y.S. Insurance Law § 4805(c).
22. *Id.*
23. The full text of both bills is available through http://public.leginfo.state.ny.us/menugetf.cgi.

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Huntington Hosp. v. Abrandt, 4 Misc. 3d 1 (2d Dep't 2004)
Huntington Hospital, Respondent, v. Eileen Abrandt et al., Appellants

24121
Supreme Court, Appellate Term, Second Department,
April 9, 2004
APPEAL from a judgment of the District Court
of Suffolk County
(Paul M. Hensley, J.)

Appearances of Counsel

Goldfarb Abrandt Salzman & Kutzin LLP, New York City (Jeffrey G. Abrandt of counsel), for appellants.

Smith, Carroad, Levy & Finkel, LLP, Commack (*Timothy Wan* of counsel), for respondent.

Opinion of the Court

Judgment unanimously affirmed without costs.

Memorandum

This action for services rendered and account stated was brought by plaintiff hospital in June of 2001 to recover the balance due for medical services rendered to defendant Eileen Abrandt in June of 1997. Defendants conceded that Ms. Abrandt was treated by plaintiff hospital on the dates in question, but they argued that the charges sought did not represent the fair market value of the services rendered. In opposition to plaintiff's motion for summary judgment, defendants specifically contended that, as an uninsured patient, Ms. Abrandt was not charged the "fair and reasonable" value of the services rendered, inasmuch as the hospital charged different fees for the same services depending upon whether a patient was covered by medical insurance or by government programs such as Medicare and Medicaid. Plaintiff stated that all patients were billed at the same rate, but admitted that lesser amounts were accepted as payment in full because of negotiated contracts with third parties and governmental regulations limiting payment. [*2]

In general, an agreement to pay for medical services may be implied, whether characterized as a contract implied-in-fact or a contract implied-in-law (*see Shapira v. United Med. Serv.,* 15 N.Y.2d 200 [1965]; *Crouse Irving Hosp. v. City of Syracuse,* 283 App. Div. 394 [1954], *aff'd* 308 N.Y. 844 [1955]). The performance and acceptance of services can give rise to an inference of an implied contract to pay for the reasonable value of such services (22A NY Jur 2d, Contracts § 591).

In *Flushing Hosp. & Med. Ctr. v. Woytisek,* 41 N.Y.2d 1081, 41 N.Y.2d 1081-1082) [1977]), the estate of a Blue Cross subscriber sought to be billed by the plaintiff hospital at the same rate as Blue Cross, which had contracted with the hospital for a lower rate. The Court of Appeals stated that "[f]or whatever may be the reasons—volume of payments, promptness in paying, assurance of payment or otherwise—Blue Cross is entitled to what amounts to a very substantial discount with respect to its 50% of the regular charges. The subscriber, however, is not entitled to derive any economic benefit from this independent arrangement between the hospital and Blue Cross" (at 1082-1083).

The fact that lesser amounts for the same services may be accepted from commercial insurers or government programs as payment in full does not indicate that the amounts charged to defendant were not reasonable (*see Albany Med. Ctr. Hosp. v. Huberty,* 76 A.D.2d 949 [1980]).

Plaintiff has established a prima facie case for relief and the absence of material facts. Defendants failed to meet their burden of providing evidentiary proof to raise a triable issue of fact. Neither the conclusory affirmation of defense counsel nor the affidavit of defendants' "expert," which suggested that a comparison of various contractual cost structures be made in order to determine the "fair and reasonable" charge for uninsured patients, are sufficient to raise a triable issue of fact. Accordingly, the court below did not err in granting plaintiff's motion for summary judgment.

McCabe, P.J., Lifson and Skelos, JJ., concur.

NEWS flash

What's Happening in the Section

New Section Leaders Nominated; Lynn Stansel to be Chair in 2005-06

The Section's Nominating Committee has proposed the following persons for election as officers for 2005-06.

Chair-Elect:	Mark Barnes
Vice-Chair:	Peter J. Millock
Secretary:	Ross P. Lanzafame
Treasurer:	Edward S. Kornreich

Lynn Stansel

The election will take place at the Annual Meeting in January, and the persons elected will take office on June 1.

In addition, Lynn Stansel will become Section Chair on June 1, 2005, as a result of having been elected Chair-Elect last June.

Lynn Stansel has been Associate General Counsel for Montefiore Medical Center, Bronx, N.Y., since 1996. Prior to Montefiore, she was an attorney with Memorial Sloan-Kettering Cancer Center for four years. She began her legal career in 1985 as a commercial litigator in Manhattan.

At Montefiore, Ms. Stansel's practice includes serving on internal compliance committees, acting as counsel on federal and state audits and investigations, and advising on regulatory issues and reimbursement. She also represents the hospital in professional discipline matters.

Before becoming the Section's Chair-Elect, Ms. Stansel was Secretary of the Section, and before that, Chair of the In-house Counsel Committee.

Ms. Stansel received a master's degree in Hospital Administration and a law degree (J.D.) from Duke University in Durham, North Carolina, in 1985. She holds a bachelor's degree in biology from Wittenberg University in Springfield, Ohio.

Health Law Section Plans Fall Retreat with a Mix of Business/Pleasure

The Health Law Section is planning a retreat for the fall that will include both professional education and a more-than-usual amount of time for social activities/networking. The retreat will be at the Gideon Putnam Hotel—an elegant Georgian-revival structure in a beautiful setting—in Saratoga Spa State Park. Attendees will have plenty of leisure time to get to know colleagues and wander through Saratoga Springs, one of New York's most picturesque towns. They will even have time for a mineral bath and massage at the famous Roosevelt Spa, within walking distance of the hotel.

The Elder Law Section will also be conducting a conference at the same time and hotel, and the two Sections are planning some joint programs, as well as separate programs. More specific information will be available soon on the Section's website.

Executive Committee Clarifies Rule on Approval of Committee Reports

On November 4, 2004, the Health Law Section Executive Committee met in Albany, and among other actions, agreed upon the following principles with respect to reports by Committees:

1. Committee Reports. A committee may publicly disseminate a report only after it is approved by majority vote of the Executive Committee. Such report may then be disseminated as a report of the Committee.

2. Section Reports. The Section may opt to adopt a committee report as a Report of the Section, or issue its own report as a Report of the Section, provided it is approved by a two-thirds vote of the Executive Committee.

Program on Senior Residential Services Planned

The Section is planning its first program on Senior Residential Services. The program will be held on a date to be announced in the spring, in New York City and Albany. Sandra Maliszewski of Ruskin Moscou Faltischek is the planning chair of the program.

Program on External Appeals Rules

The Section will be sponsoring a half-day program examining the external appeals process relating to the denial of coverage by health insurers or HMOs. The program is scheduled to be held on March 11, 2005 in New York City.

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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