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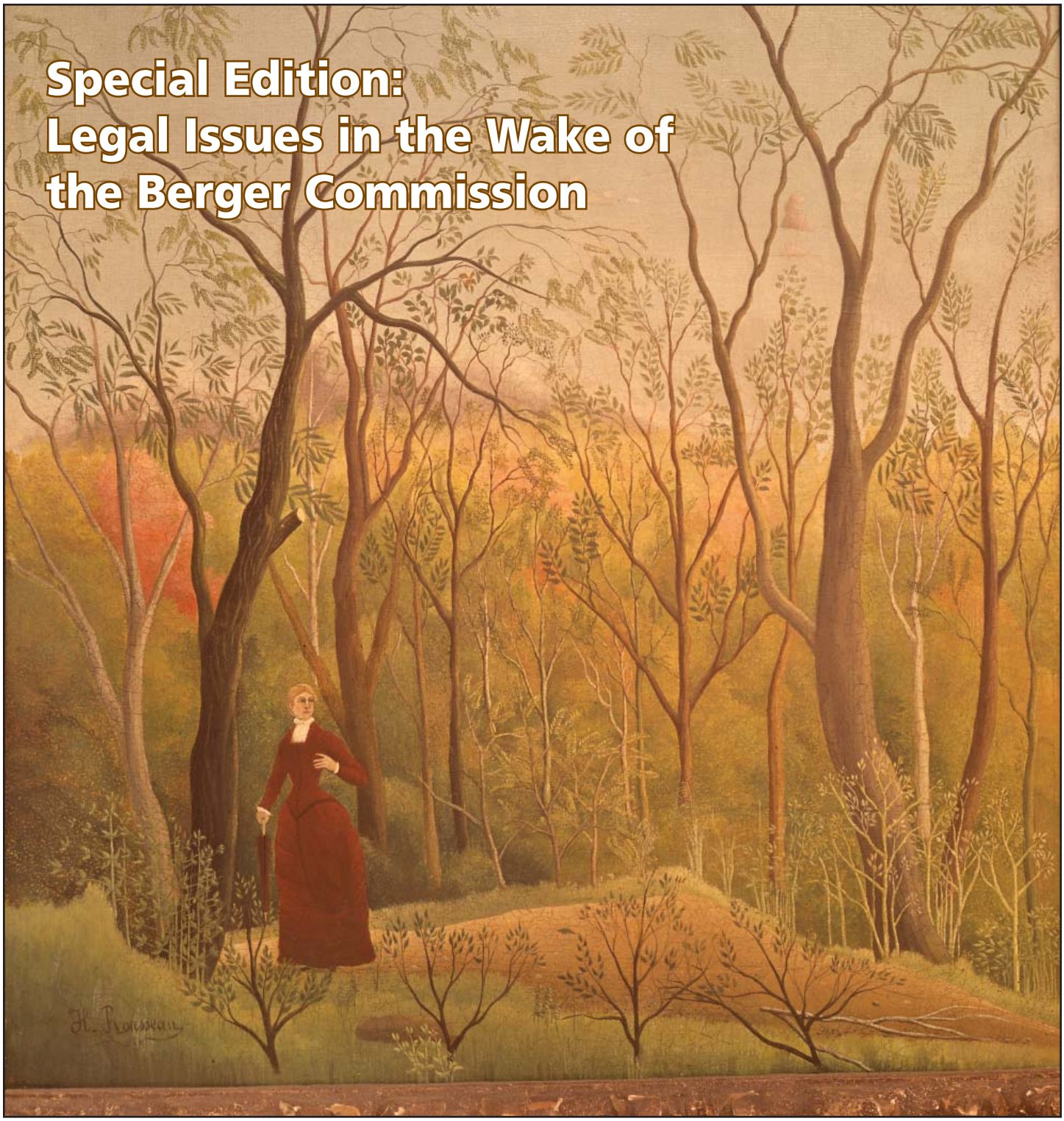
Health Law Journal

A publication of the Health Law Section of the New York State Bar Association



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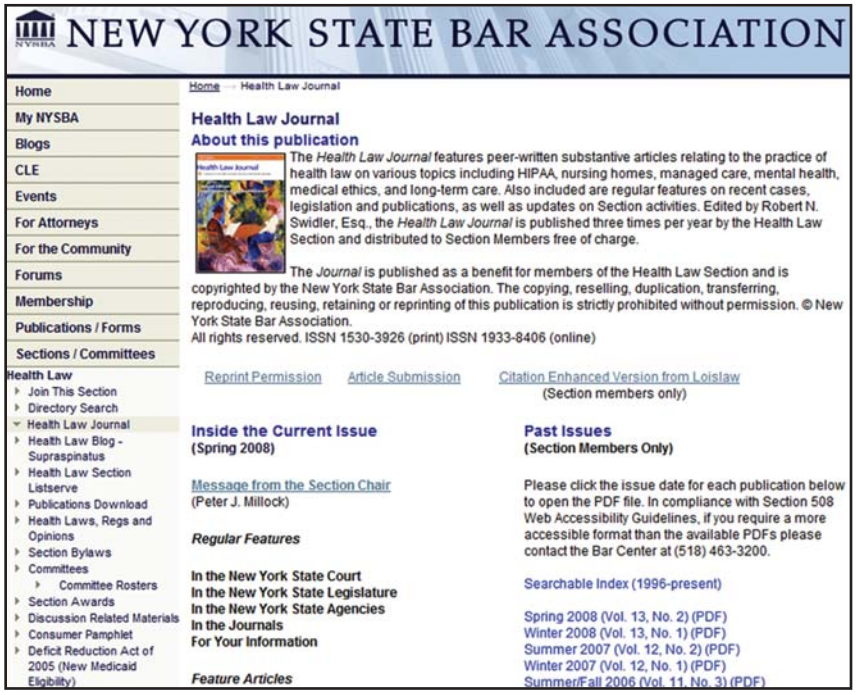

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THE HEALTH LAW SECTION
NEW YORK STATE BAR ASSOCIATION

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Cover artwork:
Rousseau, le Douanier, Henri. *A walk in the woods*, 1886-90. Oil on Canvas.

A Message from the Section Chair

It is my pleasure, as the new Chair of the NYSBA Health Law Section, to welcome you to this edition of the *Health Law Journal* and to share with you some thoughts on this coming year and the challenges we face as health care lawyers.

First, however, I must recognize Peter Millock for the outstanding job he did as the immediate past Chair of the Section. Peter accomplished many things throughout his tenure, including streamlining and updating the Section's Committees and focusing attention on membership and diversity, thereby enabling the Section to grow and reflect the legal community we practice within. Thank you, Peter, for what you have accomplished and for your efforts to effectuate a seamless transition—all of which will make my job easier.

Ever since its inception, the Health Law Section has served as a forum for health care lawyers from all settings to dialogue, as well as a resource for elected officials and government regulatory agencies on a variety of health care topics ranging from AIDS to voluntary/self-disclosure programs. The challenges health care lawyers and the clients we serve face in these days of economic uncertainty and political change are indeed daunting. We are fortunate as Section members to have available to us tools including the *Health Law Journal* and our groundbreaking health law blog *Supraspinatus* that foster both learning and the exchange of ideas. (If you have yet to visit *Supraspinatus*, I encourage you to do so at http://nysbar.com/blogs/healthlaw.) While there is no shortage of issues to be tackled, one that is rising to the fore and will be addressed by the Section's E-Health and Information Committee is the exchange of patient health information across Regional Health Information Organizations (RHIOs).

Across the state and nation, RHIOs are being established with the purpose to enable authorized physicians and other health care providers to share patient clinical results across institutional boundaries. No more waiting for diagnostic test results to be faxed, or having to log into one portal for radiology results and another for laboratory results. No more guessing as to a patient's medications or allergies, or relying upon a patient's potentially faulty memory to recall his or her medical history, or waiting for medical records to be released from a prior caregiver or institution. RHIOs offer participating patients and their health care professionals a single source for health information as the patient moves through the region's health care delivery system. RHIOs have been described as offering the first "patient-centric" view of health information with a clear roadmap of the way services are actually delivered and received.

The potential benefits of the free information exchange RHIOs offer is great—fewer repeated tests, reduced risk of mistakes caused by illegible handwriting or hard to read faxes, lessened chance of drug interactions, prompt access to complete medical history information, and easier second opinions and consultations. Yet, counterbalancing the benefits of the free flow of information is the panoply of privacy issues attendant to the access to and use of electronic health information. Generally speaking, these issues fall into four buckets: (1) who has access to the information? (2) what information is accessible? (3) for what purposes and under what circumstances may information be accessed? and (4) how will privacy, security and integrity of the information be maintained so as to prevent "browsing" and/or record alteration?

Patient choice clearly has a central role, since most RHIOs permit patients to opt in or out of the health information exchange. For patients whose privacy concerns override the benefits they may realize from participation, there is the choice to opt out of most RHIOs. But what about the patient who opts in for most providers or episodes of care, yet asks to opt out for one or more care episodes? Such a patient presents a challenge not only to the RHIO but also to the health care providers who may seek to rely on the information contained in the RHIO's exchange as complete. As RHIOs seek to address these key privacy questions, they do so in light of HIPAA, Public Health Law § 18, Public Health Law Article 27-F, and the other statues and regulations controlling the maintenance, use, disclosure and redisclosure of medical records and patient health information.

Striking the balance between the benefits of the free flow of information among caregivers and patient privacy will be like finding the intersection between art and science. If any group can do it, I am confident that the Section's E-Health and Information Committee will be at the forefront. If you have yet to join this or any other of the Section's committees, I urge you to go online, check them out and sign up today.

These are indeed exciting times in which we live. Mark your calendars now and plan to attend the Section's Annual Meeting to be held on January 28, 2009 at the New York Marriott Marquis. Ellen Weissman and Margaret Davino are working on a program addressing payment and reimbursement for health care services. In times of extraordinary budget challenges, this certainly will be a "must see" program.

I look forward to working with you all over the course of this year to address the health law issues facing New York State and the clients we serve.

Ross P. Lanzafame

In the New York State Courts

By Leonard M. Rosenberg

The New York Court of Appeals Rules that Filing a Claim Under New York's Whistleblower Law Does Not Bar a Simultaneous or Subsequent Claim Under New York's Health Care Whistleblower Law, and to Bring a Claim Under the Latter, an Employee Must Be Qualified to, and Actually Is Required to, Make Quality-of-Patient-Care Determinations

Reddington v. Staten Island Univ. Hosp. et. al., 11 N.Y.3d 80 (2008). After receiving a right-to-sue letter from the Equal Employment Opportunity Commission, Plaintiff Carmel Reddington ("Reddington"), a former employee of Staten Island University Hospital ("Hospital"), brought suit against the Hospital and other defendants in the U.S. District Court for the Eastern District of New York. The suit alleged violations of various federal and state laws, including violations of New York's Whistleblower Law § 740 ("Section 740") and New York's Health Care Whistleblower Law § 741 ("Section 741").

In responding to a motion to dismiss, Reddington amended the complaint by withdrawing the Section 740 claim, which was time-barred, and several of the other claims. Defendants again moved to dismiss the complaint, which the District Court granted in part and denied in part. The District Court found that Reddington adequately pleaded several claims under federal and state laws, but dismissed her remaining claims, including that under Section 741. In dismissing the Section 741 claim, the District Court determined that Reddington waived this claim when she first asserted the Section 740 claim in her original complaint, pursuant to the election of remedies in Section 740. The District Court further noted that the Section 741 claim could have been dismissed, alternatively, because Reddington did not assert in the complaint that she actually performed

health care services while employed by the Hospital; rather, she worked for the Hospital as an interpreter and a volunteer coordinator.

In reviewing the District Court's decision on appeal, the Second Circuit Court of Appeals found no controlling rulings in New York State, and, in fact, found substantial disagreement between the state and federal courts related to the relationship between Section 740 and Section 741, and the scope of coverage provided by Section 741. Accordingly, the Second Circuit certified two questions to the New York Court of Appeals: (1) Does the institution of a time-barred claim pursuant to Section 740 simultaneously with a claim pursuant to Section 741 trigger the waiver provision in Section 740 and thereby bar the Section 741 claim even if the Section 740 claim is subsequently withdrawn? and (2) Does the definition of employee in Section 741 encompass an individual who does not render medical treatment, and under what circumstances? The New York Court of Appeals answered both questions in the negative.[1]

In answering the first certified question in the negative, the New York Court of Appeals noted that Section 740 and Section 741 have "uniquely interconnected elements," and that every Section 741 claim "expressly relies on and incorporates § 740 for purposes of enforcement." Specifically, Section 741(4) states that a health care employee may seek enforcement of Section 741 pursuant to Section 740(4)(d). Section 740(4)(d) states that a health care employee "who has been the subject of a retaliatory action by a health care employer . . . may institute a civil action in a court of competent jurisdiction . . . ." As such, Section 740—not Section 741—creates the private right of action for a health care employee. The New York Court of Appeals held that because Section 741 provides no independent private right of action, the pleading of a Section 741 claim after a Section 740 claim is instituted does not implicate any election of remedies under Section 740.

The New York Court of Appeals also determined that the election of remedies in Section 740 was included to prevent duplicative recovery—meaning a health care employee may recover damages either for a specific violation under Section 741 (through the enforcement mechanisms of Section 740), or for general violations under Section 740. A health care employee, however, cannot recover twice under both Section 740 and Section 741. Accordingly, the election of remedies found in Section 740 does not preclude a simultaneous or subsequent claim under Section 741.

In answering the second certified question in the negative, the New York Court of Appeals noted that the protections offered under Section 741 prohibit an employer from taking retaliatory action against an employee—defined as one "who performs health care services for and under the control and direction of any public or private employer which provides health care services for wages or other remuneration"—for disclosing, objecting to, reporting, or otherwise taking action with regard to anything the employee believes constitutes improper quality of patient care. The Court noted that this definition contains limitations both on the type of employer and the type of employee: (1) the employer must be in the business of providing health care services, and (2) the employee must perform health care services. After reviewing the plain meaning of "perform,"

the court construed this definition to mean that, to be qualified as a health care employee under Section 741, the employee must "actually supply health care services, not merely . . . coordinate with those who do."

In further support of this interpretation, the court turned to the legislative history behind the enactment of Section 741. In so reviewing, the court found that the specialized protections offered under Section 741 were "meant to protect professional judgments regarding the quality of patient care," not just to those employees who possess professional licenses but to any employee who, through training and/or experience, is qualified to make "knowledgeable judgments as to the quality of patient care, and whose jobs require them to make these judgments." Accordingly, Section 741 does not encompass an employee who does not render medical treatment.

Southern District Dismisses Antitrust Suit Against Cardiothoracic Surgeons and Westchester County Medical Center Based on Immunity from Antitrust Liability Under the State Action Doctrine

Rocco J. Lafaro, M.D., et al. v. New York Cardiothoracic Group, PLLC, et al., No. 07-7984, slip. op. (S.D.N.Y. September 11, 2008); *appeal docketed*, No. 08-4621 (2d Cir., September 24, 2008). Cardiothoracic surgeons and their professional corporation ("Plaintiffs") brought an action against other cardiothoracic surgeons and their professional group, New York Cardiothoracic Group, PLLC (NYCG), Westchester County Health Care Corporation (WCHCC) and Westchester Medical Center (WMC), with which the defendant physicians contracted, on an exclusive basis, for the provision of cardiothoracic services at WMC (the "Exclusive Agreement"). Plaintiffs practiced as cardiothoracic surgeons at WMC for a number of years prior to the Exclusive Agreement, and were permitted to continue practicing there pursuant to a "grandfather" clause in the Exclusive Agreement.

Plaintiffs alleged that the Exclusive Agreement violated the federal Sherman Antitrust Act because it gave the defendant physicians latitude to determine use of the cardiothoracic operating rooms, and because new hires had to be approved by NYCG. Thus, Plaintiffs argued that the Exclusive Agreement, *inter alia,* limited patient choice and chilled competition for cardiothoracic patients at WMC. Plaintiffs also argued that the Exclusive Agreement prohibited them from expanding their practice within the hospital.

Defendants moved to dismiss Plaintiffs' federal antitrust claims on various grounds, including that the Defendants were immune from antitrust liability under the State Action or *Parker* Doctrine, named for the seminal case *Parker v. Brown*, 317 U.S. 341, 63 S.Ct. 307 (1943). The District Court (Hon. Stephen C. Robinson) dismissed Plaintiffs' Sherman Act claim based on the State Action Doctrine, and declined to maintain supplemental jurisdiction over the remaining state law claims.

In reaching its decision, the Court first analyzed the traditional two-prong test to establish State Action immunity, i.e., was it foreseeable to the state that WCHCC would act in an anticompetitive manner based on the authority granted to it, and did the state actively supervise WCHCC's actions? As for the first prong, the Court initially cited to *Parker v. Brown, supra*, and explained that states acting as sovereigns are exempt from liability under the Sherman Antitrust Act, and that a state subdivision, such as a public-benefit corporation like WCHCC, enjoys the protection of State Action immunity when it acts "pursuant to a clearly expressed state policy" to displace competition. *See Town of Hallie v. City of Eau Claire*, 471 U.S. 34, 39-40, 105 S.Ct. 1713 (1985); *City of Lafayette v. Louisiana Power & Light Co.*, 435 U.S. 389, 98 S.Ct. 1123 (1978). To meet this element, the Court noted that the state subdivision's enabling legislation must make clear that it was "foreseeable" to the state that the entity could operate in a manner to suppress competition. *See City of Columbia v. Omni Outdoor Adver*, *Inc.*, 499 U.S. 365, 372-73, 111 S.Ct. 1344 (1991); *Cine 42nd St. Theatre Corp. v. Nederlander Org., Inc.*, 790 F.2d 1032, 1042-43 (1986).

Applying the law to this case, Judge Robinson pointed to WCHCC's enabling statute which grants it, a public benefit corporation, the power, *inter alia*, "to enter into contracts . . . necessary or convenient or desirable for the purposes of the corporation to carry out any powers expressly given to it" and "[t]o provide health and medical services for the public directly or by agreement or lease with any person, firm or private or public corporation or association . . . and to make internal policies governing . . . health and medical services . . ." *See* N.Y. Pub. Auth. §§ 3305(11), 3306(2). The Court also focused on the provision of WCHCC's enabling statue that grants the corporation the authority "[t]o determine the conditions under which a physician may be extended the privilege of practicing within a health facility." *See id.* at § 3306(6). Based on these provisions, the Court concluded that the legislature intended for WCHCC to be free to enter into contracts with private parties to provide medical care, and that the state contemplated that WCHCC could and would impose restrictions with regard to doctors' ability to practice at WMC in an anticompetitive manner. Thus, the Court held that under the first prong of the analysis, WMC and WCHCC were immune from antitrust liability under the State Action Doctrine, and were free to enter into the Exclusive Agreement with the individual physician defendants and NYCG.

Turning to the second prong, the Court relied on precedent, holding that publicly created state agencies, such as WCHCC, do not need to meet the "active supervision" prong

to be afforded State Action immunity because, as a public entity, their interests are necessarily aligned with the public's. *See Cine 42nd St. Theatre, supra* at 1047.

The Court also found the individual defendant physicians and NYCG to be immune under the State Action Doctrine based on Second Circuit precedent holding that private parties who contract with immune state agencies are likewise protected since "allowing successful tangential attacks on the [public entity's] activities through suits against third parties [acting in concert with it] would effectively block the efforts of the [public entity]" to perform its duties by contracting with third parties. *See Cine 42nd St. Theatre, supra* at 1048; *see also Electrical Inspectors, Inc. v. Village of East Hills*, 320 F.3d 110, 125-27 (2d Cir. 2003).

Finally, the Court rejected Plaintiffs' argument that WCHCC's enabling statute cannot be viewed as a clearly expressed state policy to displace competition due to the enactment of the New York Health Care Reform Act (HCRA), a hospital rate reimbursement statute. Plaintiffs argued that HCRA lead to a large-scale policy shift to deregulate hospitals, and that, as a result, for the State Action Doctrine to apply, WCHCC's enabling statute would have to affirmatively exempt it from the state's competition-favoring policies. The Court countered this by noting that Plaintiffs' position is undermined by the fact that the legislature, rather than relying on market forces, created the Commission on Health Care Facilities in the 21st Century (a/k/a the Berger Commission) to assess and decide which New York hospitals should be closed or restructured due to excess capacity. [Ed. Note: Garfunkel, Wild & Travis, P.C. represented the defendants in this suit.]

Southern District Dismisses False Claims Act Allegations That HIP Fraudulently Altered Data in Order to Obtain Accreditation Needed to Maintain a Contract with the U.S. Government

U.S. ex rel. Sterling v. Health Ins. Plan of Greater New York, Inc., slip. op., 2008 WL 4449448 (S.D.N.Y. September 30, 2008). In this suit brought under the Federal False Claims Act, 31 U.S.C. § 3729, the relator alleged that Health Insurance Plan of Greater New York, Inc. (HIP) fraudulently altered data in order to obtain accreditation needed to maintain a contract with the U.S. Government. Specifically, the relator alleged that after she performed a computer analysis to determine the percentage of children diagnosed with pharyngitis who were tested for strep throat showed that between 2.35% to 2.95% were tested, the relator's supervisor altered the data to reflect that 56.76% to 78.04% of the children were tested. The relator alleged that as a result of the fraudulent alteration, National Committee for Quality Assurance (NCQA) (HIP's accrediting agency) allegedly provided HIP with a high rating, and that had the government been aware that HIP generated such fraudulent data it would not have issued contracts and paid premiums to HIP.

The District Court granted HIP's motion to dismiss. First, the Court found that the relator failed to state a claim under the conspiracy provision of 31 U.S.C. § 3729(a)(3) because the complaint did not provide that two or more people from HIP were involved in the alleged fraud. Second, citing to the recent Supreme Court decision, *Allison Engine Co. v. United States ex rel. Sanders*, __ U.S. __, 128 S.Ct. 2123, 170 L.Ed.2d 1030 (2008), the Court dismissed the relator's claim pursuant to 31 U.S.C. § 3729(a)(2) because the relator failed to allege that HIP's alleged fraudulent statement to NCQA was made with the intent that the Government rely on it as a condition of payment. Third, the Court dismissed the relator's claim pursuant to 31 U.S.C. § 3729(a)(1) because the Court did not find that presentment of a false claim to NCQA, an independent accreditation organization, constitutes presentment of a claim to the government.

Insurer's Failure to Advise an Insured of the Right to Independent Counsel Under *Goldfarb* Held a Deceptive Business Practice Under New York GBL 349(a)

In a 1981 decision, the New York Court of Appeals recognized that a conflict of interest arises between an insurer and its insured, in a litigation involving both covered and uncovered claims—i.e., where the insurer faces liability with respect to only some of the claims therein asserted, but the insured alone faces liability with respect to others. *See Public Service Mutual Ins. Co. v. Goldfarb*, 53 N.Y.2d 392, 401 (1981). Moreover, the *Goldfarb* court recognized that, in such cases, the insured is entitled to a defense attorney of its own choosing at the expense of the insurer.

In the case of *Elacqua v. Physicians' Reciprocal Insurers*, the New York Appellate Division, Third Department, rendered two decisions relative to *Goldfarb*. First, in *Elacqua v. Physicians' Reciprocal Insurers*, 21 A.D.3d 702, 707 (3rd Dep't 2005), the Court held that, upon becoming aware of a *Goldfarb* conflict of interest, an insurer has an affirmative obligation to advise its insured of the right to independent counsel at the insurer's expense.

Thereafter, Physicians' Reciprocal Insurers (PRI) entered into a settlement of the underlying action, which settlement satisfied all claims against the insureds. The insureds, licensed physicians Mary Elacqua and William Hennessey, and their LLP, continued their action despite the settlement, seeking to recover attorneys fees incurred in compelling PRI to indemnify them. Following a bifurcated trial on liability, the Supreme Court dismissed the complaint, and the in-

sureds appealed the dismissal of their General Business Law § 349(a) claim alleging deceptive business practices. The Supreme Court had found that the failure to inform an insured of its right to independent defense counsel at the insurer's expense, as recognized in *Goldfarb*, is a consumer-oriented deceptive business practice that is likely to deceive reasonable consumers—however, it dismissed the insureds' GBL § 349(a) claims on the ground that they had failed to demonstrate actual harm as a result of not being represented by independent counsel.

The Appellate Division reversed, holding that the failure to notify the insureds of their right to independent counsel, together with the insureds' showing that conflict-free representation had not been provided to them, constituted actual harm for purposes of GBL § 349(a). The Court cited the fact that the insureds had not been fully informed of the ramifications of a motion to dismiss the complaint only as against the physicians, which defeated liability on the part of PRI but left the LLP vicariously liable for uncovered claims alleging negligence by an employee nurse. Additionally, the attorney representing the LLP had fully joined in the motion, despite the fact that there were legally sufficient grounds upon which to base an opposition. The Court held that this demonstrated lack of independent representation, uncompromised by conflicts of interest, constituted sufficient harm to sustain a claim for deceptive business practices under GBL § 349(a). The case was remitted for a trial on damages.

Appellate Division Rules That a Physician Who Performs a Statutory Medical Examination Does Not Have a Physician-Patient Relationship with the Person Examined

Bazaokos v. Lewis, 2008 WL 4356120 (2d Dep't September 23, 2008). Plaintiff sued Defendant, an orthopedic surgeon, for injuries allegedly sustained during Defendant's statutory medical examination (IME) of Plaintiff. Plaintiff's IME was conducted in connection with a personal injury suit he had commenced. Plaintiff alleged that during his IME, Defendant "took [Plaintiff's] head in his hands and forcefully rotated it while simultaneously pulling," causing Plaintiff personal injury.

Approximately two years and 11 months after the IME took place, Plaintiff sued the examining physician for negligence. Defendant then moved to dismiss the complaint as time-barred, contending that the action was one for medical malpractice, which is subject to a two-and-a-half-year statute of limitations, rather than one of negligence, which is subject to a three-year statute of limitations. The motion court agreed with Defendant and dismissed the complaint. The Appellate Division reversed, in a 3-to-2 decision.

The majority reasoned that critical to a finding of a physician-patient relationship is the consensual nature of the relationship and the expectation and receipt of medical services by patient for a medical condition. Here, the Court noted that there was no patient at all in this relationship, only an examinee compelled to participate in an adversarial situation because of the rules pertaining to pre-trial discovery and disclosure in personal injury actions. The Court also noted that the examining physician was not engaged in diagnosis and treatment on the examinee's behalf but for the benefit of a defendant, defense counsel, and a defendant's insurance carrier. Lastly, the Court looked to the legislative history of CPLR 214-a, which makes clear that the period of limitations for medical malpractice actions was shorted from three years to two-and-a-half years as part of a comprehensive overhaul to deal with the critical threat to the delivery of health care services, and not to provide "a significant litigation advantage to physicians not engaged in providing health care services, but instead engaged in business relationships structured to provide expert witness services to insurance carriers in the defense of personal injury litigation."

The dissent cites prior Appellate Division rulings that support the proposition that the examinee and the physician conducting a statutory medical examination are indeed in a patient-physician relationship, albeit a limited one that merely imposes a duty upon the physician to conduct the examination in a manner that does not affirmatively injure the examinee. Accordingly, the dissent found that the two-and-a-half-year statute of limitations for medical malpractice should apply and, therefore, concluded that the complaint was properly dismissed by the lower court as time-barred.

Court Holds That Defendants Cannot Apportion Liability to Non-Party Physician Father of Medical Malpractice Plaintiff Based Solely on Ordinary Parental Care Given to Offspring

Antaki v. Lerman, No. 00662806, Decided 09/22/08, 10/8/2008 N.Y.L.J. 28 (col. 1). Defendants in a medical malpractice suit filed a motion, pursuant to CPLR 1601, to charge liability to non-party Dr. Antaki.

Plaintiff is a 36-year-old man with cerebral palsy, who was suffering from severe diarrhea. Dr. Antaki, a retired or semi-retired pathologist, is Plaintiff's father. As a consequence of Plaintiff's condition and after Dr. Antaki spoke with the family physician, Plaintiff was taken to the hospital for treatment. Dr. Antaki was with Plaintiff in the Emergency Room, but Plaintiff signed the consent forms. After approximately four hours, Plaintiff felt better, and he was given a prescription and sent home. His father, Dr. Antaki, signed the discharge sheet, although Plaintiff had signed the initial consent forms himself.

A few days later, Plaintiff felt progressively worse, and Dr. Antaki called the family physician, who sug-

gested that Dr. Antaki listen for bowel sounds. Dr. Antaki did so and reported to the physician that Plaintiff did have bowel sounds. Plaintiff was later admitted to a different hospital, and later underwent surgery.

The Supreme Court ruled that, except in rare and egregious circumstances, the ministrations of a parent, who happens to be a physician, in the ordinary care of his or her offspring, shall not be deemed to create a physician/patient relationship capable of resulting in medical malpractice liability.

In reaching its decision, the Court first analyzed the applicability of CPLR 1601, which may reduce or affect the respective liability of the named defendants if there is a plaintiff's verdict against one or more of same. When the liability of a single named defendant exceeds 50%, that defendant shall be responsible for all commensurate "non-economic loss" established by the plaintiff. When the named defendant's liability is less than 50%, however, such named defendant shall be responsible only for its proportionate share.

The Court noted that application of this rule to Dr. Antaki would, in effect, constitute an indirect claim for malpractice by a son against his parent.

The Court determined that Article 16, though it is a diminution provision, cannot be invoked to attribute liability to a parent in the absence of any clear and convincing showing of authority. The court pointed out that Plaintiff was 36 years old at the time, and had the mental capacity to make his own decisions. To hold a parent responsible under these circumstances would flip the familial and nuclear family and institution to such a degree that it would, in effect, prohibit a parent from giving any sort of advice.

The Court concluded that in the interest of justice and in the interest of maintaining societal equilibrium, fairness, the family unit and its hierarchy and responsibilities, there cannot be a determination, except under the most grievous of circumstances, that could hold the parent responsible for any kind of advice or action given to the child. Accordingly, the court ruled that Dr. Antaki's interaction with his son was that of a parent with his offspring, rather than a physician with his patient.

Court Holds That Doctor's Statements in IME Report Are Protected by Absolute Privilege

Kaisman v. Carter, 13 Misc.3d 1227(A), 831 N.Y.S.2d 348 (Table) (Sup. Ct., N.Y. County 2006). Plaintiff physician brought a defamation action for statements made about him by Defendant, also a physician. The statements in question were made in an independent medical examination report (IME report) prepared by Defendant in connection with a personal injury action brought by a plaintiff identified as Ms. L.C.

In Defendant's IME report detailing his findings regarding Ms. L.C., he included an "editorial comment" that Plaintiff, an anesthesiologist, performed an unnecessary lumbar dissectomy on Ms. L.C., a procedure usually performed by a surgeon. Defendant also stated, "There is a certain lack of morality and good clinical judgment in an anesthesiologist performing such a procedure . . . it is inappropriate and, in my view, immoral for the anesthesiologist to perform surgical procedures whose complications he cannot himself treat. I must say that given the total lack of findings on physical examination or MRI, there was no good reason to submit this woman to an unneeded procedure. . . ."

Defendants moved, pursuant to CPLR 3211(a)(7), for summary judgment dismissing the complaint on the basis that the statements are afforded the privilege of absolute immunity, and are otherwise protected as opinion. Plaintiff opposed the motion on the basis that the statements are, at most, subject to a qualified privilege, because they were only tangentially related to a legal proceeding.

The Court found that the statements made by Defendant in the IME report were protected by an absolute privilege, noting that "[s]tatements made by parties, attorneys, and witnesses in the course of a judicial or quasi-judicial proceeding are absolutely privileged, notwithstanding the motive with which they are made, so long as they are material and pertinent to the issue to be resolved in the proceeding" (*Sinrod v. Stone*, 20 A.D.3d 560, 561–562, 799 N.Y.S.2d 273, 274 (2d Dep't 2005)). The Court explained that statements made in connection with a judicial proceeding are broadly construed to be "pertinent" for the purpose of absolute immunity in order to protect counsel, witnesses and parties to a judicial action, and encompass not only statements that are pertinent, but also those statements which may become pertinent.

To support its conclusion, the Court relied on the reasoning in *Aequitron Medical, Inc. v. Dyro*, 999 F.Supp. 294 (E.D.N.Y. 1998). In that case, the Court held that experts' statements in a video tape, made after the commencement of an action, were absolutely privileged, and it was of no import that the statements were made during trial preparation rather than in open court, because the experts were retained to provide their opinion concerning whether a product was defective.

Similarly, Defendant was retained as an expert to evaluate Ms. L.C.'s injuries, treatment and progress, and his statements were material and pertinent to the issues to be resolved in the underlying personal injury action, and thus afforded immunity from litigation. The Court rejected Plaintiff's contention that, at most, Defendant's statements were entitled to qualified privilege and, accordingly, dismissed Plaintiff's defamation action.

Appellate Court Affirms Ruling That Nurse's Examination of Injured Child Falls Within the Good Samaritan Law Shielding Nurse from Liability

McDaniel v. Keck, 53 A.D.3d 869, 861 N.Y.S.2d 516 (3d Dep't 2008). Plaintiff brought personal injury action against an elementary school, which took its students on a bus trip to a private school/working farm, and against a nurse who was at the farm to provide nursing services to the school's students. Plaintiff appealed from the Supreme Court's decision dismissing her complaint seeking to recover damages for an eye injury that her child, who was not a student at school, sustained while on farm premises. The school moved to dismiss the complaint against it on the ground that the nurse was an independent contractor, not an employee of the school, and thus the school could not be vicariously liable. The nurse cross-moved to dismiss the complaint as to her on the ground that her conduct was protected by the Good Samaritan law.

The Appellate Division dismissed Plaintiff's complaint in its entirety, ruling that the nurse was entitled to immunity under Good Samaritan statute in connection with her examination of child, and since the claim against the school relied upon purported vicarious liability for the acts of the nurse, the Court consequently dismissed the claims against the school.

In reaching its decision, the Court first analyzed whether the nursing Good Samaritan statute applied. That statute provides, in relevant part, that a nurse is liable only for acts or omissions constituting gross negligence when the nurse "voluntarily and without the expectation of monetary compensation renders first aid or emergency treatment at the scene of an accident or other emergency, outside a hospital, doctor's office or any other place having proper and necessary medical equipment, to a person who is unconscious, ill or injured." Education Law § 6909[1]. The statute further states that "[n]othing in this subdivision shall be deemed or construed to relieve a licensed registered professional nurse or licensed practical nurse from liability for damages for injuries or death caused by an act or omission on the part of such nurse while rendering professional services in the normal and ordinary course of her [or his] practice." Education Law § 6909[1].

The Court pointed out that the overriding purpose of the Good Samaritan statute is to encourage laypersons and professionals to help those in need, even when they are under no legal obligation to do so, by providing immunity from liability claims arising out of an attempt to assist a person in peril.

In applying the statutory law to this case, the Court reasoned that the nurse was under no duty to render assistance to the child. She was at the premises to provide nursing services exclusively to the elementary school students, of which the child was not one. The nurse volunteered to help with the child and she had no expectation of monetary compensation for such assistance. While her examination of the child occurred in the farmhouse and not the barn where the accident occurred, the farmhouse is where the child presented himself in distress immediately after the injury and, under the circumstances, the Court found this to be sufficiently close in time and proximity to being at the scene of an accident or emergency within the meaning of the Good Samaritan statute.

The Court noted that the Good Samaritan statute's exclusion for care within a hospital, doctor's office, or other place having proper and necessary medical equipment did not apply to this case because the nurse was located in a room in a farmhouse with no medical equipment or supplies other than a first-aid kit supplied by the elementary school for its students on a bus trip to a farm and a similar first-aid kit that the farm had available.

Based on the foregoing, the Court ruled that the nurse's examination of the child fell within the general purpose of the Good Samaritan law and each of the specific statutory criteria applicable to a nurse providing treatment in this state was established. There was no contention of gross negligence and, accordingly, the complaint against the nurse was dismissed.

Southern District Upholds DOH's Regulation Prohibiting Medicaid Reimbursement for Treatments of Gender Identity Disorder

Casillas v. Daines, __ F. Supp. 2d __, 2008 WL 3157825 (S.D.N.Y. 2008.) Plaintiff filed suit against the New York State Department of Health (DOH) for the denial of Medicaid coverage for surgeries and services that Plaintiff claimed were medically necessary to treat her Gender Identity Disorder (GID). The DOH denied Medicaid coverage for an orchiectomy (removal of testes) and vaginoplasty (removal of penis and creation of a vagina) pursuant to a DOH regulation that "prohibits state Medicaid reimbursements for treatments for the 'purpose of gender reassignment (also known as transsexual surgery).' 18 N.Y.C.R.R. § 505.2(1)." In response, Plaintiff filed a lawsuit claiming that the denial of Medicaid coverage deprived her of rights secured by the federal Medicaid statute and the Fourteenth Amendment. The DOH moved for judgment on the pleadings, which was granted by the Court.

In her lawsuit, Plaintiff asserted three causes of action pursuant to 42 U.S.C.A. § 1983, claiming that three sections of the federal Medicaid statute unambiguously confers a right to Medicaid coverage for the GID treatments and surgeries that her doctor claimed were medically necessary. Specifically, Plaintiff asserted that a right was created by: (1) the Medicaid statute requiring that the state make assistance available to certain broad categories (42 U.S.C. § 1396(a)(10)(A)), (2) the Medicaid statute "prohibit-

ing discrimination against or among categorically needy persons" (42 U.S.C. § 1396a(a)(10)(B)(i)) and (3) the Medicaid statute requiring the state to develop "'reasonable standards' for its plan" (42 U.S.C. § 1396a(a)(17)). Plaintiff also asserted one cause of action claiming that the denial of Medicaid coverage violated the Equal Protection Clause of the Fourteenth Amendment.

The Court began its analysis of Plaintiff's Section 1983 claims by noting that "not all violations of a federal statute by a state official are actionable" and that Plaintiff carried the burden of showing that "a right secured by a federal statute has been violated." To carry this burden a plaintiff must establish (1) that the statute unambiguously confers a right to support a cause of action brought under Section 1983, (2) that the right is not so vague that its enforcement would strain judicial competence, and (3) that the statute unambiguously imposes a binding obligation on the state.

The Court held that each of Plaintiff's three Section 1983 claims failed the first two prongs of this test and the Court, therefore, did not consider the third prong. In rejecting these claims, the Court stated that "nothing in the statute suggests that participating states are required to fund every medical procedure that falls within the delineated categories of medical care" and that the statute allows for "categorical limits on treatments." Specifically, the Court focused on the Secretary's regulation, 42 C.F.R. § 440.230(d), which affords a state the authority to "place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures." The Court noted that "in the Secretary's view, Section 1396a(a), permits a state plan to place 'appropriate limits' upon a 'service' regardless of an individual medical doctor's view of the appropriateness of the categorical limitation." The Court held that the three sections of the federal Medicaid statute relied on by the Plaintiff were all subject to this regulation. As such, the allowance of appropriate limitations precluded a finding that those three sections of the statute unambiguously confer the right to Medicaid treatment for the GID services sought by Plaintiff, and that enforcing the statutes in the manner suggested by Plaintiff would strain judicial competence. Accordingly, the Court dismissed all of Plaintiff's Section 1983 causes of action.

The Court also dismissed Plaintiff's claim that New York's regulation prohibiting Medicaid reimbursements for gender reassignment surgeries violated the Equal Protection Clause of the Fourteenth Amendment. Plaintiff did not assert that she was a member of any suspect class or that the denial of Medicaid reimbursement for the GID surgeries implicated a fundamental right. Accordingly, this claim was governed by the rational basis standard.

In dismissing this claim, the Court recognized that "in adopting the prohibition, the DOH cited 'serious complications' from the surgeries and danger from life-long administration of estrogen." The Court dismissed Plaintiff's final cause of action, finding that this "provided a more than sufficient rational basis which was related to legitimate government interests—the health of its citizens and the conservation of limited medical resources."

Endnote

1. Justice Smith issued a partial dissent, answering the first certified question in the affirmative.

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In the New York State Legislature:

New York State Health Care and the State's Fiscal Crisis

By James W. Lytle

The economic crisis facing the country has had a profound impact on New York State's economy and on its government. New York State now faces almost unprecedented fiscal challenges in the months and years ahead—with potentially very serious consequences for New Yorkers who depend on state support for health care programs, including Medicaid.

Even before the national and international economic crisis fully manifested itself in the fall of 2008, Governor Paterson had summoned the legislature to Albany in the middle of the summer to address the deterioration of the state's finances. The legislature approved $427 million in cuts in its extraordinary August legislative session, $127 million of which were achieved through Medicaid cuts. While the enacted cuts were substantially less than Governor Paterson had proposed, health care facilities experienced a further reduction of the otherwise applicable trend factor (which had already been reduced as part of the 2008–09 budget adopted in April) and Medicaid managed care and Managed Long Term Care plans experienced a 1% premium reduction. Other health care programs were subject to across-the-board reductions in local assistance spending.

In addition to these budgetary reductions, the Paterson Administration had also achieved $1.3 billion in administrative savings—principally from a 10% cut to state agency operations—which brought the overall reduction in spending in the current fiscal year to approximately $1.7 billion. Even with these extraordinary midyear reductions, it was acknowledged last August that the state would still experience very significant out-year deficits. Notwithstanding the fiscal restraint demonstrated by the Governor and the legislature in August, the Division of the Budget projected a deficit of approximately $5.4 billion in SFY 2009–10 and a cumulative deficit of over $24.4 billion over the next three years.

And then the economic picture actually went from bad to worse.

As this column goes to press, the Division of the Budget now estimates that, if no corrective action is taken, the state will experience at least a $1.2 billion budget shortfall for State Fiscal Year (SFY) 2008-09 and out-year deficits are likely to be several billion dollars further in the red. According to the Division of the Budget, this current year deficit is chiefly due to actual and projected losses of revenue to the state in the third and fourth quarters of the fiscal year, as follows:

- ***$950 Million Loss in Personal Income Tax Payments***: The state estimates that the financial services sector accounts for 20% of state tax revenue, with 30% (or $6 billion) of that revenue coming to the state in the fourth quarter of the fiscal year due to the timing of Wall Street bonuses. Current projections are that such bonuses will be 43% (or $20 billion) less than last year. As a result of losses in the sale of real estate, stocks and other assets, capital gains tax payments are now expected to decline by 35%.
- ***$350 Million Loss in Business Taxes***: The state estimates that the amount of taxes paid by 16 of the state's largest banks will amount to one-third of what was paid just last year (or $111 million compared with $333 million in SFY 2007–08) and payments by the top 20 corporate taxpayers will be reduced by 38% (or $82 million) from last year.
- ***$300 Million Loss in Revenue Due to a Delay in Certain State Financial Transactions***: The state projects that, due to adverse market conditions, it will not receive $200 million from the conversion of GHI/HIP to a for-profit company or $100 million from the sale of surplus state property.

Governor Paterson's Response to the Fiscal Crisis: In response to the dramatic further erosion of state revenues from the Wall Street crisis, Governor Paterson summoned the legislature to return on November 18 to take further action to reduce the current year and out-year budget deficits. He has also pledged to submit his 2009–10 Executive Budget to the legislature by December 16, 2008—approximately one month before it is due—to encourage prompt action on the next year's fiscal plan.

While Governor Paterson invited legislative leaders to propose budgetary savings of their own for consideration at the special November 18 session, the agenda for that session was largely set by the Governor. The Governor proposed sweeping cuts to eliminate the $1.2 billion current year deficit and to make a down payment on the budget reduction necessary to diminish the large subsequent year shortfalls. Most of the health care and medicaid cuts were "across the board," as was the case with the Governor's mid-year budget proposal. At least for now, no tax increases will be proposed by the Governor or supported by the State Senate.

The challenges faced by the Governor in achieving any meaningful reductions this year include the following:

- With only a few months left in the fiscal year, reducing spending by more than $1 billion requires far more drastic cuts than would otherwise have been necessary earlier in the year. Since some of these cuts may require some time to implement, it is not altogether clear whether sufficient appropriation reductions can actually be implemented by April 1, 2009, the commencement of the next State fiscal year.
- The timing of the special session, just weeks after the biennial election for the New York State legislature, provides very little time for serious legislative review or negotiation of any of the Governor's proposals.
- With the Executive Budget for the next fiscal year scheduled to be released only one month after the special session, legislators may wonder whether the very difficult debate should await the release of the 2009–10 budget proposal.
- Perhaps most significantly, the legislature that convened in November was the lame duck legislature of 2008—and included those members who either chose not to run for re-election or who were defeated at the polls. Moreover, with the narrow majority in the State Senate shifting to the Democrats, the lame duck session proved to be particularly unlikely to produce any budget savings for the Governor.

2009–10 Budget Proposal: Regardless of the outcome of the November special legislative session, the Governor has promised to submit his Executive Budget proposal for SFY 2009–10 to the legislature by December 16, 2008, well over a month before the date the Governor is constitutionally required to submit his budget. The budget proposal will contain the more dramatic and severe reductions in state expenditures than have been seen in many decades and that no sector of state expenditures is immune from significant reduction.

What does this portend for health care in New York State?

- The Paterson Administration's commitment to reforming the health care system and ensuring universal access to health care will probably be delayed, while the implications of the budget crisis sort themselves out.
- The crisis may, however, spur more dramatic reimbursement reform in the hospital and long term care arenas—just as was the case when the state faced similar fiscal challenges in the 1970s, which led to some of the most significant cost containment/reimbursement reforms in the history of the Medicaid program.
- Some possibility exists that other issues with fiscal implications—including the need for medical liability reform—may take on new urgency in the midst of this crisis.
- The state will be carefully examining, as well, new "public-private partnerships," which might include evaluating whether there are New York State health care programs or services that might be "privatized": an 11-member panel will be making recommendations to the Governor on how to maximize the value of state assets, including toll roads, state real and intellectual property and the Lottery. Conceivably, state-operated health care facilities may be considered in this mix.
- The prospect of a new federal Administration, potentially more pre-disposed to New York State, may also offer some hope to mitigate the otherwise devastating impact of the budget crisis on health care.

By the time you are reading this column, it may become clearer how well the New York State health care system will weather the fiscal storm.

Jim Lytle is a partner in the Albany office of Manatt, Phelps & Phillips, LLP. **Jim gratefully acknowledges the assistance of James Walsh of Manatt's Albany office in the preparation of this column.**

In the New York State Agencies

By Frank Serbaroli

HEALTH DEPARTMENT

Licensed Home Care Services Agency Regulations

Notice of adoption. The Department of Health amended §§ 763.12, 766.10 and 766.12 of Title 10 N.Y.C.R.R. to require licensed home care services agencies (LHCSAs) to submit annual cost reports and comply with annual administrative and general cost requirements applied to certified home health agencies (CHHAs). Filing date: May 20, 2008. Effective date: June 4, 2008. *See* N.Y. Register, June 4, 2008.

DRGs, SIWs, Trimpoints and the Mean LOS

Notice of emergency rulemaking. The Department of Health amended §§ 86-1.55, 86-1.62 and 86-1.63 of Title 10 N.Y.C.R.R. to update the calculation of outlier payments based on the Department of Health and Human Services (HHS) audit findings and recommendations. Filing date: July 1, 2008. Effective date: July 1, 2008. *See* N.Y. Register, July 16, 2008.

Non-Prescription Emergency Contraceptive Drugs

Notice of adoption. The Department of Health amended § 505.3(b)(1) of Title 18 N.Y.C.R.R. to allow U.S. Food and Drug Administration (FDA) approved non-prescription contraceptive drugs to be dispensed by a pharmacy without a written order to women 18 years of age and older. Filing date: July 8, 2008. Effective date: July 8, 2008. *See* N.Y. Register, July 23, 2008.

Controlled Substances Data Submissions

Notice of emergency rulemaking. The Department of Health amended §§ 80.2, 80.23, 80.67-80.69, 80.71, 80.73-80.74, 80.132, and 80.134 of Title 10 N.Y.C.R.R. to prevent diversion of prescription controlled substances; provide practitioners increased flexibility when treating chronic pain from conditions other than diseases; increase the time for hospice patients to partial fill their controlled-substance prescriptions; and allow more humane euthanasia of animals in municipal animal shelters. Filing date: July 28, 2008. Effective date: July 28, 2008. *See* N.Y. Register, August 13, 2008.

Approval of Nonclinical Projects

Notice of proposed rulemaking. The Department of Health gave notice of its intent to amend § 710.1(c)(6) of Title 10 N.Y.C.R.R. to substitute prior limited review for administrative certificate of need (CON) review of construction projects with costs between $3 million and $10 million. *See* N.Y. Register, August 20, 2008.

Ambulatory Patient Groups (APGs) Outpatient Reimbursement Methodology

Notice of proposed rulemaking. The Department of Health gave notice of its intent to add Subpart 86-8 to Title 10 N.Y.C.R.R. to provide a new, more cost effective payment methodology, for certain ambulatory care fee-for-service Medicaid services based on APGs. *See* N.Y. Register, September 3, 2008.

Physical Therapist Assistants and Occupational Therapy Assistants

Notice of emergency rulemaking. The Department of Health amended § 505.11 of Title 18 N.Y.C.R.R. to include physical therapist assistants and occupational therapy assistants as qualified professionals who can provide physical and occupational therapy, respectively, as a Medicaid billable service. Filing date: August 25, 2008. Effective date: August 25, 2008. *See* N.Y. Register, September 10, 2008.

Enactment of a Serialized New York State Prescription Form

Notice of emergency rulemaking. The Department of Health added Part 910 and amended Parts 80 and 85 of Title 10 N.Y.C.R.R., and amended § 505.3 and repealed §§ 528.1 and 528.2 of Title 18 N.Y.C.R.R., to enact a serialized New York State prescription form to combat and prevent prescription fraud by curtailing theft or copying of prescriptions by individuals engaged in drug diversion. Filing date: September 2, 2008. Effective date: September 2, 2008. *See* N.Y. Register, September 17, 2008.

Payment for Federally Qualified Health Center (FQHC) Psychotherapy and Offsite Services

Notice of emergency rulemaking. The Department of Health amended § 86-4.9 of Title 10 N.Y.C.R.R. to permit psychotherapy by certified social workers in an Article 28 FQHC as a billable service under certain circumstances. Filing date: September 8, 2008. Effective date: September 8, 2008. *See* N.Y. Register, September 24, 2008.

Notification and Submission Requirements for Continuing Care Retirement Communities (CCRCs)

Notice of proposed rulemaking. The Department of Health gave notice of its intent to amend § 901.9 of Title 10 N.Y.C.R.R. to revise necessary approvals required for CCRCs' extended construction completion date. *See* N.Y. Register, September 24, 2008.

Hospital-Based Residential Health Care Facilities

Notice of proposed rulemaking. The Department of Health gave notice of its intent to amend § 86-2.10 of Title 10 N.Y.C.R.R. to eliminate reference to a federal designation process that no longer exists when determining the hospital-based status of a residential health care facility. *See* N.Y. Register, October 8, 2008.

Criminal History Record Check

Notice of proposed rulemaking. The Department of Health gave notice of its intent to add Part 402 to Title 10 N.Y.C.R.R. to require nursing homes, certified home health agencies, licensed home care services agencies and long-term home health care programs to perform criminal background checks of certain prospective unlicensed employees who provide direct care or supervision to patients, residents or clients of such providers. *See* N.Y. Register, October 8, 2008.

INSURANCE DEPARTMENT

Market Stabilization Mechanisms for Individual and Small Group Market

Notice of adoption. The Department of Insurance amended §§ 361.5 and 361.7(a), renumbered §§ 361.6-361.7 to §§ 361.7-361.8, and added new § 361.6 to Title 11 N.Y.C.R.R. to create a new market stabilization process in the individual and small group market, to share among plans substantive cost variations attributable to high-cost medical claims. Filing date: June 6, 2008. Effective date: June 25, 2008. *See* N.Y. Register, June 25, 2008.

Establishment of the Industry Standard Rate for Use in Conjunction with Payments to the Aggregate Trust Fund

Notice of adoption. The Department of Insurance amended Part 151 (Regulation 119) of Title 11 N.Y.C.R.R. to establish the interest rate applicable when workers' compensation insurers are required to deposit the present value of unpaid benefits for permanent partial disability and death benefit cases into the aggregate trust fund. Filing date: June 10, 2008. Effective date: June 25, 2008. *See* N.Y. Register, June 25, 2008.

External Appeals of Adverse Determinations of Health Care Plans

Notice of proposed rulemaking. The Department of Insurance gave notice of its intent to amend Part 410 (Regulation 166) of Title 11 N.Y.C.R.R. to provide that external appeal agents shall not be subject to legal proceedings to review their determinations. *See* N.Y. Register, August 27, 2008.

Minimum Standards for the Form, Content and Sale of Health Insurance, Including Standards for Full and Fair Disclosure

Notice of proposed rulemaking. The Department of Insurance gave notice of its intent to amend Part 52 (Regulation 62) of Title 11 N.Y.C.R.R. to prohibit coverage of certain benefits to sex offenders registered pursuant to article 6-C of the Correction Law. *See* N.Y. Register, September 3, 2008.

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- *Immigrant Access to Health Care and Public Health: An International Perspective*, Sana Loue, J.D., Ph.D., M.P.H.
- *The Immigrant Health Care Narrative and What It Tells Us About the U.S. Health Care System,* Brietta R. Clark
- *Access to Health Care for Elderly Immigrants*, Marguerite Angelari
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- *Achieving Quality and Responding to Consumers: The Medicare Beneficiary Complaint Process: Who Should Respond?*, Diane E. Hoffmann, J.D., M.S. & Virginia Rowthorn, J.D.
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- *Finally Moving Beyond the Fiction: An Overview of the Recent State Rally for Health Care Reform,* Mark E. Douglas
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- *Are Health Care Conflicts All That Different? A Contrarian View*, Diane E. Hoffmann
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- *Washington v. Glucksberg Was Tragically Wrong*, Erwin Chemerinsky
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For Your Information

By Claudia O. Torrey

It has been said in many ways by many people that the best way to have a window into the future is to study the past. Thus, "[s]tudying the rise and fall of health care 'regimes' is an important step toward understanding how the health of our society can be maintained and improved."[1] Health care is critical to the survival of the individual, the community, the nation and the world.[2] This introductory statement by this columnist was submitted to the *Health Law Journal* more than a year ago in a column that commented on the *then* Berger Commission Report Recommendations. Some of the words from that column follow:

> After an eighteen month review process the November 2006 Berger Commission Report, regarding The Commission on Health Care Facilities in the 21st Century ("Commission"),[3] lays the foundation for strengthening New York State's acute and long term care delivery systems. In an attempt to carry out the mandated charge to "rightsize" these institutions, the report recognizes that the Commission was created to ensure that the statewide supply of hospital and nursing home facilities is best configured to respond to community needs for high-quality, affordable and accessible care, with meaningful efficiencies in delivery and financing that promote infrastructure stability.[4]
>
> According to the Commission report, rightsizing includes the possible consolidation, closure, conversion, and restructuring of institutions.[5] Among other things, the report gives: policy recommendations, facility recommendations, and financing recommendations; time will tell how the State Legislature will receive these recommendations. One of the policy recommendations submits that New York State "should strive for health coverage that is universal, continuous, affordable to individuals and families, and affordable and sustainable for society at large. New York should study coverage expansion efforts in other states, and adopt additional strategies to sustain its recent progress in reducing the number of uninsured New Yorkers. . . ."[6]

Given both the prophetic context of the above stated words and the historic nature of the Presidential election in November 2008, it is unfortunate that a July 2008 national health scorecard produced by The Commonwealth Fund placed the United States at the bottom of a list of 19 industrialized countries concerning timely access to effective health care.[7] The Commission Report Recommendations, which became law on January 1, 2007,[8] are attempting to do the very thing our federal government is having a difficult time accomplishing.[9] According to Dr. Richard Daines, Commissioner of the New York State Department of Health, the projected closures and restructuring are to help attain the goals of better care and reduced costs. "By the end of 2008, nine hospitals will have been closed, . . . [a]nother 1,700 will be eliminated by 2010 through mergers, affiliations and downsizing. Seven nursing homes will have been closed by the end of 2008, . . . [a]nother 1,600 will be taken out of the system by 2011. While the reform process must be ongoing, New York has a stronger, better health care system today because of the Berger measures we have implemented."[10] **New York, you are in the driver's seat—drive carefully!**

Endnotes

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2. *Id.*
3. The Commission on Health Care Facilities in the 21st Century, Executive Summary, http://www.nyhealthcarecommission.org/final_report.htm (last viewed on November 30, 2006).
4. *Id.* at 8.
5. *Id.*
6. *Id.* at 9.
7. http://www.commonwealthfund.org/newsroom.
8. *Id.*
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Introduction to the Special Edition: In the Wake of the Berger Commission

By Martin Bienstock, Special Editor

In the summer of 2006, the New York State legislature passed a unique, fascinating and challenging health care reform: it empowered a politically appointed body, the Commission on Health Care Facilities in the 21st Century (later known as the "Berger Commission," after its chair, Stephen Berger), to restructure entirely the state's massive health care delivery system.

As a policy matter, the proposal was unique; a centralized, state commission would determine the precise configuration of the state's health care delivery system. The legislation thus seemed to fly in the face of federal regulatory policy, which emphasized competition, not planning, as the best means of allocating health care resources. Nonetheless, the process was widely acclaimed and received overwhelming support from hospital associations, unions, editorial pages, a politically divided legislature, three governors (two Democratic, one Republican), and a Republican presidential administration. The response begged the question: what public policy justified this approach?

"[T]his Journal *is devoted to addressing the legal and policy issues that arose from the unique, fascinating and challenging reform."*

As a political matter, the proposal was fascinating; a neutral commission, empowered by the force of state law, had been tasked to reform a system beset by intransigent challenges. In some small cities, for example, competing religious and secular institutions desperately needed to merge, but had for decades been unable to reconcile their competing missions. In other cities, beloved, community-supported facilities had survived for years on financial life support, their historic missions trapped in a vortex of financial reality. Could the reform legislation and the process it unleashed overcome these hurdles?

As a practical matter, the proposal seemed almost impossibly challenging; hospital closures and mergers are notoriously difficult to effectuate, and the legislation contemplated wholesale restructuring in a small window of time. Could wholesale reform be implemented in a safe and efficient way?

This Special Edition of the *Health Law Journal* is an attempt to respond to some of the issues raised by this historic legislation. It is not intended to describe the implementation of the Commission report; implementation is described in great detail in the Department of Health's implementation report, available online at the Department's Web site (http://www.health.state.ny.us/facilities/commission/docs/implementation_of_the_report_of_the_commission.pdf). It is also not intended to describe the litigation challenging the legislation and its implementation; some of that litigation is still ongoing, and court decisions have been published in previous editions of the *Journal*.

Instead, this *Journal* is devoted to addressing the legal and policy issues that arose from the unique, fascinating and challenging reform.

The first article, "Law and Policy of Health Care Competition for the Twenty-First Century," is my own, and grows out of my attempt to answer the question: how could this have happened? How could a rational polity reach the conclusion that central planning was the best method of allocating health care resources in New York State? To answer that question, the paper first analyzes how "market failure" pervades the health care delivery system, how the state has responded with a highly regulated gatekeeping system, and how, in light of this background, the Berger Commission was a rational response to the New York health care marketplace.

The paper takes these conclusions a step further by analyzing the implications of this policy for antitrust enforcement. Unlike New York State, federal antitrust regulators believe that competition, not planning, is the best method for allocating health care resources, and they have been vigorously prosecuting the antitrust laws. But under the State Action Doctrine, New York's determination to employ planning, rather than competition, as a means of allocating resources means that mergers and clinical integration approved and supervised by the state may be protected from antitrust enforcement, notwithstanding federal regulators' concerns. The article describes how and when this might occur, and the policy justifications behind it.

Mark Ustin served as Deputy Executive Director and General Counsel to the Berger Commission, and is cur-

rently of counsel to the firm of Manatt, Phelps & Phillips, LLP, positions that enable him to look back clearly to the past to inform his understanding of reforms yet to come. In his article, "Constructive Convener or Obstructive Bureaucracy? The Rise, Fall and Potential Return of Local Health Planning in New York State," Mark identifies how the Berger Commission has placed a renewed focus on the role of supply in the health care equation, and on the concept of local health planning. The article accordingly examines the history of local health planning in New York State, offers a brief look at how the process works in New York today, examines current efforts to reform that process, and attempts to identify likely themes for future reform.

Peter Millock served for 15 years as the General Counsel of the New York State Department of Health, and is a partner at Nixon Peabody LLP; he is also the past chair of the Health Law Section, and in 1993 he served on the President's Task Force on Health Care Reform. Peter represented a broad range of facilities affected by recommendations of the Berger Commission. Perhaps none was more interesting than the recommendation that The Kingston Hospital, a secular institution, and Benedictine Hospital, a Catholic one, be aligned under a common corporate parent. Peter's article, "The Berger Commission and Catholic/Secular Hospital Alignments," identifies the unique challenges posed by the merger of secular/religious hospital systems. It describes the unique governance structure of religious hospitals, and the issues raised by proscribed services and access to services, with a special emphasis on facilities affected by the Commission.

The next article, "Serving Your 'Berger' Well Done: A Recipe for Closing or Reconfiguring a Not-For-Profit Hospital in New York," is the product of a collaborative effort by attorneys at and associated with Garfunkel, Wild & Travis, P.C. (GWT). Robert Wild, one of *the* senior statesman of the New York health care Bar, was one of the founding partners of GWT, where he has served as the firm's chairman since its inception in 1980. His partner, Judith Eisen, specializes in representing hospitals and other health care providers, and was honored by *Long Island Business News* as one of "Long Island's Top 50 Most Influential Women in Business" for 2007. Their partner, Peter Mancino, focuses on representing hospitals, physicians and other health care providers in a broad range of corporate and regulatory matters. David A. Langner is an experienced corporate and health care attorney who works regularly with GWT on a wide variety of matters. The article presents an important, practical, how-to guide for lawyers advising their clients on how to close a hospital in New York.

"It is also my hope that this edition will serve both to enlighten readers concerned with the difficult policy and legal issues arising out of the Berger Commission mandate, and to provide practical, everyday advice to practitioners seeking to best represent their clients."

Finally, Jeffery Alexander is a partner, and Sarah Shannon Carlins is a senior associate, in the firm Eckert Seamans Cherin & Mellott, LLC, where they represent important health care institutions and other types of providers. Mr. Alexander previously served as in-house counsel at Cabrini Medical Center in New York City and Strong Memorial Hospital in Rochester. Their article, "Successor Liability in New York Post-Berger," reflects their experience with the Berger Commission and examines how facilities engaged in mergers and acquisitions might ensure that they are protected from successor liability.

Successful implementation of the Berger Commission report required unusual insight and commitment by a wide range of professionals at the Department of Health.

It also required creative and thoughtful advocacy and lawyering from the private Bar. It is my hope that my editing of this edition reflects some of the wisdom that I learned from my friends and colleagues both in the Department and out. It is also my hope that this edition will serve both to enlighten readers concerned with the difficult policy and legal issues arising out of the Berger Commission mandate, and to provide practical, everyday advice to practitioners seeking to best represent their clients.

Law and Policy of Health Care Competition for the Twenty-First Century

By Martin Bienstock

During the 1990s, the national health care delivery system entered a period of hyper-competition—a period of rapid change and increased competition that threatened many facilities' very survival. The advent of managed care, reductions in average lengths of stay, the proliferation of ambulatory care centers, and other competitive pressures combined to create crisis conditions for many facilities. New York State facilities were especially hard hit when the state eliminated the price control system that protected their profitability.

"In the past few years, two different regulatory systems have adopted nearly diametrically opposed responses to the benefits and challenges of increased integration."

In this hyper-competitive environment, providers began anew to examine opportunities to combine with each other in new and creative ways. Increased integration presented them with an opportunity to create new health care products and new methods of delivering services, reducing cost and improving quality. Increased integration presented them with an opportunity to achieve economies of scale and scope, and to improve planning. Increased integration also presented them with an opportunity to drive a harder and more lucrative bargain with payers, increasing profitability but at the same time potentially driving up the cost of health insurance.

In the past few years, two different regulatory systems have adopted nearly diametrically opposed responses to the benefits and challenges of increased integration. On the one hand, the New York State legislature created the Commission on Health Care Facilities in the 21st Century (popularly known as the "Berger Commission," after its chair, Stephen Berger) and charged it to "align bed supply with need." Thus, New York State responded to competitive pressures by reinforcing its pre-existing paradigm of a planned health-care marketplace, in which centralized planning supersedes competition as a means of allocating resources.

On the other hand, federal antitrust regulators continued their policy of emphasizing health care competition, and refusing to treat the health-care industry as a unique industry. They successfully prosecuted their first successful anti-merger case in years, declined to provide safe-harbor rules for hospital clinical integration, and issued letter rulings that set a high hurdle for clinical integration.

This article describes first the competing policies underlying these competing approaches. Section I provides the context for the state's extraordinary charge to the Berger Commission that it align supply with need, by describing the gate-keeping and support system in which New York State health care is provided. It describes how market failure pervades the health care delivery system, and explains how a rational legislature might determine that a centrally planned health care delivery system might be preferable to a free-market system.

Section II describes the counterpoint: antitrust laws, and recent efforts by federal regulators to employ those laws in the health care arena. It describes the free-market theory that underlies their approach, and their recent efforts to oppose health care mergers, and to limit the scope of health care joint ventures.

Section III describes the legal synthesis between these two points; it shows how the State Action Doctrine is designed to address potential conflicts between state policies and the antitrust laws, and how health care entities who integrate in a manner that ensures consistency with the state's goals may be protected from antitrust prosecution. That is, by carefully crafting mergers and joint ventures to align with the state's public health goals, and submitting those joint ventures to active state supervision, those activities may be exempt from the antitrust laws.

Section IV describes the policy implications of applying the State Action Doctrine to health care mergers and joint ventures. It concludes that applying the doctrine in the context of New York health care does not change the underlying cost-benefit analysis applied to mergers and joint ventures so much as afford an opportunity to change the locus of decision-making from antitrust regulators to health care regulators. Section V provides a brief look ahead to the future.

I. New York's Centrally Planned Health Care Delivery System

A. The Berger Commission

The 2005 New York State budget created a new commission invested with extraordinary power: the Commission on Health Care Facilities in the 21st Century was empowered to restructure entirely the state's hospital and nursing-home system.

It was empowered to close down hospitals and nursing homes entirely; and it did, requiring the closure of facilities from Queens to Buffalo. It was empowered to require hospitals to consolidate; and it did, requiring more than 20 facilities to engage in some form of consolidations, from mergers to joint ventures to affiliations. It was empowered to re-shape entirely a hospital's service mix; and it did, eliminating services in some hospitals, adding them in others, and converting other hospitals from full-service to outpatient facilities.

In total, the Commission issued 57 mandates, requiring 81 facilities to engage in a broad range of activities, in the process restructuring more than one-quarter of the facilities in the State. Its 57 mandates go on for pages, describing in the process how hospitals are to be governed, how management is to be structured, how contracts are to be negotiated, and, in great and intricate detail, how many beds in each facility are to be used for what purpose. ("Eastern Long Island Hospital, currently certified for 80 beds, should expand its certified capacity to 85, to be comprised of 37 medical surgical, 5 alcohol detox, 23 psychiatry, and 20 alcohol rehabilitation . . . .") Reflecting the nature of its charge, "competition" is decried throughout the report as a wasteful, if not dangerous, practice.

If the Commission's powers appear extraordinary, the legislature's rationale supporting these powers appears even more so: the legislature directed the Commission to restructure the health care system in order to "align . . . supply with need." No "invisible hand" of the market was at work here; centralized decision-making would be utilized as a means of allocating resources.

B. The Regulatory Context

The legislature's preference for central planning over market economics, while seemingly extraordinary, actually proceeded reasonably from the structure of New York State's health care delivery system. There was already little of the "invisible hand" at work in the health care marketplace because the marketplace is not based on a free-market model. It is instead based upon a gatekeeping model, in which the state significantly restricts entry into the health care delivery system while providing support for approved providers.

The state's Certificate of Need (CON) program is perhaps the most significant form of gate keeping. Under the Certificate of Need program, a new facility proposing to open its doors must demonstrate that (1) there is a public need for its services, (2) the facility is financially feasible and (3) its operators are of good character and competence. Even an existing facility that merely wishes to add a new health-care service must obtain approval from the Department of Health and the State Hospital Review and Planning Council. By limiting facilities and programs to those that are needed, the state gate-keeping function effectively replaces competition with centralized planning.

Once facilities have passed through the gate and become providers, the state makes significant efforts to protect them. Indeed, until 1993, the state set reimbursement rates for all payers, thereby ensuring that providers would be profitable. The elimination of that system significantly curtailed state protection, and opened the delivery system to some level of competition.

Nevertheless, the transition from a protected system to a competitive system is still quite limited. The CON process continues to serve not only as a gatekeeper, but also to protect established providers from facing new competitors. Significant grant programs, such as the HEAL program, continue to support providers by making funds available based upon need. Through the Medicaid program, the state continues to be the largest payer for health care services, and subsidizes a large portion of health care demand within New York State. Through its tax-exempt loan program, and various subsidy programs, the state subsidizes the supply of hospitals. Medicaid payments continue to take account of facilities' underlying costs; some aid programs are directed specifically to financially low-performing facilities. In sum, the state continues to maintain a gate-keeping system, and then provide significant support to existing providers.

C. The Need to Restructure

A gatekeeping system of this kind—designed to limit supply and then to support existing providers—may function adequately in a growing industry. It works far less well in a period of shrinking demand, when these providers face reduced demand for their services.

During the late 1990s, however, the national health care delivery system entered a period of hyper-competition, characterized by a significant drop in demand for hospital services. The advent of managed care, significant reductions in average lengths of stay, the proliferation of ambulatory care centers—these and other competitive pressures combined to reduce demand significantly.

In New York State, these changes were amplified when the state eliminated the price control system that

had previously sheltered hospitals from competition. As a result, many facilities struggled with break-even or even negative financial margins. New York's gate-keeping system was especially ill-suited to such a period because the system was designed to protect incumbent providers.

In theory, the state regulatory system included a safety valve designed to eliminate such excess capacity. An obscure provision of the Public Health Law authorizes the Commissioner of Health to suspend, limit, modify, or revoke a hospital operating certificate in order to conserve resources.[1] That is, the Commissioner may close a hospital or nursing home, or reduce its size, or convert it to other uses, based on the demands of the market.[2]

It is exceedingly unrealistic, however, to expect state regulators to close down businesses, especially in as sensitive an industry as health care. The fact that this provision has been used only once, in the face of the significant excess capacity identified by the Commission, highlights the ineffectiveness of the regulatory system in eliminating excess capacity.

In these circumstances, the need for the Berger Commission to effect a controlled reduction in capacity became clear.

D. The Policy Context: Why the Certificate of Need Law Persists and Planning Commissions Are Necessary

The fact that the Berger Commission grew naturally from the state's regulatory system begs the question: why does the state maintain such a system?

Originally, when Certificate of Need laws and central planning were first adopted, payers reimbursed providers on a cost-plus basis; providers were guaranteed a return on their investment. In that model, a gatekeeping method was needed to ensure that facilities did not create excess capacity to take advantage of guaranteed profits. When the state eliminated price controls, however, this justification ceased to exist, and the gatekeeping system appears at first blush to be inefficient.

One explanation for the continued existence of CON is that it is maintained to protect entrenched institutional interests (such as hospitals) against encroachment by new competitors (such as ambulatory surgery centers). Defenders of the system argue that such protection is necessary to level the uneven playing field that existing providers face, since they are called upon to provide extensive un-reimbursed public goods.

A more comprehensive, policy-based explanation, however, would invoke economic theory and patient safety to justify maintaining the Certificate of Need process. This policy-based argument would maintain that CON is necessary because market failure pervades the health care marketplace.

Market failure rises from a number of causes. First, the industry suffers significantly from "moral hazard." Moral hazard exists because patients, acting rationally, often do not take cost into account at all when they purchase health care services because their costs will be indemnified by their insurers. Even when patients face co-payments, those payments are typically capped, so that the patient has no incentive to avoid high-cost procedures and treatments.

Second, the industry suffers from the problems of agency: physicians diagnose patients, recommend treatment, and are then paid for the very services that they themselves had recommended were necessary. While health care is not unique in suffering from this problem—your car mechanic, for example, presents you with the very same conflicts—health care is unique in the way it combines the agency problem with other flaws of the health care markets.

Third, because most patients exhibit some unique combination of health deficits, health care outcomes are exceedingly difficult to quantify. Accordingly, information on quality is limited, and consumers are frequently unable to differentiate between providers based upon rational criteria.

Finally, the industry is dominated by (and in New York, exclusively run by) not-for-profit entities, which make their decisions not based upon optimizing profits but upon fulfilling their missions. Not-for-profit entities may persist in their markets long after a for-profit entity would have abandoned them.

These factors and others have combined to produce observable distortions in the health care market. For example, "Roemer's Law" states that a "built bed is a filled bed"; that is, empty hospital beds, by their very existence, induce increased demand for medical services.

Similarly, research has shown that a "medical arms race" will occur in a market in which patients are unconcerned about costs, and excess capacity forces hospitals to compete with each other for physician referrals. In these markets, hospitals will compete with each other to provide the most expensive equipment and attractive amenities, even when their value is not commensurate with their cost.

Consider, for example, a small city in which two hospitals with different missions—one Catholic, and one secular—were built in the 1970s, when demand for hospital beds was greater than today. Faced with today's inadequate demand, these facilities would respond not by eliminating excess capacity (which would yield limited

savings) but by trying to induce greater demand, such as through new purchases of high-tech services.

Those high-tech services would induce greater demand from the hospitals' existing physicians and their patients by providing new opportunities for spending. In addition, the new technology would help each facility to attract physicians from the competing hospital. Of necessity, costs would escalate—even while payers played the facilities against each other in negotiating lower rates. When their best efforts failed, the facilities would nevertheless struggle to remain open and fulfill their not-for-profit mission to the point at which their return on capital would ordinarily not justify their existence. Ultimately, one or the other hospital might fail, but only after a long period of wasteful spending.

This type of market distortion is not only economically wasteful, but also has adverse health effects. For example, volume is an important element of health care quality; the more frequently a procedure is performed, the more likely it will be performed well. Competition, however, can have the effect of diluting volume, so that no one will have the necessary volume to perform at optimum levels. In ordinary markets, quality information would force competitors to combine and create a better product; in health care, however, the absence of good outcome information interferes with this effective response.

Competition also demands failure, but failing hospitals pose a particular challenge to patient health, as the failing hospital fills up with unnecessary hospitalizations, creating increasing risks for patients.

Too much competition could also force the closure of hospital emergency departments, quintessential public goods that need to be maintained in appropriate locations to protect the public health.

In certain circumstances, then, "competition" between hospitals may produce a host of undesirable outcomes.

Even in these circumstances, competition could provide an important benefit by reducing the price of services. Payers may be able to negotiate a lower price in a competitive marketplace than in a non-competitive marketplace, and then pass along their savings to consumers. This can in some circumstances be a mixed blessing; payers overly empowered by a competitive marketplace may negotiate a rate that is inadequate to pay for their fair share of hospital costs. Nevertheless, competition at least serves as a check on a provider's untrammeled power to raise prices indiscriminately.

Along all of the other important dimensions, though—quality, efficiency, even overall cost—competition may produce negative outcomes. That is, due to various market failures a non-competitive market in New York State may produce lower overall costs, and better quality, than a competitive marketplace.

In these circumstances, replacing competition with central planning becomes a reasonable policy choice. And even if this policy choice is misguided, once it is made the Berger Commission becomes a rational outgrowth of the system.

Of course, rather than engage in planning at all, New York State could choose to move toward the more competitive system. It could eliminate the Certificate of Need process and reduce subsidies. It could encourage quality measures, and selective contracting. Market distortions would continue to exist, but the underlying strategy for addressing those distortions would change from acceptance to comprehensive reform. Absent such reform, which is not likely in the near future, central planning (and the Berger Commission) remains a rational response to today's New York State health care marketplace.

II. The Federal Antitrust System: Competition Based

Federal antitrust regulators have adopted a starkly contrasting position. As a senior official at the Justice's Department's Antitrust Division recently explained:

> Certificate of Need laws pose a substantial threat to the proper performance of healthcare markets. By their very nature, CON laws create a barrier to entry and are thus anathema to the free market. They undercut consumer choice, weaken markets' ability to contain healthcare costs, and stifle innovation.[3]

More generally, as a recent book by Harvard economists Porter and Teisberg has argued the United States faces today a crisis in the value produced by its health care system. Too many of its citizens are uninsured, an often deadly condition for those it afflicts, and one that results in excessive costs for untreated conditions. For those who are insured, the health care delivery system is not nearly equal to the sum of its parts; exceptionally talented doctors and nurses apply cutting-edge technologies within an almost haphazard delivery system, so that procedures of the highest quality (and expense) often substitute for more effective (and lower-cost) procedures. The result is that the (non-)system is extraordinarily expensive, and growing ever more so at a rapid and unsustainable pace. Under this argument, competition can and should be employed to increase value across the entire health care system, much as it does throughout the rest of the economy.

Based on this type of analysis, antitrust regulators have continued vigorously to prosecute health care facilities much as they do other industries. Indeed, in ordinary circumstances—that is, but for the legislative command that established the Commission—some of the mergers and consolidations required by the Commission would have been subject to significant scrutiny under the antitrust laws. Facilities not named in the Commission report could face potential liability if they simply, on their own, entered the types of arrangements mandated by the Commission.

Thus, while under the New York view described above, mergers can produce significant savings and efficiencies, the Federal Trade Commission (FTC) recently issued a decision in the *Evanston* case that cast significant uncertainty on any hospital merger that has the effect of increasing the prices charged to managed-care companies.[4] Similarly, while joint ventures may create economies, these arrangements are not viewed favorably by the FTC when they involve joint negotiations designed to reduce price.

Two types of integration are at the forefront of federal antitrust prosecutions: mergers and clinical integrations. A brief discussion of each follows.

1. Mergers

Generally speaking, the antitrust laws prohibit parties from merging if the merger may substantially reduce competition or create a monopoly.[5] Because mergers are most often analyzed prospectively, the antitrust enforcement agencies have outlined a multi-factor framework to determine whether anti-competitive effects are likely to occur.[6]

First, they define the product market (e.g., "acute care hospitals") and geographic market (e.g., "the Capital District region") affected by a merger. They then analyze the merged firm's market power within those markets and the likelihood that it would be able to exercise its power to adversely affect competition.

The ultimate goal is to determine the transaction's probable effect on competition in a relevant market.[7] If the merger is likely to raise prices above a competitive level for a significant period of time, reduce quality, or hinder innovation, then the merger would violate the antitrust laws.[8]

Health care mergers, including those by not-for-profit hospitals, are subject to the same antitrust laws as mergers in other industries. Prior to *Evanston*, however, government agencies had lost seven consecutive cases seeking to enjoin hospitals from merging with each other[9] (including the Department of Justice's challenge to the North Shore-Long Island Jewish Medical Center merger[10]). Courts were apparently sufficiently sensitive to the unique nature and mission of hospitals that they were reluctant to prohibit even mergers opposed by federal regulators on antitrust grounds.

Seeking to reverse the tide, the FTC brought a *post*-merger challenge to Evanston Hospital's acquisition of Highland Park Hospital, a neighboring facility in the Chicago suburbs. It filed a complaint more than four years *after* the merger had been completed. By delaying the suit, the FTC was able to demonstrate, through actual, real world experience, that the merger had the effect of increasing the prices that hospitals could charge to managed-care companies.

Three aspects of the decision stand out. First, the very fact that the merged hospitals had increased their prices was sufficiently powerful to satisfy many of the requirements typically necessary to demonstrate an antitrust violation. For example, one of the most important and contentious issues in hospital antitrust cases is determining the scope of the geographic market. In the North Shore merger, for example, the court held that Manhattan hospitals would continue to compete with North Shore for tertiary services, and that Winthrop Hospital and New York Hospital at Queens would continue to compete in the secondary market.

In *Evanston*, however, the FTC relied upon the post-merger price increase to help it define the relevant geographic market. Had the *Evanston* panel been required first to establish a relevant market, it might not have been able to demonstrate that ENH had power in that market. Instead, by relying on the price increase to help it establish the market, the *Evanston* panel created an inference that where there is a price increase, the relevant market would be determined by reference to that increase. It created almost a tautology: if health care facilities merge and increase their prices to managed-care companies, then they have demonstrated sufficient market power to make the merger unlawful.

Second, even though ENH had invested more than $100 million in improving quality of care, the FTC rejected its arguments that quality improvements justified the price increases. In contrast, the North Shore case found that the hospital system's promise to reinvest $100 million in savings by investing half in the community and half in quality care justified the anti-competitive effects of the merger.

Finally, despite its findings that the merger violated the antitrust laws, the FTC did not require ENH to divest itself of its acquisition. Instead it merely required that the ENH and Highland Park create separate negotiating teams, establish a firewall between them, and offer all of its managed-care contracting partners the opportunity

to renegotiate its contracts. That is, the remedy focused exclusively on price.

The *Evanston* decision creates significant uncertainty for merging hospitals. Under its precedent, merged hospitals—which may have merged for myriad reasons—must be concerned that any increase in their negotiated rates would make them vulnerable to an antitrust challenge, with the increased rates themselves serving as evidence of anti-competitive effect. While courts might eventually uphold the merger, the uncertainty and potential costs might well discourage them from merging in the first place.

2. Joint Ventures

At the same time that federal regulators continue to prosecute health-care mergers, they have declined to provide any safe-harbor rules that would allow hospitals to engage in joint ventures, and have issued advisory opinions that imply a high hurdle for such integration.

Joint ventures are subject to section 1 of the Sherman Act, which prohibits any agreements that restrain trade.[11] As Justice Brandeis observed, however, every agreement "restrains" trade. The true test is whether it promotes or suppresses competition.[12]

Determining whether an agreement promotes or suppresses competition, however, entails significant costs.[13] Courts have accordingly divided agreements into two categories. Some agreements are deemed so pernicious that they are considered "*per se* illegal"—it is illegal to enter such agreements, no matter what their actual effect on the market.[14] Agreements among competitors to fix prices,[15] or divide markets,[16] or not to compete on certain products,[17] for example, are *per se* illegal. If an agreement is not *per se* illegal, then it is subject to a rule-of-reason analysis, in which courts look to the facts peculiar to each case, including the market's condition before and after the restraint was imposed, the nature of the restraint, and its effect.[18]

Providers are (and should be) extremely wary of entering any agreement that might be a *per se* violation, both because a plaintiff may prevail in such cases without a significant investment of resources and because federal prosecutors may pursue criminal sanctions.

Joint ventures, however, are analyzed under the rule of reason, and will not be viewed as *per se* illegal if (1) the integration is likely to produce significant efficiencies that benefit consumers, and (2) any agreements to engage in anti-competitive conduct (such as jointly negotiating contracts) is "ancillary to" (i.e., reasonably necessary to) realizing those efficiencies.[19]

In the case of physicians, the federal government has provided safe-harbor rules that allow physicians to enter joint ventures without running afoul of the antitrust laws. Those rules generally provide that a joint venture must include an active program to evaluate and modify practice patterns, and must have a high degree of interdependence to control costs and ensure quality. The FTC has supplemented the safe harbor rules with letter rulings that permit physicians to negotiate jointly with managed care companies as part of their clinical integration. (For example, the Greater Rochester IPA recently received a letter ruling that its integrated delivery system justified a joint negotiation strategy.)

In the case of hospital joint ventures, however, there is far less guidance on which to rely. The American Hospital Association has for years unsuccessfully sought guidance from federal regulators, including by seeking the establishment of safe-harbor provisions for hospital-based clinical integration. The AHA has argued that the same types of clinical integration that may justify physician's joint contracting also may apply to joint efforts by hospitals themselves to improve quality or reduce costs.

Nevertheless, the federal regulators have argued that safe-harbor provisions would provide too ready a roadmap for hospitals to enter an agreement whose true purpose was anti-competitive. Many hospitals are concerned that it is not even entirely clear that hospitals may use clinical integration to justify joint negotiations. (In one case, Suburban Health Organization (SHO), the FTC did engage in the traditional physician-type analysis—that is, was there clinical integration (there was), and did it justify joint negotiations (it did not).)

In any event, there is literally no established legal precedent on which to rely in creating a clinically integrated hospital joint venture that justifies potentially anti-competitive behavior, such as joint negotiations. The absence of any safe-harbor provisions, the lack of relevant precedent and the threat of *per se* liability and potential criminal sanction cast a pall over even valuable clinically integrated facilities that seek to negotiate jointly.

III. Synthesis I: The State Action Doctrine

The two competing streams described above create the difficult cross-currents in which potential merger or joint venture partners must operate in New York. On the one hand, the state has expressed the goal of creating a centralized, planned health care market, in which "need" is pre-determined and excess capacity is to be abhorred. On the other, the antitrust laws adopt a competition approach and seemingly proscribe the very types of coordinated activities, such as mergers, that were sanctioned by the legislature in the Berger legislation.

The State Action Doctrine is the legal doctrine designed to address precisely this type of conflict. This doctrine recognizes that state regulatory systems are often created to temper, if not override, the effects of pure market competition. That is, the doctrine authorizes states to employ regulatory systems even when those systems authorize private activity that would otherwise violate antitrust law and doctrine.

Two processes available in New York might implicate the State Action Doctrine. In the case of mergers, state action immunity might be conferred through the Certificate of Need process. In the case of clinical integration, state action immunity might be conferred through a Health Care Efficiency and Affordability Law of New Yorkers (HEAL NY) capital grant. That is, hospitals and nursing homes may be able to merge or enter joint ventures under the protection of the State Action Doctrine that they might otherwise be reluctant to undertake.

Merely receiving a Certificate of Need, or a HEAL NY grant, would not be sufficient to provide immunity. Under established case law, private activity is immune from scrutiny under the antitrust laws only when (1) the state has articulated a clear policy to allow the conduct, and (2) the state actively supervises the conduct to ensure that it complies with the state policy.[20]

The following discussion describes how immunity might apply to facilities that merged or integrated in a manner that improved the health care delivery system.

1. Mergers

A facility that received an appropriate Certificate of Need appeal might qualify for state action immunity.

In *New York v. St. Francis*,[21] the federal court concluded that New York State's Certificate of Need process is a clearly articulated state policy that satisfies the State Action Doctrine. In that case, St. Francis and Vassar Brothers, both located in Poughkeepsie, had agreed to allocate services between them. Together, they established Mid-Hudson Health as a "hospital-without-walls"; Mid-Hudson would not provide any services, but would allocate services between the two hospitals. The court ruled that the CON process through which Mid-Hudson was established represented a clearly articulated state policy to allow the arrangement between them.

Mid-Hudson was *established* prior to the repeal of price controls, but the court case was *decided* after the repeal of price controls. The court specifically limited its holding to the pre-repeal period, suggesting that the price controls themselves were central to the holding that the state had a clearly articulated purpose to replace competition with central planning.

However, the Berger Commission legislation resolves whatever doubts the *St. Francis* court left about the state's intended policy; after Berger, the health care delivery market place is to be centrally planned and highly regulated. Accordingly, there is little doubt that a facility submitting a CON could meet the first test, that the state has in place a clear policy to replace competition with a centralized, planned health care economy.

In order to satisfy the State Action Doctrine, however, the state must also actively supervise the facilities' conduct. In the two cases in which courts have relied upon the CON process to identify the state's clearly articulated policy, they have rejected a facility's use of the State Action Doctrine because the conduct at issue had not been supervised by the state to insure that progress was being made towards achieving the state's regulatory objectives.

A facility might address this issue by submitting a CON application that implicitly or explicitly required active state supervision. For example, the state could actively supervise a merger by establishing a parent corporation or a newly merged hospital for a "limited life." The hospital's authority to operate would terminate at some regular interval, and would be renewed only if certain targeted goals were met. In this way, the state would be compelled to actively supervise the facility to ensure that state goals were being met.

Alternatively, the state could condition its CON approval on the facility implementing and maintaining particular processes, and have those processes serve as a means of supervising the hospital. For example, a hospital merger might be approved conditionally, with the hospital required to demonstrate improvements in quality and efficiency of care. In either case, the CON process would identify a public health goal and approve and supervise the applicant's conduct in reaching that goal. The conduct likely would then be immune from antitrust attack.

2. Clinical Integration

When two facilities engage in a clinical integration, even one that includes joint contracting, they do not necessarily require a Certificate of Need. In that case, there is another regulatory system that might afford state action immunity from the antitrust laws: the HEAL NY capital grant program.[22]

HEAL NY clearly articulated a state policy in support of regulation; it authorized up to $1 billion in health care grants for projects "consistent with objectives and determinations of the [Berger] Commission." As described above, the objectives and determinations of the Berger Commission themselves reflected the legislature's intention to avoid competition and utilize planning as a means of allocating health care resources. Thus, the state

has through the HEAL NY program articulated a clear policy to allow (and fund) Commission "look-alikes" and other activities consistent with the objectives of the Commission.

As with the CON process, a clearly articulated state purpose is a necessary but not sufficient condition for the State Action Doctrine; active state supervision is also required. Accordingly, applicants who sought to engage in a joint venture would need to seek approval for that conduct through a state grant. They would also need to submit applications that included an active state supervisory role over their venture. If accepted and actively supervised by the state, the private conduct would then be exempt from the antitrust laws.

The Department's HEAL NY Phase 4 grant application process is an example of a process that provided an opportunity for antitrust exemption. Under that application process, applicants were invited to submit a proposal for "Berger look-alikes." In the event that a proposal implicated antitrust concerns, the proposal was required to identify a means for active supervision by the state. If adopted and funded by the state, the requirements of the State Action Doctrine would then be met.

IV. Syntheses II: Improving Health Care Through the State Action Doctrine

The preceding discussion highlighted *how* the state legislative and regulatory system might give rise to state action immunity for private conduct undertaken in furtherance of the state's policies. Perhaps a more important question, however, is *whether* and *when* the doctrine should be employed.

One simple approach would involve approving integration activities when they would improve the overall quality, efficiency and safety of the health care delivery system. If overall a proposal would improve health care, it would be approved; if it would not, it would be rejected.

This common-sense approach has the additional advantage of being entirely consistent with traditional antitrust law. Under traditional merger analysis, a merger will be approved even if it has anti-competitive effects, provided the merger will create efficiencies that would offset those anti-competitive effects. Similarly, clinical integration will be approved if the integration is likely to produce significant efficiencies and joint negotiations are "ancillary" (i.e., reasonably necessary) to realizing those efficiencies.

The common sense approach would thus mirror those employed by the antitrust agencies; efficiency and quality-improving activities would be protected, while detrimental activities would not.

A model for this approach already exists. In the early 1990s, 18 states adopted State Hospital Cooperation Laws. Under these laws, departments of health grant applications for a "certificate of public advantage." A certificate is granted when the department of health determines that, overall, the likely benefits from an integration outweigh any disadvantages attributable to a reduction in competition.

The common sense approach, though essentially a mirror of existing antitrust standards, would have the substantial effect of moving the locus of antitrust decision-making from federal (and state) antitrust regulators to state health industry regulators. That is, assuming that the requirements of the State Action Doctrine were met, the Commissioner of Health and the Public Health Council could approve of the overall effect of a merger or integration, and not the FTC or DOJ. State power would not be unlimited; the active supervision requirement would force public disclosure of the benefits and burdens of integration, and antitrust enforcement agencies would ensure at least that the benefit/burden analysis was performed and enforced. Nevertheless, the benefits and burdens of integration would be weighed by those with the most immediate knowledge of the local health care economy.

In each case, of course, one crucial question would involve the impact of any integration on the prices charged to payers. As described above, health care competition may be ultimately inefficient, but the absence of competition may lead to monopoly pricing. In egregious situations, providers could capture all of the financial benefits of integration, and nevertheless charge payers unfair monopoly prices.

When such a threat existed, providers seeking state protection might include in any proposed integration some methods for ensuring fair pricing. Proposals might include limits on rate increases that were linked to Medicaid or Medicare reimbursement rates, to comparable providers, or some other criterion. Alternatively, they might include a firewall of the type employed in *Evanston*. They might also include some method of dispute resolution.

If proposals truly created economic efficiencies, they should be capable of implementation with limited price increases. The more comprehensibly any agreement addressed the issue of price, the more likely that antitrust regulators would find that the state had "actively supervised" the parties' actions. Including a pricing element in any proposal, or the support or concurrence of payers, would undoubtedly increase the chances that the proposal would meet with approval.

V. Looking Ahead

This article began by identifying the diametrically opposed approaches taken by the State of New York regulatory system, which employs a centrally planned health care system, and federal antitrust enforcers, who use free-market principles in analyzing integrations.

"As health care reform continues at all levels of government, it is critical that our understanding of the relative roles of regulation and competition keep pace."

In truth, however, New York's health system is ultimately a hybrid of competition and central planning. The state's regulatory gate-keeping system controls the supply of health care providers only at the entry point. When market forces dynamically alter the landscape—such as with the hyper-competition that preceded the Berger Commission—then competition will evolve on its own. Even a perfectly devised central planning system that could adjust immediately to excess supply would still allow for significant competition, since many hospitals operate in overlapping service areas and naturally compete with each other. In any event, the gatekeeping system does not regulate the price that hospitals may charge, which both reflects a system of competing hospitals (since in the absence of competition, some form of price controls would be necessary) and encourages it.

In New York, then, both regulation *and* competition play a central role in the health-care delivery system. Understanding and delimiting a proper role of both is critical to understanding and improving the public health. It is my hope that this article has contributed to this understanding.

Of course, good policy requires a constant re-examination of its underlying premises, to ensure that changing facts do not render existing policies obsolete. As health care reform continues at all levels of government, it is critical that our understanding of the relative roles of regulation and competition keep pace.

Endnotes

1. Public Health Law, § 2806, subd. 6.
2. *See Herkimer v. Axelrod*, 88 A.D.2d 704 (3d Dep't 1982) (approving Health Commissioner's conversion of hospital to nursing home despite Department's failure to promulgate regulations), *aff'd on other grounds*, 58 N.Y.2d 1069 (1983).
3. Mark J. Botti, *Competition in Healthcare and Certificates of Need,* before a joint session of the Health and Human Services Committee of the State Senate and The CON Special Committee of the State House of Representatives of the General Assembly of the State of Georgia, *available at* http://justice.gov/atr/public/comments/223754.pdf.
4. *In re* Evanston Northwestern Health Care (FTC 2007), *available at* http://www.ftc.gov/os/adjpro/d9315/070806opinion.pdf.
5. Clayton Act, § 4, 15 U.S.C. § 18.
6. 1992 DOJ/FTC Merger Guidelines, *available at* http://www.ftc.gov/bc/docs/horizmer.shtm.
7. *United States v. Sungard Data Sys., Inc.*, 172 F. Supp. 2d 172, 181 (D.D.C. 2001). *See also Marine Bancorp., Inc.*, 418 U.S. at 618–23.
8. Merger Guidelines § 1.21.
9. *See Improving Health Care, A Dose of Competition: A Report of the Federal Trade Commission and the Department of Justice*, July 2004, Chapter 4, pp. 1–2 and n.7.
10. *United States v. Long Island Jewish Medical Center*, 983 F. Supp. 121 (E.D.N.Y 1997).
11. The Sherman Act, 15 U.S.C. § 1, prohibits "any contracts, combinations or conspiracies in restraint of trade."
12. *Chicago Board of Trade v. United States*, 246 U.S. 231 (1918).
13. *Arizona v. Maricopa County Med. Soc'y*, 457 U.S. 332 (1982).
14. *See, e.g., id; United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150 (1940).
15. *Catalano, Inc. v. Target Sales, Inc.*, 446 U.S. 643 (1980).
16. *Addyston Pipe & Steel Co. v. United States*, 175 U.S. 211 (1899).
17. *Palmer v. BBG of Georgia, Inc.*, 498 U.S. 46 (1990).
18. *Chicago Board of Trade v. United States* at 238. The history of the restraint, the evil believed to exist, the reason for adopting the particular remedy, the purpose or end sought to be attained, are all relevant facts.
19. Health Care Statements, Statement 8 at § B1.
20. *California Retail Dealer's Assoc. v. Midcal Aluminum*, 445 U.S. 97 (1980).
21. *New York v. St. Francis Hosp.*, 289 F. Supp. 2d 378 (S.D.N.Y. 2003).
22. Public Health Law, § 2818.

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Constructive Convener or Obstructive Bureaucracy? The Rise, Fall and Potential Return of Local Health Planning in New York State

By Mark R. Ustin

Introduction

Like any other system for the distribution of goods and services, the health care system in New York State is subject to laws of supply and demand. The precise application of those laws is, of course, subject to debate, and the health care sector in general does frequently seem to respond to typical economic incentives in atypical ways. Nonetheless, the system is, at its core, a function of some people needing health care services, and others attempting to meet those needs in return for payment.

Lately, much attention has been given to the nature of that payment—that is, who pays and how much they pay. An increasing amount of attention is also given to the product that is being purchased by those payments—that is, the quality of the health care services available to consumers. Finally, considerable attention has been given in recent years to the question of demand—that is, whether consumer demands are adequately being met, whether all consumers have an equivalent opportunity to have those demands met, and how to ensure that consumer demands are reasonable. These three factors—cost, quality and access—have been called the "iron triangle" of health care,[1] according to which no one factor can be adjusted without impacting the other two.

By itself, this construct fails to take into account the impact of supply as well as demand on all three factors. Certainly, the relative supply of health care services impacts access—the more services are offered, the easier they are to utilize. It has also been established that the relative supply of services can impact quality—when volume is concentrated (i.e., a service is offered by only a limited number of providers), quality often improves, and when it is dispersed, it often declines.[2] In addition, the recent experience of the New York State Commission on Health Care Facilities in the 21st Century (the "Berger Commission") was premised at least in part on the link between supply and cost, and posited substantial savings attributable to supply reductions.[3] Thus, the supply of health care services is an essential element of the health care system, and in the past, at least, was a focus of efforts to understand its impact, and, when necessary, to control its size and scope.

The Berger Commission represented an unusually comprehensive, albeit short-lived, effort to address concerns about the supply of institutional health care services in New York State.[4] However, it was far from the only—or even the primary—mechanism by which the State has attempted to control the supply of health care services. That honor falls on the Certificate of Need (CON) process, which is charged with controlling the supply of health care services by requiring providers to prove both the public need for such services and their ability to meet that need. It does so by requiring applicants seeking to establish new facilities or engage in construction activities at existing facilities to seek the approval of both the Department of Health and often at least one of two influential policy councils, regularly requiring many pages of application material and a significant delay in construction.[5] While both the CON process and the Berger Commission have been useful, if sometimes controversial, tools to control the supply of health care services in New York State, both have had inherent limitations.[6] Recognizing those limitations, the state in general, and the Department of Health (DOH) in particular, have recently placed a renewed focus on the role of supply in the health care equation, and the concept of local health planning, loosely defined as the process by which regulators "match health care resources to community needs."[7]

This article will examine that renewed focus in light of the state's previous experience with local health planning initiatives. First, it will examine the history of local health planning in New York State. Then, it will offer a brief look at how the process works in New York today. Then, it will examine current efforts to reform that process and will attempt to identify likely themes for future reform.

History of Local Health Planning

As noted, the traditional focus of local health-planning efforts has been on controlling the supply of health care facilities via the CON process. Perhaps the earliest federal effort to encourage local health planning was the Hill-Burton Act of 1946, which provided federal subsidies for hospital construction and promoted planning to identify local needs.[8] However, the real impetus for the development of local health planning initiatives nationwide was the National Health Planning and Resources Development Act of 1974 (NHPRDA), which established a nationwide system of local health planning

agencies focused on CON—"health systems agencies" (HSAs)—and provided federal funding for state and local health planning activities.[9] As a result, by 1980 all states except Louisiana had enacted CON programs.[10] Not surprisingly, that initial enthusiasm for local health planning waned when NHPRDA—and the funding that came with it—was repealed between 1983 and 1986.[11] In the decade that followed, 14 states discontinued their CON programs.[12] Many of the remaining states have substantially loosened their programs.[13]

New York's experience with local health planning reflects the same trends affecting local health planning nationwide, but is in many ways unusual. In fact, New York was a leader in the local health-planning movement, having enacted the first CON law nationwide in 1964, prior to NHPRDA.[14] Some commentators have identified the earliest precursor to a full-fledged CON program to be the Rochester Patient Care Planning Council, a community group established in 1964, composed of insurers, patients and providers, and charged with determining local health services needs.[15]

New York did not join the wave of states repealing their CON laws in the wake of the NHPRDA's repeal. However, New York's local health-planning system was not immune to national trends. When NHPRDA was repealed in 1986, the state's system of eight HSAs lost an important source of revenue. Then, in 1988, they lost their state funding, as well; the cause of this event is variously described as a philosophical disagreement over the nature of state regulation, a particular concern over the authority of and funding for one particular HSA that straddled state lines, or dissatisfaction with one particular decision by that HSA.[16] In any case, six of those eight HSAs subsequently closed, leaving only two in existence today[17]—the Finger Lakes Health Systems Agency (FLHSA),[18] located in Rochester (the home of the original Rochester Patient Care Planning Council), and the Central New York Health Systems Agency,[19] located in Syracuse. Of those two, only FLHSA retains all the functions of a fully functioning HSA.[20]

Other changes have also impacted the health planning process at the state level. Perhaps the most significant change was the Health Care Reform Act of 1996,[21] which deregulated commercial health insurance rates and consequently diminished state control over institutional health care providers in general. As noted by one commentator,

> Though its focus was not Article 28 or the CON program, the principles underlying the changes made, namely the shift toward less regulation and to a more market-oriented health care system, and the new political atmosphere reflected in the passage of the bill set the stage for a series of major shifts in New York's CON program.[22]

These shifts included expanding the list of projects that can avoid full review, modifying or eliminating some needs-assessment standards, and expanding "permissible governance arrangements to permit more active involvement of proprietary corporate interests in selected services."[23]

In spite of this trend toward deregulation of health care facility establishment and construction, New York's CON program remains "the oldest, the largest, and one of the more comprehensive in the nation."[24] Thus, DOH has been expected to retain a robust CON program notwithstanding the decline of the HSAs, increased private sector activity in health care markets, and increasing public sector concerns about the cost of health care. The results were predictable: increased workload for DOH staff administering the program, longer average review times, and reduced opportunity for public input.[25] DOH responded to these challenges by reducing the number of applications subject to full review (as noted), by working with applicants to develop "approvable" applications,[26] and by liberally using conditions and contingencies on approval to avoid inappropriate delays.[27] Nonetheless, DOH has still been accused of approving more "marginal or unwarranted proposals" than ever before[28] and institutional capacity has increased to levels generally acknowledged to be unacceptable.[29]

The result has been a series of initiatives aimed at reforming the health-planning system, including the CON process. Before discussing those initiatives, it is first useful to review the fundamental characteristics of CON in New York.

Basics of CON

In general, a provider is required to obtain CON approval in several circumstances: to establish a new facility, to engage in construction activity at an existing facility, to acquire major medical equipment or add or delete services, or to change or transfer 10% of more of the ownership or control of a facility.[30] The providers subject to CON review include hospitals, diagnostic and treatment centers, residential health care facilities, adult care facilities, home care providers, hospices and various others.[31] By law, applicants must prove three things in order to obtain approval: their character and competence, the fiscal feasibility of their proposal, and the public need for the proposed service.[32] In practice, they must also prove that they will conform to the applicable statutes, codes, rules and regulations relating to structural, archi-

tectural, engineering, environmental, safety and sanitary requirements.[33]

The exact nature of the CON process depends on the level of review required by law. In general, there are four kinds of review:

1. **Full Review:** In general, this applies to establishment of new facilities or programs, additions of beds, conversions to a different level of care, changes in the method of service delivery, construction projects over $10 million, purchases of major medical equipment, changes in ownership, or the addition of certain highly specialized services.[34]

2. **Administrative Review:** In general, this applies to proposals with total project costs between $3 million and $10 million or projects over $10 million that are equal to or less than 10% of the total operating costs of the facility, no more than $25 million in cost, and not financed, or proposed by a facility that is financed, by state or local government debt. Such projects include changes in licensed services or numbers or types of beds within the same level of care, operation or relocation of extension clinics or other primary care sites, and various kinds of minor facility upgrades or purchases of certain types of equipment. The total value of applications that may be subject to annual review are capped at an amount related to the anticipated increase in annual operating costs attributable to such applications.[35]

3. **Limited Program Review:** In general, this applies to proposals to decertify beds or services, proposals to add services that have total project costs that do not exceed $3 million, or proposals to convert beds within listed categories.[36]

4. **Limited Architectural Review:** This applies to proposals for the acquisition, relocation, installation or modification of certain equipment, inpatient and surgical areas, and facility support systems with total project costs that do not exceed $3 million , or proposals for the reallocation, relocation or redistribution of certain equipment or services from one hospital to another within the same established network.[37]

The nature of the project and the applicable level of review determine the length and complexity of the CON review process. In particular, they determine whether and to what extent an application is subject to review by an applicable HSA and one or both of the two policy councils involved in the CON process. The first, the State Hospital Review and Planning Council (SHRPC), consists of 31 individuals representing hospitals, nursing homes, physicians, home care agencies and mental health services, and is primarily responsible for advising on CON matters, as well as taking other actions "to improve the quality, efficiency and economy of health care throughout the state."[38] The second, the Public Health Council (PHC), consists of 14 individuals "reflective of the diversity of the state's population, including, but not limited to, the various geographic areas and population densities throughout the state," and is primarily responsible for both overseeing the State Sanitary Code and making determinations regarding applications to establish new providers.[39]

Projects subject only to limited architectural review require only that relatively simple applications be filed with DOH.[40] Projects subject to limited program review or administrative review require that applications be filed with both DOH and the local HSA.[41] Projects subject to full review require, at a minimum, that lengthy applications be filed with DOH, and that they be reviewed by the HSA and SHRPC.[42] Applications for the establishment of a new provider are the most onerous, and are subject to review by the HSA, SHRPC and PHC.[43]

The ability of the HSA and councils to impact final approval is limited. If there is an HSA that has jurisdiction over the project, and it disagrees with DOH's approval of the project, the most it can do is prevent the possibility of limited program review[44] or administrative review[45] and force a formal hearing in the case of full review.[46] The most SHRPC can do is force a formal hearing in the case of an establishment application.[47] PHC is the one significant exception to this rule: its approval is required in the case of establishment applications.[48]

As noted, this system has been subject to criticism. Much of this criticism was recounted in a 2002 report prepared by the American Health Planning Association for the Rockefeller Institute of Government at the request of DOH. That report, entitled *Certificate of Need in New York State: A Program in Transition* (hereinafter the "Rockefeller Report"), noted, among other things, that (1) some stakeholders are concerned that standards have been relaxed too much, (2) staff workload is considerably heavier than in other CON programs, (3) there are inappropriate delays in review times for some applications, (4) there is only limited public involvement in the process, and (5) some stakeholders perceive some needs standards to be applied more rigorously than others.[49] The report proposed a variety of measures to address these issues, which will be discussed in more detail below.

There are even more fundamental problems with the use of the CON process as the sole mechanism for local health planning. For one, it does not necessarily bear any

relationship to traditional health-planning goals such as improving patient health status.[50] In the most basic sense, it is not even true planning; as DOH itself acknowledges, it is "typically reactive—responding to applications filed by health care facilities that are based on the facilities' perception of their needs or of the demands of the health care market in their communities."[51] In some ways, as a quasi-judicial proceeding, it is subject to the same limitations as any court proceeding: DOH or the councils may only act when faced with an actual case or controversy, and their decision is necessarily limited to the cases before them. While they can establish standards against which applications will be judged, they can seldom, within the context of the CON process, make broad-based changes to statewide infrastructure, or indeed, changes to any individual provider who is not an applicant.

Recognizing all these concerns and limitations, in recent years the state has undertaken several initiatives either to reform the CON process, or to otherwise support local health-planning efforts. The reform initiatives fall into several different categories. Each will be examined in turn below.

Reform Initiatives: Revising CON

As noted, the Rockefeller Report itself recommended several reform measures to address some of the shortcomings in the CON process. Among those were recommendations that DOH (1) "attempt to articulate a more explicit policy on the direction and pace of any further deregulation within the CON program"; (2) "consistently use established need methodologies and need standards in CON regulation"; (3) replace static methodologies with "dynamic, self-adjusting formulae"; (4) "include consideration of all relevant facilities and services, regardless of their Article 28 status"; (5) acquire a more adequate data base; (6) engage in "ongoing analysis of the inventory, utilization, and cost of these facilities and services"; (7) consider limiting CON to projects involving "new or expanded clinical service capacity"; (8) "consider modifying the CON program to incorporate a formal planning-based 'request for proposals' process for selected services"; (9) establish more realistic review period timeframes by review level and project type; (10) require full review for anything requiring an assessment of public need or new clinical capacity; (11) limit the use of contingencies and conditions; and (12) make the CON process more accessible to the public in various ways.[52]

In response to these recommendations, DOH developed a variety of specific reform initiatives that it began to implement over the next several years. One of its earliest actions was to promulgate (in 2004) a new nursing home need methodology that, among other things, (1) updated the applicable base, planning and projection years, (2) created a rebuttable assumption that there is no need for additional beds in a planning area where the overall occupancy rate is less than 97%, (3) explicitly allowed DOH to perform the local planning function formerly performed by the HSAs by allowing needs estimates to be developed without reference to HSA regional long term care plans when such plans have not been developed, and allowing such estimates to independently take into account any "significant local factors," (4) added 300 additional nursing home beds available for allocation in the event of "emergency situations or other unanticipated circumstances," and (5) required DOH to evaluate the new methodology by December 31, 2007.[53] Interestingly, DOH did not eliminate the role of the HSAs altogether, thus tacitly recognizing their value to the planning process—rather, the new methodology simply allowed DOH to perform HSA-type functions when no HSA is available to do so.

Both the Rockefeller Report recommendations and the new nursing home bed need methodology reflect one approach to reform in this area that continues today—namely, to continue to rely on CON as the primary health planning mechanism while attempting to infuse the CON process with the broad scope and increased flexibility necessary for true local health planning. That approach was echoed by the State Senate in the 2003 report of the landmark Senate Medicaid Reform Task Force, which, among other significant recommendations, noted that

> [v]arious changes and trends in the health care system, including increased competition in the marketplace and increased instances of need for restructuring, merit a comprehensive reexamination of the structure and circumstances of the CON process in order to assure that it best meets the State's public health policy needs and the needs of the current health environment.[54]

At around the same time that the Senate Task Force was assembling, the Governor appointed a small group of stakeholders to undertake an even more wide-ranging study of all aspects of the health care system. That group, known officially as the Health Care Reform Working Group (and colloquially as the "Berger Group," after its chairman, Stephen Berger) issued two reports that included recommendations regarding the CON process and local health planning. Among those recommendations were recommendations: (1) "to reward operators whose applications produce quality innovations, contain Medicaid costs, design less restrictive alternative housing models, and reduce nursing home bed capacity"[55]; (2) "to amend existing CON policies and regulations to ensure that other specialized services where there is a distinct

correlation between quality and volume will be delivered only in designated centers of excellence" (like the Rockefeller Report, the Berger Group recommended utilizing a request for proposals process for this purpose),[56] and (3) "new policy and regulatory options be developed" with the CON process to better enable providers "to respond in a timely manner to business opportunities and to the actions of competitors."[57] Thus, both the Senate and the Governor, while recognizing the potential flaws in the CON process, continued to support it as a useful means of regulating the supply of health care services.

Reform Initiatives: Voluntary Rightsizing

Both the report of the Senate Medicaid Reform Task Force and the report of the Berger Group also recommended another distinct approach to local planning reform: in addition to recommending changes to the CON process itself, they recommended the creation of incentives to encourage providers to undertake their own local planning efforts. For example, both recommended a voluntary program to enable nursing homes to convert a portion of available bed capacity to other service categories in the long-term care continuum.[58] Such a program was subsequently enacted by Chapter 750 of the Laws of 2004, and memorialized in Public Health Law § 2801-3.

Both the Senate Task Force and the Berger Group also recommended providing new ways to finance the kind of rightsizing necessary to conform supply to demand. Specifically, both recommended expanding federal Medicaid waivers "to further facilitate the transition of disabled individuals out of institutional settings,"[59] and "to create a new system under which long term care is provided to Medicaid consumers who are not yet nursing home eligible as well as those who are."[60] This, too, was subsequently enacted as Chapter 615 & 627 of the Laws of 2004. It has continued through several iterations, the most recent having issued in February 2008.[61]

The Berger Group also recommended measures to "encourage and assist communities and hospitals" in restructuring the acute care system by creating "a Hospital Rightsizing Assistance Program (HRAP) to provide financing to close or restructure hospitals," as well as a mechanism for the "redirection of taxpayer-funded subsidies for fiscally unstable and unneeded facilities to other parts of the acute care system."[62] This was one of the conceptual antecedents of what eventually became the Healthcare Efficiency and Affordability Law for New Yorkers (HEAL NY)," a capital grant program established in 2005 in the amount of $1 billion over four years to "encourage improvements in the operation and efficiency of the health care delivery system."[63] It is administered by the Commissioner of Health and the Director of the Dormitory Authority of the State of New York (DASNY), through a process that is generally competitive but not necessarily bound by all the rules normally governing state procurements—specifically, it requires only "a process which ensures to the maximum extent practicable and where appropriate, competition among" applicants.[64] The first iteration (Phase 1), as well as two others (Phases 3 and 5), provided funding for HIT initiatives, but it was clear from its inception that a substantial portion of the funding was intended to fund facility rightsizing activities, and thus far, at least five iterations (Phases 2, 4, 6, 7, and 8) have been aimed at facility restructuring.

That same year, the state established another significant funding stream for rightsizing activities in the form of the Federal-State Health Reform Partnership (F-SHRP). Established as a mechanism for recapturing some of the federal savings generated through implementation of the state's 1115 waiver (the waiver of federal Social Security Act requirements that, since 1997, has allowed the state to require most Medicaid beneficiaries to enroll in a managed care plan), it represents a potential investment of $1.5 billion of federal funds over five years.[65] In practice, that funding has been used for the same purposes as the HEAL NY funding.

Both HEAL NY and F-SHRP represent efforts to encourage providers to voluntarily conform their supply to actual need. In theory, this could obviate the need for any kind of externally imposed planning goals. However, this approach suffers from the same fundamental shortcoming as the CON process itself—namely, it is dependent upon facilities' own perceptions of markets needs. By themselves, neither HEAL NY nor F-SHRP can compel actual local health planning.

Reform Initiatives: Mandatory Rightsizing

Recognizing the unlikelihood of a facility ever voluntarily closing its doors or eliminating relatively lucrative but unnecessary services, in 2005 the state also took the much more controversial step of authorizing mandatory rightsizing. The Berger Group had opened the door to such an option when it recommended that the State "develop measures to reduce excess hospital capacity" and "help devise a mechanism for distinguishing between needed and unneeded institutions," "assist with orderly closures" and "develop a financial mechanism for redirecting public resources to support other regional medical centers."[66] The form this approach took was the Commission on Health Care Facilities in the 21st Century (also known as the "Berger Commission," once again named after Stephen Berger, who became chairman after completing his role as chairman of the Berger Group), a broad-based, non-partisan panel created by the Governor and the Legislature to undertake a rational, independent review of health care capacity and resources in New

York State.[67] The Berger Commission was required "to develop recommendations for reconfiguring the state's general hospital and nursing home bed supply to align bed supply to regional needs"[68], taking into account such factors as current capacity, financial status, access for the underserved, quality of care and economic impact,[69] and with substantial local input.[70] In short, it was expected to engage in comprehensive statewide local health planning, but on a one-time basis and within only around 18 months.[71]

The Berger Commission differed from traditional local health planning (at least, as administered by the HSAs) in one other important respect—unless rejected in whole by the Governor or the Legislature, its recommendations became mandatory.[72] The latter did in fact occur, and DOH is still in the process of implementing some of them.[73]

Thus, the Berger Commission represented a departure from both traditional forms of local health planning and from then-current attempts at reform. Its relationship with those extant reform initiatives varied. It had almost no relationship with the ongoing CON process. By statute, the Commission had a liaison relationship with DOH, SHRPC and PHC.[74] However, an early attempt by the Commission to ensure its activities were taken into account during the CON process was rebuffed,[75] and any subsequent linkages between the two were largely informal.

Its linkages to voluntary rightsizing efforts, especially including HEAL NY and F-SHRP, were far more extensive. By statute, HEAL NY awards must be "consistent with objectives and determinations" of the Berger Commission.[76] Moreover, HEAL NY Phase 4 was explicitly issued to assist facilities that were the subject of Berger Commission recommendations.[77] The Commission was also very explicit in its support for voluntary alternatives. It specifically encouraged such alternatives and developed a procedure to offer protection from antitrust enforcement to providers engaging in rightsizing discussions.[78] Ultimately, one-third of its recommendations resulted from such discussions.[79]

The Commission's recommendations for restructuring the hospital and nursing home systems were far-reaching, including the merger or restructuring of more than 50 hospitals and nursing homes, and the closure of nine hospitals and seven nursing homes, removing almost 1,700 hospital beds and 1,100 nursing home beds from the system.[80] Clearly, the Berger Commission represented a watershed event for local health planning, and, indeed, for the health care system in general in New York State. However, it is important to acknowledge the Commission's limitations. Most importantly, it was a single event that was the result of a fortuitous confluence of opportunities, including not only the availability of unprecedented amounts of state and federal funding (as noted), but also significant stakeholder buy-in[81] and a change in state government leadership that allowed the Commission's work to proceed without some of the political concerns that would otherwise drive such a process.[82] Thus, it is not easily duplicated.

The Commission itself realized that it was no substitute for ongoing local health planning. In addition to its binding structural recommendations, it issued a series of non-binding policy recommendations addressing other segments of the health care system over which it had no direct control. Those included recommendations to (1) review and adjust reimbursement policy to support realignment of health services delivery; (2) strive for health coverage that is universal, continuous and affordable; (3) expand primary care capacity; (4) develop and test "hybrid" delivery models "that are less than a hospital and more than a primary care center"; (5) undertake a comprehensive analysis of the feasibility and advisability of privatizing the State University of New York (SUNY) teaching hospitals at Stony Brook, Syracuse, and Brooklyn; (6) address the persistent health care worker shortages around the state; (7) promote the increased use of health information technology; (8) undertake a comprehensive review of the future role of county-owned and operated nursing homes; (9) develop a mechanism whereby niche providers share in the burden of paying for public goods and charity care; and (10) implement an ongoing process to sustain the efforts initiated by the Commission.[83] While all these reflect, in one degree or another, traditional local health-planning functions, the last item is a particularly explicit call for the creation of a new form of local health planning to "address an ongoing need for structured decision-making regarding health care resource allocation."[84]

Current and Future Reform Initiatives: All of the Above?

More recent reform initiatives have built on the foregoing themes. DOH has continued to reform the CON process, most recently working with SHRPC to reevaluate the nursing home bed need methodology,[85] revising the CON process for ambulatory care services,[86] soliciting stakeholder input for further reforms,[87] and pursuing various other changes to the CON system.[88] Including among these initiatives are efforts to improve the data upon which CON decisions are based. One such effort is a Web-based tool, Prevention Quality Indicators (PQI), that will allow the general public to examine hospital discharges for specified ambulatory care sensitive conditions by zip code and demographic group.[89] DOH is also begin-

ning to utilize an Absorption and Access Analysis similar to the one utilized by the Berger Commission to assist it in determining where patient volume will move in the event of significant changes to the supply of hospital beds in a given region.[90] It has also continued to encourage voluntary rightsizing, issuing Requests for Grant Applications under HEAL NY and F-SHRP to increase primary care capacity[91] and engage in further Berger-type rightsizing.[92]

As noted, however, none of these efforts can substitute for genuine local health planning. As noted by one commentator, "it is important to differentiate this new call for better health planning [from] reform of the CON process," and "CON alone is not able to fully incorporate regional health planning."[93] Similarly inadequate would be a simple return to the HSA system, which would meet with substantial opposition.[94] Even the last remaining fully functional HSA, the Finger Lakes HSA in Rochester, has rejected this approach, undertaking a strategic planning process in 2005 to redefine its mission, which resulted in a new focus on promoting community engagement.[95]

Heeding these various calls for a new approach to local health planning, in the 2008–09 state budget DOH sought and received a $7 million appropriation for:

> [S]ervices and expenses related to local health care planning including but not limited to: examining racial and ethnic disparities in the provision of health care; developing a process to measure and integrate consumer needs for health care services as the basis for health care provider planning; assessing future long term care needs taking into account consumer preferences for care; and reviewing the impact of the migration of services from hospitals to ambulatory care providers on the cost, quality and availability of services.[96]

DOH has recently released $6 million of those funds pursuant to a Request for Grant Applications "intended to stimulate and subsidize the development of multi-stakeholder, collaborative local health planning efforts aimed at promoting healthy communities by identifying community health care needs and aligning the health care delivery system with those needs."[97] Eligible applicants include not-for-profit corporations, local governments, and public benefit corporations, and coalitions incorporating a broad array of stakeholders are encouraged.[98] There are two categories of grants: "small project grants" of up to $200,000 each, and "large project grants" of up to $1 million each. Grants will be awarded on a regional basis.[99]

One interesting aspect of this RGA is the fact that DOH has opted not to identify a preferred model for future local health planning. Rather, "[t]he Department recognizes that a one-size-fits-all local planning strategy may be unrealistic and would like to encourage multiple models of health planning suitable for different types of communities with diverse health care challenges."[100] Applicants may focus on one issue or a variety of issues, so long as their work results in recommendations for the configuration of the health care system that can inform state planning efforts and the CON process.[101] All grantees will be expected to engage in community collaboration, community health assessment, identification of priorities, and self-evaluation.[102]

As of this writing, it is not clear what the ultimate grantees will look like. One can assume that at least some will resemble old-style HSAs, reworked to reflect the new emphasis on convening local stakeholders for useful input and collaboration. At least one commentator has suggested that the new emphasis might be on "targeted, time-limited problem solving."[103] One thing, however, is certain: if the primary focus of local health planning will now be on encouraging provider collaboration, DOH must determine how that collaboration is to be organized. If these efforts are to be sustainable, they must include a sharing of burdens between public sector and private sector participants, including financial burdens.

In the meantime, the state will continue to pursue its efforts at CON reform and voluntary rightsizing. As yet, there has been no movement to engage in a renewed effort toward mandatory rightsizing in the manner of the Berger Commission. However, the threat is there, and is serving as an ongoing impetus toward collaborative solutions. Whether those solutions will be successful remains to be seen.

Endnotes

1. *See* Department of Justice and Federal Trade Commission, *Improving Health Care: A Dose of Competition*, July 2004, *available at* http://www.ftc.gov/reports/healthcare/040723healthcarerpt.pdf (hereinafter "DOJ/FTC Report"), p. 6.
2. *See* Halm, E.A., Lee, C. & Chassin, M.R., *Is Volume Related to Outcome in Health Care? A Systematic Review and Methodologic Critique of the Literature*, 137 Annals of Internal Medicine 6 (September 7, 2002), pp. 511–20.
3. *See* New York State Commission on Health Care Facilities in the 21st Century, *A Plan to Stabilize and Strengthen New York's Health Care System*, December 2006, *available at* http://www.nyhealthcarecommission.org/final_report.htm (hereinafter "Berger Commission Report"), pp. 219–31.
4. *See* Part K of Chapter 58 of the Laws of 2005, *as added by* Section 31 of Part E of Chapter 63 of the Laws of 2005 (hereinafter "Part K").

5. American Health Planning Association report to the Rockefeller Institute of Government, *Certificate of Need in New York State: A Program in Transition*, September 2002 (hereinafter "Rockefeller Report"), pp. 28–64.
6. *See, e.g.,* Lee, Jin Hee, *A Civic Republican View of Hospital Closures and Community Health Planning*, 35 Fordham Urb. L. J. 561 (April 2008).
7. Department of Health Request for Grant Applications, *HEAL NY Phase 9: Local Health Planning Initiatives*, July 9, 2008 (hereinafter "HEAL NY 9"), *available at* http://www.health.state.ny.us/funding/rfa/0806061239/0806061239.pdf, pp. 5–6.
8. Hospital Survey and Construction (Hill-Burton) Act of 1946, Pub. L. No. 79-725, 60 Stat. 1040 (1946).
9. Pub. L. No. 93-641, 88 Stat. 2225 (1975).
10. DOJ/FTC Report, *supra* n. 1, at 301.
11. *See* Cavanaugh, S. & Tallon, J.R., *Reconsidering Community Health Planning for New York City*, United Hospital Fund (2008) (hereinafter "UHF Report"), *available at* http://www.uhfnyc.org/pubs-stories3220/pubs-stories_show.htm?doc_id=698603, p. 5.
12. National Conference of State Legislatures, *Certificate of Need: State Health Laws and Programs*, May 2008, *available at* http://www.ncsl.org/programs/health/cert-need.htm.
13. DOJ/FTC Report, *supra* n. 1, at 301.
14. Metcalf-McCloskey Act of 1964 (codified in N.Y. Pub. Health Law § 730 (McKinney 1971)).
15. Sagness, J., *Certificate of Need Laws: Analysis and Recommendations for the Commission on Rationalizing New Jersey's Health Care Resources*, January 12, 2007, *available at* http://nj.gov/health/rhc/documents/con_laws.pdf, p. 3; *but see* UHF Report, *supra* n. 11, at 2 (arguing the health planning in New York City began with the UHF's efforts to collect uniform costs reports and other data in the early 1900's).
16. *See Albany Impasse May Force 8 Health Agencies to Close*, New York Times, August 19, 1988.
17. *See* HEAL NY 9, *supra* n. 7, at 9.
18. *See* www.flhsa.org.
19. *See* www.cnyhsa.com.
20. *See* UHF Report, *supra* n. 11, at 6.
21. Chapter 639 of the Laws of 1996.
22. Rockefeller Report, *supra* n. 5, at 13.
23. *Id.*
24. *Id.* at iv.
25. *Id.* at v–viii.
26. *Id.* at 56–9.
27. *Id.* at 50–6.
28. *Id.* at 61.
29. Berger Commission Report, *supra* n. 3, at 48–53.
30. *See, e.g.,* Public Health Law §§ 2801-a, 2802; *see also* 10 N.Y.C.R.R. § 710.1(c)(1).
31. *See, e.g.,* Public Health Law Articles 28, 36 and 40; Social Services Law Article 7.
32. *See* Public Health Law § 2801-a.
33. *See* Rockefeller Report, *supra* n. 5, at 9.
34. 10 N.Y.C.R.R. § 710.1(c)(2).
35. 10 N.Y.C.R.R. § 710.1(c)(3).
36. 10 N.Y.C.R.R. § 710.1(c)(6).
37. 10 N.Y.C.R.R. § 710.1(c)(5).
38. Public Health Law § 2904.
39. Public Health Law §§ 220, 225.
40. *See* 10 N.Y.C.R.R. § 710.1(c)(5)(ii).
41. *See* 10 N.Y.C.R.R. § 710.1(c)(6)(i).
42. *See* Public Health Law § 2802(2).
43. *See* Public Health Law § 2801-a(2).
44. *See* 10 N.Y.C.R.R. § 710.1(c)(6)(i)(b).
45. *See* 10 N.Y.C.R.R. § 710.1(c)(3)(i).
46. *See* Public Health Law §§ 2801-a(2), 2802(5).
47. *See* Public Health Law § 2801-a(2).
48. *See* Public Health Law § 2801-a(1).
49. Rockefeller Report, *supra* n. 5, at v-xi.
50. *See* UHF Report, *supra* n. 11, at 9.
51. *See* HEAL NY 9, *supra* n. 7, at 5.
52. Rockefeller Report, *supra* n. 5, at xii-xvi.
53. *See* 10 N.Y.C.R.R. § 709.3.
54. Report of the Executive Committee of the Senate Medicaid Reform Task Force (December 2003) (hereinafter "Senate Report"), pp. 16-17.
55. Health Care Reform Working Group Interim Report (January 2004) (hereinafter "Berger Group Interim Report"), p. 23.
56. Health Care Reform Working Group Final Report (November 2004) (hereinafter "Berger Group Final Report"), p. 16.
57. Berger Group Final Report, *supra* n. 55, at 19.
58. *See* Senate Report, *supra* n. 54, at 25; Berger Group Interim Report, *supra* n. 55, at 25–27.
59. Senate Report, *supra* n. 54, at 24-25.
60. Berger Group Interim Report, *supra* n. 55, at 10.
61. *See* http://www.health.state.ny.us/facilities/rightsizing/2008-02-05_solicitation_letter.htm.
62. Berger Group Final Report, *supra* n. 55, at 12.
63. Public Health Law § 2818(1); *see generally*, Public Health Law § 2818, Public Authorities Law § 1680-j.
64. Public Health Law § 2818(1). In addition, up to 25% of annual funding may be awarded without even the minimal competitive process otherwise required. Public Health Law § 2818(2).
65. *See* http://www.health.state.ny.us/health_care/managed_care/appextension/health_reform_partnership/.
66. Berger Group Final Report, *supra* n. 55, at 6, 11.
67. *See* Part K, *supra* n. 4.
68. *See* Part K, *supra* n. 4, at § 8(a).
69. *See* Part K, *supra* n. 4, at § 5(a).
70. *See* Part K, *supra* n. 4, at § 7.
71. *See* Part K, *supra* n. 4, at § 11.
72. *See* Part K, *supra* n. 4, at § 9(b).
73. *See* http://www.nyhealth.gov/press/releases/2008/2008-07-02_berger_commission_measures_implemented.htm.
74. *See* Part K, *supra* n. 4, at § 4(b).
75. *See* http://www.nyhealthcarecommission.org/docs/2005-11-17_meeting_transcript.pdf.
76. Public Health Law § 2818(1).

77. Department of Health Request for Applications, *HEAL NY Phase 4: Implementation of Commission Mandates*, May 16, 2007, *available at* http://www.health.state.ny.us/funding/rfa/0705141214/0705141214.pdf.
78. *See* Berger Commission Report, *supra* n. 3, at 71–72.
79. *See* http://www.nyhealthcarecommission.org/docs/final/pressrelease.pdf.
80. *See* http://www.nyhealth.gov/press/releases/2008/2008-07-02_berger_commission_measures_implemented.htm.
81. *See, e.g.*, Paybarah, Azi, *1199 Goes to War*, New York Observer, January 31, 2007, *available at* http://www.observer.com/node/31323.
82. Governor George E. Pataki had declined to seek another term in 2006 after 12 years in office, and his likely successor (who was subsequently elected), then-Attorney General Eliot Spitzer, was on record in support of the Commission's work.
83. Berger Commission Report, *supra* n. 3, at 73–85.
84. Berger Commission Report, *supra* n. 3, at 85.
85. *See* Letter to New York State Commissioner of Health Richard F. Daines, MD, from SHRPC Chair Jeffrey A. Kraut and SHRPC Planning Committee Chair James X. Kennedy, January 23, 2008, *available at* http://www.health.state.ny.us/nysdoh/cons/nursing_home_bed_need_methodology_recommendations_2008-01-23.htm.
86. *See* http://www.health.state.ny.us/press/releases/2008/2008-03-04_health_department_announces_con_reform.htm.
87. *See* http://www.health.state.ny.us/nysdoh/cons/pdf/2008-07-23_shrpc_planning_committee_stakeholders_letter.pdf.
88. *See, e.g.,* Testimony of Healthcare Association of New York State President Daniel Sisto to the State Hospital Review and Planning Council, July 23, 2008, *available at* http://www.hanys.org/members_only/press_pass/testimony/loader.cfm?url=/commonspot/security/getfile.cfm&pageid=118596&utm_source=hanys+news&utm_medium=email&utm_content=health+planning+and+con+testimony+to+shrpc&utm_campaign=hanys) (hereinafter "Sisto Testimony"), p. 13.
89. *See* HEAL NY 9, *supra* n. 7, at 6.
90. *See* Berger Commission Report, *supra* n. 3, at 70–71.
91. *See* http://www.nyhealth.gov/funding/rfa/0712201140/.
92. *See* http://www.nyhealth.gov/funding/rfa/0712200252/; http://www.nyhealth.gov/funding/rfa/0712200320/.
93. *See* Sisto Testimony, *supra* n. 88, at pp. 3–4.
94. *See* Sisto Testimony, *supra* n. 88, at pp. 2, 8; Testimony of United Hospital Fund President James R. Tallon to the State Hospital Review and Planning Council, July 23, 2008 (*available at* http://www.uhfnyc.org/pubs-stories3220/pubs-stories_show.htm?doc_id=697250) (hereinafter "Tallon Testimony"), p. 2.
95. *See* UHF Report, *supra* n. 11, at 11.
96. *See* Chapter 54 of the Laws of 2008, p. 319–320.
97. HEAL NY 9, *supra* n. 7, at 7.
98. *Id.*
99. *Id.* at 8.
100. *Id.* at 7.
101. *Id*.
102. *Id.* at 10–11.
103. *See* Tallon Testimony, *supra* n. 94, at 6.

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The Berger Commission and Catholic/Secular Hospital Alignments

By Peter Millock

Many Catholic-sponsored and secular New York hospitals have been compelled by economic realities and, in some cases, Berger Commission mandates, to close, downsize, or align with other hospitals. Possible alignments between a Catholic-sponsored hospital and a secular hospital include a full asset transfer from the Catholic hospital to the secular hospital, the merger of the Catholic hospital into the secular hospital or vice versa, or the creation of a common corporate "parent" over both the Catholic and the secular hospitals. While an alignment between a Catholic and a secular hospital poses the same legal questions as does a corporate combination between any two not-for-profit hospitals (e.g., governance changes, debt and liability assumption concerns, antitrust exposure analyses, labor and employment issues, Certificate of Need and other regulatory requirements, reimbursement impacts, appropriate use of gifts, and state court approval of major asset sales), it also poses special additional challenges. This article identifies and addresses those challenges.

The Berger Commission was sensitive to the special nature of Catholic/secular alignments, and was remarkably unassertive in its few recommendations relating to them. In Kingston, the Commission recommended what the hospitals there had already tentatively agreed to—consolidation of the Catholic hospital (Benedictine Hospital) and the secular hospital (The Kingston Hospital) under a common corporate parent with certain women's reproductive services in a location "proximate" to the secular hospital.[1] In Schenectady County, the Commission ordered that the Catholic hospital (St. Clare's Hospital) and one of the county's two secular acute-care hospitals (Ellis Hospital) should be joined under an unspecified "unified governance structure." The county's other secular acute-care hospital (Bellevue Woman's Hospital) was ordered closed.[2] In Elmira, the Catholic hospital (St. Joseph's Hospital) and the secular hospital (Arnot Ogden Medical Center) were ordered to participate in joint discussions and to "explore affiliation."[3] In Niagara County, the Catholic hospital (Mount St. Mary's Hospital and Health Center) and the secular hospital (Niagara Falls Memorial Medical Center) were ordered to "explore the creation of a unified governance structure."[4] Other possible alignments (e.g., in Troy and Poughkeepsie) were not mentioned.

What's different about an alignment between a Catholic and a secular hospital?

First, and particularly in two-hospital communities, the Catholic and secular hospitals often have had a history of virulent competition. In this context, it should not be shocking to learn that a few years ago a hospital board member opposing a Catholic-secular hospital merger invoked the revocation of the Edict of Nantes by Louis XIV (which triggered renewed persecution of French Protestants) to derail the merger!

Second, abortion and certain other procedures performed at secular hospitals are condemned by the Catholic Church no less strongly than continued access to these services is supported by secular hospital boards, pro-choice advocates and state government officials who are charged with maintaining access to all health care services. Finances generally do not figure in this debate because hospitals often perform few of the controversial procedures and realize little net revenue from them.

Third, the governance of a Catholic-sponsored hospital is much more complicated than the governance of a secular not-for-profit hospital. Both Catholic and secular not-for-profit hospitals have boards of directors, senior management, and often a corporate member who will get deeply involved in negotiations and decision-making, but Catholic hospitals have additional classes of decision-makers whose assent is required to negotiate a deal.

Corporate Structure and Church Approvals

A Catholic hospital often has a "sponsor"[5] (e.g., a religious order) which organized and still provides staff and financial support to the hospital. Under the Church's internal Canon Law, the sponsor is responsible for assuring that the facility remains true to its Catholic mission. As an extension of that responsibility, the certificate of incorporation and bylaws of the hospital often require the approval of the sponsor for anything as momentous as a sale, merger or affiliation under a common corporate parent with a secular hospital.

The sponsor's position with regard to a proposed alignment is influenced by divergent factors. The sponsor usually has strong ties to the facility. Individual members of the sponsoring order may have devoted their lives to the hospital, and the hospital may provide employment, housing and long-term financial security to them. Alignment with a secular hospital may threaten these ties and/or constitute the only way for the religious sponsor of a financially stressed Catholic hospital to preserve them.

At the same time, the sponsor's view of its charitable mission may not be limited to the operation of the hospital. Rather, the sponsor may see the health care mission

of the hospital as a particular expression of a broader religious purpose, sometimes expressed through the "charism,"[6] or focus of the sponsoring religious order.

The religious sponsor may look to the broader healing mission of the Church and be less committed than the hospital boards to continued operation of a particular facility. This disjunction can generate misunderstanding between the Catholic sponsor and the secular hospital board.

Each Catholic hospital is located within the jurisdiction of a bishop, archbishop or cardinal. These high officials have substantial legal, moral, financial and political force within the Catholic community. In addition, they may serve under Canon Law as "canonical stewards"[7] of the affairs of certain Catholic institutions. And, when it considers the prospect of an alignment with a secular hospital, the religious sponsor may be very wary of running afoul of the wishes of Church representatives. For these reasons, the approval of these officials is required before a sale, merger or affiliation of a Catholic hospital to or with a secular hospital may occur.

Finally, when an entity controlling the property of a Catholic-sponsored hospital seeks to transfer control or "alienate" property with a value exceeding a specified amount (commonly, $3 million, but possibly higher or lower depending on the size of the diocese), the approval of the Vatican is required.[8] "Alienation" is not limited to property transfers under civil law. The term is interpreted broadly under Canon Law to include even the delegation of power over a Catholic institution to a secular corporate parent. Therefore, unless the net value of the hospital has sunk below the approval threshold (and this may be the case when a hospital is in extremely poor financial condition), the Vatican must approve many alignments between Catholic and non-Catholic hospitals.

The review and approval process within the Church can be obscure and frustrating to the secular hospital and even to community members of the Catholic-sponsored hospital. The process may involve much more consensus-building than an outsider with preconceived notions of hierarchical Church decision-making may expect. This consensus-building inevitably takes much more time than the alignment negotiators anticipate. And the secular hospital board may feel that it is being forced to compromise continually to meet changing demands as the consensus within the Church is reached.

Proscribed Services

The operation of Catholic-sponsored hospitals is governed by the Ethical and Religious Directives for Catholic Health Care Services (the "Ethical and Religious Directives" or ERDs) promulgated by the United Conference of Catholic Bishops.[9] Many of the 72 ERDs are general commitments to community service and can be found in similar form in the mission statements of secular not-for-profit hospitals. Some are very particular to Catholic hospitals. For example, ERD #45 prohibits abortion[10] and ERD #54 prohibits sterilization.[11]

Part six of the ERDs bears specifically on relationships between Catholic and secular health care providers. Of special relevance are the directives dealing with "scandal" and "material cooperation."

ERD #67 states that decisions about arrangements with other providers that "entail the high risk of scandal" must be made in consultation with the diocesan bishop.[12] ERD #71 states that "the possibility of scandal must be considered when applying the principles governing cooperation."[13] "Scandal" in this context refers to the likelihood that the faithful in a Catholic community will misconstrue the alignment as contrary to Catholic tenets. The test of scandal is strongly fact-oriented.

What this means in practice is that the bishop (or in some cases, the Archbishop of New York) must consider the possible reaction in the Catholic community to whatever arrangements are envisioned between a Catholic and secular hospital. This may permit vocal opponents in the Catholic community to delay or defeat an alignment that otherwise may be acceptable under Canon Law and beneficial to the community as a whole. It also gives the bishop and archbishop and their advisors the blessing and burden of broad discretion as to what constitutes scandal and the grounds to refashion the terms of a negotiated alignment in order to avoid scandal. Church leaders in different parts of the state may not reach exactly the same conclusion as to what constitutes scandal.

ERD #70 relates to material cooperation and is the key factor in determining the acceptability of a proposed arrangement to the Church. It reads in full as follows: "Catholic health care organizations are not permitted to engage in immediate material cooperation in actions that are intrinsically immoral, such as abortion, euthanasia, assisted suicide, and direct sterilization."[14]

The determination as to whether a proposed arrangement constitutes "immediate material cooperation" is made by the bishop or the archbishop in whose jurisdiction the Catholic hospital is located. Again, this may lead to slightly different decisions in different parts of the state and at different times.

The Church has approved certain "carve-outs" of proscribed services. Carve-outs may allow certain services to continue in some fashion but possibly not directly by or in the secular hospital if the secular hospital continues to operate under the alignment (e.g., if the Catholic and secular hospitals continue as distinct entities under a common corporate parent).

The determination as to whether a particular carve out of proscribed services involves immediate material cooperation is fact-driven. Here are some of the factors that may affect the determination: what proscribed services are offered (e.g., elective abortions, vasectomies and tubal ligations vs. contraceptive counseling); where the proscribed services will be offered (e.g., in the secular hospital, in a hospital within a secular hospital, in a separate but proximate building); what control will be exercised by boards on which priests and nuns or nominees of the Catholic hospital sit over facilities where proscribed services will be offered; what managerial, clinical and support services will be made available by the secular hospital or by jointly controlled entities to facilities where proscribed services are offered (e.g., clinical staff, administrative staff, billing staff, food and housekeeping staff); where these facilities will look for financial support (e.g., the secular hospital, a related foundation, outside sources); and how any net revenues from their activities will be used or distributed (e.g., to the secular hospital, to a common corporate parent).

Access to Services

Pro-choice advocates in the community served by the secular hospital and in broader based groups like Merger Watch, the New York Civil Liberties Union and Planned Parenthood, often view proposed alignments between Catholic and secular hospitals with skepticism and suspicion. What the ERDs condemn, the advocates extol as personal civil rights. Any concession by a secular hospital to win the consent of a Catholic hospital to a merger or other alignment may be viewed as impinging on these rights and overstepping the boundary between state-financed health services in secular settings and religious beliefs.

The advocates' main concern is assuring complete access to reproductive health services and not allowing, in principle or in practice, those services to be marginalized. Advocates may offer many legal arguments against alignments that restrict services at a secular hospital, both constitutional (e.g., free exercise, right of privacy, establishment of religion)[15] and statutory (e.g., failure to provide needed services, misuse of donated funds, failure to fulfill already approved not-for-profit purposes), but their immediate focus is on state officials who, to effect the alignment, must approve Certificate of Need applications, amendments to certificates of incorporation,[16] transfers of control over all or most of the assets of a not-for-profit corporation, and state grants and reimbursement for services.

It is incumbent on the proponents of an alignment between a Catholic and a secular hospital to demonstrate that there will be undiminished access to women's reproductive health services if the secular hospital, as the price of a deal, has to agree to cease abortions and other procedures in space controlled by the secular hospital. Access may be unhampered if there already are adequate alternative facilities in the community or if there is a commitment to build new facilities or to dedicate existing hospital space under independent management to reproductive health services.

Even if immediate access to services is arguably unimpaired, advocates are understandably concerned that any alternative provider be committed to providing women's reproductive services over the long term and has the financial resources to do so. This is particularly problematic because reproductive health services do not generate much revenue and a provider of these services must supplement revenue from other services or from other sources to remain financially viable.

Additionally, advocates are concerned about the personal security of patients and staff at any new service site. Proximity to the secular hospital and careful attention to security staff, location and ingress and egress controls may offer some comfort on this issue.

Advocates oppose any arrangement that requires the secular hospital in a joint Catholic/secular system to adhere to the ERDs, any requirement that the professional staff of the secular hospital follow the ERDs, and any plan for reallocation of clinical services between the hospitals that transfers control over all maternity services to the Catholic hospital.

Finally, advocates have voiced concern about the fluidity of the ERDs and their interpretation. For example, they question whether a new bishop might interpret the ERDs more conservatively and attempt to redraw arrangements already agreed to and implemented and whether the ERDs themselves might be expanded to prohibit current or future services that a secular hospital might wish to provide to meet community needs and increase hospital revenues.

Impact of the Berger Commission

The economic realities compelling alignments between Catholic and secular hospitals existed long before the Berger Commission convened and issued its report. The Commission's report treaded carefully regarding Catholic/secular arrangements, and did not address, much less overcome, any of the barriers to those arrangements described above. Nevertheless, the Commission and its recommendations, later enshrined as state statutory mandates, have facilitated some Catholic/secular arrangements. Hospitals like those in Kingston which, for economic reasons, flirted with a closer relationship for decades were given an extra nudge to align by the Berger's Commission deliberations and recommendations.

In some cases, the Commission was used by the parties as an additional rationale for doing what they already

sought to do. And the imprimatur of the Berger Commission also quieted antitrust concerns and sped up needed CON approvals.

The promise of substantial funds under The Health Care Efficiency and Affordability Law for New Yorkers (HEAL-NY)[17] and the Federal-State Health Reform Partnership (F-SHRP)[18] to finance alignments blessed by the Commission was also a potent motivation to align. St. Clare's Hospital and Ellis Hospital in Schenectady were awarded $50 million to fund St. Clare's pensions and other expenses and thereby induce Ellis Hospital to take over the St. Clare's facility and continue some services there. The state awarded the two hospitals in Kingston $43.5 million for service reallocations, plant renovations and debt retirement, and The Kingston Hospital alone $4.1 million for the construction of an ambulatory surgery center under independent ownership and control for services proscribed under the ERDs.

The prospect of substantial state funds for cash-strapped hospitals and communities has made it more difficult for would-be opponents to speak out against an alignment and thereby jeopardize much needed financial aid. And the Department of Health, which was made responsible for implementing the Berger Commission recommendations, has effectively used funding to keep hospitals focused on fulfilling their commitments to satisfy the Berger Commission mandates.

Overall, the Berger Commission achieved limited success with Catholic/secular alignments. One clear success to date is in Kingston, where the Catholic and the secular hospital boards have had the will to compromise and accommodate for the good of the community and, on that basis, are progressing steadily to complete an alignment under a common corporate parent.[19] In Schenectady County, after long negotiations about joint governance, St. Clare's Hospital closed.[20] In Elmira[21] and in Niagara[22] County, the parties dutifully engaged in the required discussions but failed to form the recommended new corporate relationships.

It would be a mistake, however, to attribute this limited success solely to the special Catholic/secular issues described in this article. Other factors unrelated to those issues may have played a role. Many secular hospitals in New York with good reason to merge have failed to do so.

It is not clear now how the expiration of the Berger Commission (December 31, 2006) and of the extraordinary powers granted to the Department of Health to implement the Berger Commission recommendations (June 30, 2008), and the inevitable exhaustion of HEAL and F-SHRP funds will affect prospects for other Catholic/secular hospital alignments. We may find that by providing an impetus to some new alignments and forcing discussion and consideration of compromise in the interest of preserving essential services in several communities, the Berger Commission has helped create useful precedents and models for future Catholic/secular alignments.

Endnotes

1. Commission on Health Care Facilities in the 21st Century, A Plan to Stabilize and Strengthen New York's Health Care System (December 2006) ("Berger Commission Report") at 109–111.
2. Berger Commission Report at 180–185.
3. Berger Commission Report at 96–98.
4. Berger Commission Report at 209–211.
5. Maida, A.J. and Cafardi, N.P., *Church Property, Church Finances, and Church-Related Corporations* (1984) ("Maida and Cafardi") at 327.
6. Maida and Cafardi at 306.
7. Maida and Cafardi at 305.
8. Maida and Cafardi at 302. *See also, Religious Identity and the Health Care Market. Mergers and Acquisitions Involving Religiously Affiliated Entities*, 38 Creighton L. Rev 927, 950 (2001).
9. United Conference of Catholic Bishops, Ethical and Religious Directives for Catholic Health Care Services, 4th Ed. (2001).
10. Ethical and Religious Directives at 26.
11. Ethical and Religious Directives at 28.
12. Ethical and Religious Directives at 36.
13. Ethical and Religious Directives at 37.
14. Ethical and Religious Directives at 37.
15. See generally, *The Misperception and Misapplication of the First Amendment in the American Pluralistic System: Mergers between Catholic and Non-Catholic Healthcare Systems*, 16 J.L. and Health 103, 119 (2001).
16. See *Nathan Littauer Hosp. Ass'n v. Spitzer*, 287 A.D.2d 202, 734 N.Y.S.2d 671 (3d Dep't 2001), *lv. to appeal den.*, 2002 N.Y. Lexis 940 (N.Y., April 30, 2002).
17. New York Public Health Law Section 2818; New York Public Authorities Law Section 1680-j.
18. http://www.health.state.ny.us/health_care/managed_care/appextension/health_reform_partnership/).
19. New York State Department of Health, Report on Implementation of the Report of the Commission on Health Care Facilities in the Twenty-First Century (July 2008)("DOH Report") at 55–56.
20. DOH Report at 62–63.
21. DOH Report at 68–69.
22. DOH Report at 80.

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Serving Your "Berger" Well Done: A Recipe for Closing or Reconfiguring a Not-for-Profit Hospital in New York

By Robert Andrew Wild, Judith A. Eisen, Peter B. Mancino and David A. Langner

Introduction. The New York State Commission on Health Care Facilities in the 21st Century, better known as The Berger Commission ("Commission"), certainly stepped into one very hot kitchen when it undertook the task of serving up recommendations for closing, rightsizing and reconfiguring New York's hospitals and nursing homes. After the New York State legislature accepted these recommendations and gave them the force of law, governing boards (each, a "Board") of affected institutions across the state were required to complete the complex task of closing or reconfiguring their facilities.[1]

This article will outline the steps that a New York not-for-profit hospital, such as those affected by the Berger Commission, must take to close a hospital facility. It is important to note that closing a hospital does not necessarily require dissolving the corporation, which may be retained for other purposes.[2] This article will, however, also discuss the key aspects of how New York not-for-profit corporations dissolve, merge or sell all or substantially all of their assets in order to present a more complete picture of the legal issues that arise in connection with these matters.

Furthermore, the restructuring arrangements that the Commission required involved a variety of affiliation arrangements, including integrating the governance of two or more institutions or creating a "parent/subsidiary" relationship through the use of a sole corporate member. Some of these transactions implicated regulatory, lender consent, antitrust and other related issues. Governing Boards faced with such mandates must carefully examine all of these concerns with the advice of counsel before embarking on any restructuring.

1. **NFPL Overview**. This section will review the Provisions of the New York Not-For-Profit Corporation Law (NFPL) governing certain major corporate changes by New York not-for-profit corporations (each, a NFP), including dissolution, merger and the sale of all or substantially all of a corporation's assets. The key concept is that a NFP cannot take any of these steps without first obtaining the consent of a Justice of the New York Supreme Court ("Court") by filing a verified petition ("Petition") on notice to the Attorney General (AG). In any case, it is a "best practice" to pre-clear the filing with the AG to resolve any issues beforehand. This way, the AG can waive statutory notice and mark the Petition "No Objection." The Court will then generally approve the Petition as a matter of course.

   a. Dissolution

      i. Adopting Resolutions. If the Board has decided to dissolve the existing corporation, it must adopt a resolution authorizing the corporation to dissolve and adopting a Plan of Dissolution ("Plan of Dissolution"). This resolution will have to be voted on and adopted by the Board and, if applicable, the corporation's members.[3] Essentially, the Plan of Dissolution must set forth:

         1. A list of the corporation's assets, if any, along with their fair market value and a statement as to whether any of them are being held for a particular purpose (i.e., donor restricted or restricted by contract, grant or a similar agreement);

         2. A statement that (a) the corporation's unrestricted assets, subject to its unpaid liabilities and any distributive rights of its members, will be distributed to one or more tax-exempt organization(s) [4] having purposes substantially similar to the corporation's and (b) any assets held for a specific purpose will continue to be used in accordance with the applicable gift or contractual instrument. The Plan of Dissolution must also include a copy of each such organization's governing documents, financial reports for the last three years, and Internal Revenue Service determination letter stating that the organization is exempt from taxation, and an affidavit from a director and officer of the organization stating its charitable purposes and that it is currently exempt from taxation;[5]

         3. A list of the corporation's liabilities, including an estimate of the

accounting and legal fees associated with the dissolution;

4. The consent of the New York State Department of Health (DOH) and the New York State Public Health Council and any other regulatory agency (e.g., the Office of Mental Health (OMH), the Office of Alcoholism and Substance Abuse Services (OASAS)) whose consent was required to form the corporation or whose consent was later required; and

5. The approval of the Court in the judicial district where the corporation is located.[6]

ii. **Carrying Out the Plan of Dissolution**. The corporation must then carry out the Plan of Dissolution by paying its liabilities and distributing its assets within 270 days from the date the corporation has authorized the plan and obtained the consent of the Court and any required regulatory body.[7] As discussed in further detail below, the Petition filed with the Court to obtain its approval must be made "on notice" to the AG. In the unlikely event of any dispute or competition regarding the distribution of the net assets, other parties, including any donors of restricted gifts, may need to be made a party to the proceeding. Once the corporation has carried out the Plan of Dissolution, it will prepare a Certificate of Dissolution,[8] which, after receiving the consent of the New York State Department of Taxation and Finance, the corporation will file with the New York Department of State to formally effectuate the dissolution.[9]

b. **Merger**. While the specific technical requirements to merge or consolidate a NFP may differ from those required to dissolve one, the basic procedure is the same, namely, the filing of a Petition with the Court, on notice to the AG. In the merger context, the AG will review the Petition to assist the Court in determining whether all of the statutory requirements have been met and that the interests of the constituent corporations and the public will not be adversely affected.[10]

c. **Sale of Assets**. In cases involving a NFP's sale of all or substantially all of its assets, the Court will seek to determine that the consideration and the terms of the transaction are fair and reasonable to the NFP and that the sale promotes the NFP's purposes or the interests of its members.[11] Special rules apply to any sale involving insiders.[12] Although not explicitly required by statute, as a practical matter, the Court will reject a Petition not supported by an independent appraisal of the assets to be sold. Furthermore, the use of the sale proceeds must be consistent with the NFP's purposes. Finally, if the NFP is insolvent or its assets are insufficient to fully satisfy its liabilities, all of its creditors must be served with a notice.[13]

d. **Appointment of Sole Corporate Member**. Significantly, a 2001 Appellate Division case[14] held that Court approval was *not* required for the proposed affiliation of two NFP New York hospitals where one sought to vest certain of its existing corporate powers in a newly formed sole corporate member. The AG took the position that the hospital could not do so without first seeking Court approval. Had the Appellate Division agreed, this case would have had a significant impact as many New York hospitals make use of this corporate structure.

2. **Assessing the Corporation's Financial Condition**. We will now focus on how the Board should analyze the corporation's financial condition. Its assets will essentially fall into one of two categories, unrestricted or restricted as to use. For purposes of this article, an asset is restricted as to use if it was donated or granted to the corporation to be used for a particular purpose or subject to a particular restriction, such as a debt service reserve fund pursuant to tax-exempt bond obligations. Other examples include a gift of cash or securities that can only be used as endowment (i.e., that the principal may not be spent) or for a specific purpose, such as providing care for the indigent or supporting a particular hospital service or division. Unrestricted assets may be used for any lawful corporate purpose.

a. Unrestricted Assets.

i. **Going Concern.** After taking an inventory of its assets, the corporation will initially have to determine which, if any, of its unrestricted assets or operations can be sold as a "going concern" (i.e., as a continuing viable business) having a

value greater than the sum of its "hard assets." These might include, for example, outpatient clinics offering dialysis, detoxification or mental health services, etc.[15]

ii. **Assets Subject to Secured Financing**. Certain assets, such as real estate or major pieces of equipment, may be encumbered in connection with a secured financing in favor of either a commercial lender or a governmental agency such as The Dormitory Authority of the State of New York. Naturally, these assets may only be sold once these lenders have been paid and have released their liens on the collateral, which may include designated funds, accounts receivable, etc.

b. **Restricted Assets**. As discussed above, the AG has broad statutory authority to enforce the terms of restricted gifts, whether made on an *inter vivos* or testamentary basis.[16] The net result is that the Board must ensure that the terms of these restricted gifts are maintained upon the transfer of these assets to another NFP. If, however, in connection with any dissolution, merger or sale of assets, the donor's terms regarding the gift cannot be honored, the Board will have to commence what is known as a *cy pres* proceeding to obtain the Court's consent to remove the restriction on the assets. The process will vary depending on how the gift was made.

i. ***Inter Vivos* Gifts**. NFPL § 522(a) provides that such restrictions can be lifted with the donor's written consent or, if this consent cannot be obtained because the donor died, is disabled or is otherwise unavailable, the corporation may apply to the Court, on notice to the AG, for an order releasing the restriction, subject to the funds being used for the corporation's existing purposes. Under the quasi *cy pres* standard, the Court may release a restriction, in whole or part, if it finds that the restriction is "obsolete, inappropriate, or impracticable."[17]

ii. **Testamentary Gifts**. If a gift was made by will or testamentary trust, a restriction can only be lifted by the Surrogate's Court, on notice to the AG, in accordance with the more stringent *cy pres* standard set forth in EPTL Article 8. In these cases, the court may lift the restriction in whole or in part if the applicant demonstrates that "circumstances have so changed since the execution of [the gift instrument]" that it is "impracticable or impossible" to comply literally with its terms, and the modification, in the court's judgment, will "most effectively accomplish" the gift's original general purposes.[18]

c. **The Corporation's Liabilities**. Along with making an inventory of the corporation's assets, the Board should assess the corporation's liabilities to determine whether it is capable of satisfying them.[19] To the extent that the corporation's aggregate liabilities greatly exceed its assets, or it finds that it is otherwise unable to pay its debts as they become due, the Board may want to consider whether to negotiate an out-of-court workout or, in more severe cases, pursue a voluntary reorganization or liquidation under Chapter 11 of the U.S. Bankruptcy Code ("Chapter 11").[20] At a minimum, the Board should thoroughly explore and discuss these options.

d. **The Board's Fiduciary Duties**. The overarching concern here is that, if a corporation is insolvent,[21] or even in the grey area between solvency and insolvency known as the "zone of insolvency," the Board's fiduciary obligations expand to include not only the interests of the corporation (including its charitable mission), but also those of its creditors. Board members may also face liability from claims by the corporation's creditors alleging "deepening insolvency." This emerging, but not universally adopted, theory provides that decision-makers can be held liable for fraudulently prolonging the company's life or concealing the incurrence of additional debt to the detriment of creditors. The underlying rationale is that deepening insolvency can undermine the corporation's relationships with its customers, suppliers and employees and damage realizable asset values; the theory further asserts that this harm can be averted if the corporation is dissolved in a timely manner, rather than kept afloat with spurious debt. Liability for deepening insolvency has not been widely accepted. It is tempered by the business judgment rule, which requires officers and directors to perform their duties in good faith with the degree of care a prudent person similarly situated would use. Nonetheless, it is

imperative that the Board develop a detailed understanding of both the corporation's financial position and its future prospects so that it may proceed in the appropriate manner.

e. **Bankruptcy: To File or Not to File**. The Board should thoroughly document, in writing, all aspects of its financial analysis to demonstrate that it made a good-faith investigation of all viable options and obtained the necessary professional advice to determine the best course of action. In the case of an insolvent corporation, filing for bankruptcy protection offers certain key advantages, such as the automatic stay, which prevents creditors from commencing or continuing any judicial, administrative or other proceedings to recover any debt that arose before the filing. This gives the corporation some "breathing room" and consolidates all of these disputes in a single forum. Bankruptcy also allows a debtor to reject executory contracts and unexpired leases, leaving the counterparties with an unsecured pre-petition claim for breach of contract. Finally, subject to certain conditions, the debtor may sell all or a portion of its assets "free and clear" of all liens, claims and interests. Bankruptcy also has a number of disadvantages. For example, the process is lengthy and entails significant fees for attorneys, consultants and accountants for both the corporation and the creditors' committees. In the final analysis, the Board will have to weigh all of the relevant factors, with appropriate legal and financial advice, to determine if a bankruptcy filing is the best choice for the institution.

3. **Personnel-Related Issues**

a. **General**. The Board also will have to deal with a variety of issues in connection with the corporation's personnel, employed or otherwise. While we will review certain specific WARN requirements below, the key concept to bear in mind is to establish and maintain open lines of communication with management, the union leadership, if any, rank-and-file and credentialed providers. In addition to keeping all of these constituencies reasonably informed as to the institution's plans, the corporation may have to offer incentives such as retention bonuses, along with job placement and training services, to ensure that the hospital will have adequate staffing during the wind-down period. Finally, the Board must deal with such related issues as the funding of employee severance and accumulated benefit obligations, including pension, health care, and other retirement benefits. Whether all of these obligations will or can be met will depend on the corporation's financial condition and whether it files for bankruptcy.

b. **WARN Act**. The Federal Worker Adjustment and Retraining Notification Act (WARN)[22] essentially requires employers with 100 or more full-time employees to provide its workers with at least 60 days written notice if there will be a:

i. "Plant Closing" (i.e., the closing of an "employment site" or one or more its facilities or operating units) resulting in an "employment loss" for 50 or more full-time employees during any 30-day period; or

ii. "Mass Layoff" which does not result from a Plant Closing, but which will result in an employment loss at the employment site during any 30-day period for 500 or more full-time employees, or for 50-499 such employees if they make up at least 33% of the employer's active workforce.[23]

4. **Closing the Hospital Facility**

a. **Plan of Closure**. The "road map" for closing the facility's various services must be set forth in a "Plan of Closure" ("Plan of Closure"), which must be filed with, and approved by, DOH (and any other applicable licensing agency) at least 90 days before the planned date of closure.[24] While the regulatory requirements regarding the Plan of Closure only explicitly cover patient notification and the maintenance and storage of medical records, each of which is discussed in further detail below, experience indicates the plan must also provide the following type of information in order to gain approval:

i. How the corporation approved the Plan of Closure;

ii. The date the hospital will close its various services (e.g., Emergency (ED), Inpatient admissions, Detoxification, Methadone, Mental Health, Family Medicine, Dialysis, Dental and Pharmacy);

iii. How the facility will arrange for transfer of its inpatients and referral of its outpatients

to nearby hospitals and other suitable facilities;

iv. How the facility will ensure the safety of those persons presenting at the ED because they, or the persons transporting them, were not aware that it had been closed;[25]

v. How the facility will ensure patient, physician and regulatory access to, and maintain the confidentiality of, all hospital medical records;[26]

vi. The disposition of all pathology samples;[27]

vii. The plan for limiting the intake of new patients during the notice period and how patients will be advised of the availability of alternate services;

viii. The disposition of all medications, supplies, medical waste, infectious, radioactive and hazardous materials and equipment and fixtures; and

ix. Notification regarding the hospital's closure, which should be sent to:

1. All active hospital inpatients and outpatients, including their physician and next-of-kin, where appropriate;

2. All hospital employees and their union representatives;

3. The office of the "chief elected official" of the local government unit in which the facility is located and the State Relocation Worker's Unit (each required under WARN);

4. All medical staff members;

5. All applicable local/regional police and fire departments, EMS providers, as well as the local Department of Transportation or Public Works so that all blue Hospital signs directing traffic to the facility are removed;

6. All local/regional hospitals, medical societies, social service agencies and community boards;[28] and

7. Any medical schools and other hospitals with which it operates any medical residency or other graduate medical education program.[29]

5. **Other Post-Closure Matters**

a. **Financial**. The hospital will have to adopt a post-closure operating budget, and arrange to keep appropriate office space and administrative and clerical personnel as may be necessary to manage its accounts receivable, accounts payable and other post-closure wind-down operations. The hospital may also wish to engage, or continue to retain, its current collection agency to assist with this effort.

b. **Operational**. The hospital should also maintain an IT infrastructure sufficient to support its wind-down activities. Winding down also will require management to assign or terminate, if possible, any real estate or equipment leases, and arrange for the sale or transfer of the corporation's assets, as set forth in the Plan. The hospital must also arrange for storage of the corporation's business, financial and employee records, as matters may arise after closure requiring reference back to the records.

c. **Physical Plant**. Management must secure all of the hospital's facilities (e.g., fence the campus, padlock the buildings and board any accessible windows), as may be appropriate under the circumstances. The hospital may also have to retain security guards and a telephone operator or set up an answering machine system to handle phone calls.

d. **Filings, Notifications**. Management will also have to ensure that final audited financial statements and Charities Registration Statements are prepared and filed with the AG,[30] that a final Medicare cost report is filed with CMS[31] and that final Medicaid and Bad Debt and Charity Care Reports are filed with DOH.[32] Finally, the hospital will have to notify vendors and suppliers of the closure, as well as any commercial and Medicaid payors.

e. **Surrender of Operating Certificate and Licenses**. Once the hospital facility is closed, it must surrender its Operating Certificate to DOH and any other licenses (e.g., laboratory, pharmacy, radiology facilities) to the appropriate regulatory bodies.[33]

f. **Insurance**. The Board should also check with its insurance broker to make certain that the corporation's real and personal property is properly insured until sold or otherwise transferred and that general and professional

liability insurance is in place to cover claims that will likely arise after the facility is closed.[34] Lastly, we strongly recommend that the Board keep a Directors' and Officers' liability policy in place until it has filed the corporation's Certificate of Dissolution.[35]

Conclusion. Closing or restructuring a New York not-for-profit hospital is a complex undertaking. The Board must be sure that it complies with myriad federal and state regulations while simultaneously honoring its fiduciary obligations to the corporation, its charitable mission and, if applicable, its creditors.

Endnotes

1. The Commission's enabling legislation is set forth in Chapter 63 of the Laws of 2005.
2. Obviously, only certain of the matters discussed will apply if the Board is implementing Commission recommendations to reconfigure or merge, rather than close, a particular hospital or if the Board develops a new business plan for the existing corporation going forward. As discussed below, the legal process of securing the consent to dissolve, merge (NFPL Article 9) or sell all or substantially all of a not-for-profit corporation's assets (NFPL §§ 510–511) is essentially the same. Furthermore, while this article will, for the sake of clarity, focus on closing a hospital, the same principles are generally applicable to a not-for-profit nursing home as well.
3. The specific voting requirements to approve the Plan are set forth in § 1002 of the Not-For-Profit Corporation Law (NFPL). Alternatively, these may be set forth in the corporation's bylaws ("Bylaws") or certificate of incorporation (COI), subject to the requirements of NFPL § 1002.
4. Often the COI will designate who receives the assets upon dissolution. While such a designation is usually followed by the Court, it is not binding, and the Court retains the final say in the matter.
5. *See* NFPL § 1001(d)(3).
6. The specific requirements for the contents and authorization of a Plan of Dissolution are set forth in NFPL § 1001 and NFPL § 1002, respectively.
7. NFPL § 1002-a(a). The statute allows for an extension of up to one year to effectuate a Plan of Dissolution.
8. The specific requirements for a Certificate of Dissolution are set forth in NFPL § 1003.
9. The corporation's rights and remedies which survive dissolution are set forth in NFPL § 1006. It is also important to note that the Court retains broad jurisdiction over the corporation even after the filing of the Certificate of Dissolution. *See* NFPL § 1008.
10. *See* NFPL § 907(e).
11. *See* NFPL § 511(d).
12. *See* NFPL § 715.
13. *See* NFPL § 511(c).
14. *Nathan Littauer Hosp. Ass'n v. Spitzer*, 287 A.D.2d 202, 734 N.Y.S.2d 671 (3d Dep't 2001), *leave to appeal denied*, 2002 N.Y. LEXIS 940 (N.Y. April 30, 2002).
15. Any of these sales will require the approval of a regulatory agency (e.g., DOH, OMH or OASAS) having jurisdiction over the particular service. Significantly, such a sale may not be permitted based upon DOH regulatory criteria and "need" determination despite the presence of a willing buyer.
16. *See* Estates, Powers and Trusts Law (EPTL) §§ 8-1.1; 8-1.4 and NFPL §§ 513; 522.
17. Of course, the issue of "existing purposes" is moot in the case of a dissolution.
18. EPTL § 8-1.1(c)(1). The leading cases in this area are *In re Donald F. Othmer*, 710 N.Y.S.2d 848 (Surr. Ct., Kings County 2000) and *In re Mildred Topp Othmer*, N.Y.L.J., Oct., 21, 1999, p. 29 (Surr. Ct., N.Y. County Oct. 15, 1999). Here, the court granted *cy pres* relief to Long Island College Hospital (LICH) such that LICH was permitted to use restricted endowment funds to secure almost $90 million of new financing for necessary capital improvements and immediate working capital needs.
19. NFPL § 1007 may be useful where the corporation is uncertain as to what claims its creditors may assert. This section essentially provides that before filing its certificate of dissolution, a not-for-profit corporation may give a notice requiring all creditors to present their claims in writing at a specified place and by a specified date. The corporation must publish the notice in a local newspaper and must also mail a copy to each person believed to be a creditor. This procedure does not waive the corporation's right to contest any claim which may be asserted, and it may submit any disputed claim to the Court for determination in accordance with NFPL § 1008.
20. The Bankruptcy Code ("Code") is codified in Title 11 of the United States Code (U.S.C.).
21. While it is beyond the scope of this article to present a detailed definition of insolvency, it is worth noting that it can be measured on a "balance sheet" (i.e., that an entity's liabilities exceed its assets) or "cash flow" (i.e., that the entity's cash flow is insufficient to cover its current obligations) basis.
22. 29 U.S.C. §§ 2101 *et seq*. The applicable regulations are set forth at 20 C.F.R. Part 639.
23. Job losses within any 90-day period are aggregated for WARN notification purposes unless the employer demonstrates that these job losses were the result of separate and distinct actions and causes. Certain other rules apply if a business is sold. Due to WARN's complexity, it is essential that the Board obtain the advice of counsel to determine their obligations, if any, under WARN.
24. 10 N.Y.C.R.R. § 401.3(g). The Board may amend the Plan of Closure to reflect any unexpected changes in the closure process.
25. The hospital could, for example, keep a physician, physician extender, nurse or security guard in the ED, maintain an ambulance, or otherwise notify the public. The steps chosen would, of course, depend on the circumstances of each hospital and its surrounding community.
26. The hospital can address this concern by entering into an agreement with a health care information management company that can store and ensure access to the facility's medical records. Alternatively, another nearby facility may be willing to assume custody of the records. The hospital should also advise its current patients, as well as any patients treated over the past six months, as to how they may access these records.
27. The rules regarding the retention of pathology reports and specimens are set forth in 10 N.Y.C.R.R. § 58-1.11(d). Notably, some of these materials must be kept for as long as 25 years.
28. The hospital may also elect to retain a public relations firm, send a press release to the local/regional newspapers, including any foreign language papers read by minority populations in the community, post notices in and outside the hospital regarding the impending closure and reach out to the community in such other ways as the Board sees fit.

29. The hospital will also have to make arrangements to transfer any current medical residents to other teaching hospitals and its residency records to a successor entity willing to accept them or to the repository at the Federation of State Medical Boards (FSMB). That service is described on FSMB's website: http://www.fsmb.org/fcvs_closedprograms.html.
30. 13 N.Y.C.R.R. § 91.9.
31. 42 C.F.R. § 413.20. The hospital must also file a final Form 855A with CMS to dis-enroll from Medicare.
32. Public Health Law § 2807-k (12).
33. Laboratory and radiology licenses are surrendered to offices within DOH, while pharmacy licenses must be sent to the Drug Enforcement Administration (*see* 21 C.F.R. Part 1301) and the New York State Board of Pharmacy (*see* § 63.6 of the Regulations of the Commissioner of Education).
34. If the hospital secured this coverage through a "claims made" policy, it will have to obtain a "tail" endorsement to cover any claims asserted after the policy is cancelled upon the hospital's closure. A "tail" is not required if the hospital was covered under an "occurrence" policy. Again, however, such matters may be resolved in Bankruptcy Court if the closure is coupled with a bankruptcy filing.
35. NFPL § 1006(b) provides that the corporation's dissolution "shall not affect any remedy available . . . against such corporation, its directors [or] officers . . . for any right or claim existing or any liability incurred before such dissolution" (emphasis added).

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Successor Liability in New York Post-Berger

By Jeffery M. Alexander and Sarah Shannon Carlins

Preface

New York hospitals and nursing homes comprise the core of the state's short-term and long-term health care systems by providing all forms of necessary medical and respite care services to millions of individuals daily. As such, they are crucial to the public's well-being, important businesses, large employers and vital to vibrant and stable communities throughout New York. This fact becomes even more significant considering the population is aging. Indeed, the Healthcare Association of New York State asserts that "[a]s 'baby boomers' enter their senior years, more families will depend on the availability of quality health care. . . . Many of New York's families take comfort in knowing their aging parents can be both near to home and close to a first-class hospital."[1]

Unfortunately, however, this health care infrastructure faces serious challenges. The precarious finances of numerous hospitals and long-term care facilities, coupled with unprecedented unmet need in communities throughout New York, spurred the government to action. In 2005, former governor George Pataki and the New York State legislature created the Commission on Health Care Facilities in the 21st Century, which was tasked with reviewing the state's health care needs and resources and "rightsizing" its health care delivery system, particularly hospitals and nursing homes (the "Berger Commission").[2] In accordance with the original legislation, as the Governor approved, and the legislature did not overturn, the Berger Commission's recommendations, on January 1, 2008 they became the Berger Law, an enforceable New York statute that mandated closing eighteen hospitals and nine nursing homes and restructuring over fifty hospitals and nursing homes by merger, consolidation or asset acquisition, directly impacting many facilities with major structural changes.

The Berger Commission Report discusses the possibility that its authority provides involved facilities state action exemptions from antitrust challenge. While not pertinent here, such a position raises an issue whether providers acting at the Berger Law's behest receive other protections, including relief from successor liability. Thus, the question whether such forced restructuring will affect generally well-settled rules regarding successor liability in New York becomes both timely and pertinent. This article examines how merging and purchasing facilities might protect against such liability.

The General New York Rule

The general New York rule of successor liability holds that a purchaser is not liable for its seller's liabilities without an express agreement between them dictating otherwise. The New York Court of Appeals has held that, ". . . a corporation which acquires the assets of another corporation is generally not liable for the torts of its predecessor."[3] The New York Supreme Court, Appellate Division, Second Department, reiterated this rule stating that "[a]s a general rule, a corporation which acquires the assets of another [corporation] is not liable for the torts of its predecessor"[4] and "[a] corporation that purchases the assets of another generally is not liable for the predecessor's tortious conduct."[5] While almost all of the available New York cases deal with predecessors' tort liability, their logic seems equally applicable to successor *contractual* liability as the general rule regarding successor liability is well settled: an entity does not automatically assume its predecessor's liabilities.

Exceptions to the Rule

At least four well-recognized exceptions to the aforesaid New York successor liability rule exist. In *Kasem v. BNC Stor., LLC*, the New York Supreme Court, Appellate Division, Second Department, explained that one might face successor liability if

(i) the successor entity expressly or impliedly assumes the predecessor's tort liability,

(ii) there was a consolidation or merger of seller and purchaser,

(iii) the purchasing entity is merely a continuation of the selling entity, or

(iv) the transaction was entered into fraudulently to escape such obligations.[6]

1. First Exception: Express or Implied Assumption of Liability

The *Kasem* Court noted that the purchaser's and seller's asset sale agreement only evidenced a simple asset transfer, establishing that the purchaser did not assume its predecessor's liabilities. The Court furthermore noted that the purchaser did not attempt to use the predecessor's identity or hire any of its supervisory personnel, causing the Court to conclude that the purchaser did not assume its predecessor's liabilities, either expressly or im-

pliedly.[7] Similarly, in *In re Seventh Jud. Dist. Asbestos Litig.*, the Supreme Court of Ontario County observed that "under the asset purchase agreement, the purchaser did not assume any of the liabilities of the seller."[8] Therefore, the asset-sale agreement itself provides the first indication whether liabilities are assumed wherein if it fails to so specifically state, the court will be reluctant to make such an assumption. This also may be true if the asset-transfer agreement delineates transfer of only specific seller liabilities to the purchaser, using a similar argument that the parties only agreed to the purchaser assuming particular, but not all, seller liabilities.

2. Second Exception: Consolidation or Merger

The New York Supreme Court, Appellate Division, First Department, in *Van Nocker v. A.W. Chesteron, Co.*[9] discussed the second successor liability exception. The court notes that asset purchases even can be constructed to constitute *de facto* mergers, thus causing successor liability to apply, if the asset purchase includes the following four factors:

(i) continuity of ownership,

(ii) the seller ceasing ordinary business operations and dissolving as soon as possible after the transaction,

(iii) the purchaser assuming liabilities ordinarily necessary to continue the seller's business uninterrupted, and

(iv) the purchaser continuing the successor's management, personnel, physical location, assets and general business operation.[10]

The court further explained that while a finding of *de facto* merger does not necessarily require all of these factors, existence of each of the first two is required. According to the Court, continuity of ownership exists "where the shareholders of the predecessor corporation become direct or indirect shareholders of the successor corporation. . . . Stated otherwise, continuity of ownership describes a situation where the parties to the transaction 'become owners together of what formerly belonged to each.'"[11] The *Van Nocker* Court, failing to find either of the first two *de facto* merger elements, thus declined to analyze the remaining factors.

In an earlier case, the Fourth Department of the New York Supreme Court, Appellate Division, took a more flexible approach to determining whether a transaction constituted a *de facto* merger, reasoning that "[w]hile factors such as shareholder and management continuity will be evidence that a de facto merger has occurred, those factors alone shall not be determinative."[12] More recently, the U.S. District Court for the Southern District of New York examined the continuity of ownership element of *de facto* merger under New York law and stated that, "'[t]he de facto merger doctrine creates successor liability when the transaction between the purchasing and selling companies is in substance, if not in form, a merger.'"[13] The Court then listed the above referenced four factors to determine whether a *de facto* merger exists, noting that "the Court should consider the factors 'in a flexible manner that disregards mere questions of form and asks whether, in substance, it was the intent of the successor to absorb and continue the operation of the predecessor.'"[14] This Court further noted, however, that continuity of ownership also is a prerequisite to finding a *de facto* merger.[15]

This Court also analyzed the *de facto* merger's fourth factor, observing that "'[t]he mere hiring of some of the predecessor's employees is insufficient to raise a triable issue as to continuity of management.'"[16] The Court did not find a *de facto* merger, holding that in this case an attorney merely switched employers, bringing some of his established caseload to his new firm, along with a secretary and an associate, which did not constitute a merger or consolidation.

Thus, when analyzing the *de facto* merger exception, courts minimally require continuity of ownership before considering the other three factors. And while the cases reference stock ownership as the exclusive evidence of ownership continuity, stock ownership, of course, is immaterial to not-for-profit corporations that have no shareholders or stock. Therefore, how would ownership continuity be determined in the not-for-profit realm? For example, would a surviving institution that retains its Board, but accedes to a new corporate member/new corporate parent or that retains its Board and/or corporate member, but adds additional, new Board members and/or corporate members to itself and/or to its parent company constitute ownership continuity?

3. Third and Fourth Exceptions: Mere Continuation and Fraudulent Transaction

Case law analyzing what constitutes a company's continuation or a fraudulent transaction is sparse. Rather than the mere continuation exception, New York has adopted the continuity of enterprise exception, which is very similar to the mere continuation exception and which is discussed further below. In the *Seventh Jud. Dist.* case, however, the plaintiff asked the court to apply a mere continuation exception in a claim against a successor. The Court reasoned that "mere continuation" essentially describes a corporate reorganization, wherein one entity is dissolved and another survives the transaction.[17] As the seller was not dissolved for more than a year after the asset sale, the Court held the mere continuation exception inapplicable. In other jurisdictions, the mere continuation exception requires continuity of owners

and/or directors between the predecessor and the successor entities.[18]

Regarding fraudulent transactions, New York courts may recognize a cause of action where an asset purchase "'is entered into fraudulently to escape [tort] obligations,' [but] no published New York decision appears to have analyzed the contours of the fraud exception."[19]

4. Other Exceptions: Continuity of Enterprise and of Product Line

In addition to the generally recognized four successor liability exceptions, there are two lesser known ones: the "continuity of enterprise" theory and the "product line" exception, both of which are discussed in *Salvati v. Blaw-Knox Food & Chemical Equipment, Inc*.[20]

a. Continuity of Enterprise Theory

In 1983, New York's Court of Appeals recognized this exception, defining it as "corporate reorganization," but failed to discuss it in detail.[21] The Supreme Court of Queens County, later in *Salvati*, explained that the continuity of enterprise theory, in which the successor entity claims to be continuing the original enterprise, was originally set forth by the Supreme Court of Michigan in *Turner v. Bituminous Cas. Co*.[22] *Salvati* noted the Michigan Court's rationale, that it "would be unjust to allow the successor to hold itself out in this manner for the purpose of sales, while allowing it to deny continuity in order to defeat products liability claims."[23] Moreover, *Salvati* set forth the Michigan court's three criteria test for the existence of such continuity:

> whether there was a continuation of the enterprise of the original entity; whether the original entity ceased its ordinary business operations and dissolved promptly after the transaction, and whether the purchasing entity assumed those liabilities and obligations of the seller normally required for an uninterrupted continuation of the seller's operation.[24]

Salvati accepted the logic of *Turner*, saying that

> [t]he *Turner* approach has the virtue that it bases its imposition of liability upon the successor corporation's own acts, in holding itself out to be an unbroken continuation of the original enterprise. . . . In each case the buyer assumed sufficient obligations to continue the seller's business without interruption . . . continuity was the purpose, continuity was the watch word, continuity was the fact.[25]

b. Product Line Exception

The product line exception to successor liability comes from the Supreme Court of California in *Ray v. Alad Corp*.,[26] and reflects a scenario where the successor company continues to make the same products (or, ostensibly, if a service industry like health care, provides the same services) as the predecessor and that it exploits the predecessor's name, goodwill and customer lists, for example, in order to help sell the products. *Salvati* noted that *Ray* set forth three criteria for imposing product liability on a successor:

> (1) the virtual destruction of the plaintiff's remedies against the original manufacturer caused by the successor's acquisition of the business,
>
> (2) the successor's ability to assume the original manufacturer's riskspreading role, and
>
> (3) the fairness of requiring the successor to assume a responsibility for defective products that was a burden necessarily attached to the original manufacturer's goodwill being enjoyed by the successor in the continued operation of the business.[27]

The *Salvati* Court, however, was unimpressed with the reasoning of *Ray* and declined to endorse the product line theory, explaining that

> [t]his court would prefer not to base its decision on the broad and sweeping principles of social policy which underlie the "product line" theory of *Ray*. . . . The analysis and criteria set forth in *Ray* look primarily to the availability of a remedy, and implicitly to the location of a "deep pocket" to furnish that remedy.[28]

For a time, New York courts remained unsettled about whether to accept these two additional exceptions. In *Schumacher*, the Court of Appeals allowed for the possibility that either theory might apply depending upon a case's particular facts. In 2006, however, the same Court rejected the product line exception, reasoning that it placed responsibility for a defective product on an entity that played no role in putting that product into the stream of commerce. While the Court acknowledged that the original company's sale could destroy a future plaintiff's product liability remedy, it also held that "'this is not a justification for suing the successor, but rather . . . merely a statement of the problem.'"[29] Thus the *Semenetz* Court further limits successful arguments that successor liability

exists even if the parties to the transaction fail to specifically address transfer of the selling entity's liabilities.

Analysis

In accordance with New York's general rule of successor liability, a hospital or nursing home that acquires another facility's assets and none—or a detailed modicum—of its contractual liabilities should not be held to have assumed all of its predecessor's liabilities. Exceptions to this rule, however, if applicable, could harm a surviving health care entity's claim that it lacks responsibility for its predecessor's liabilities. Each exception must be considered and each factual scenario examined within their context.

1. First Exception: Has the successor expressly or impliedly assumed the predecessor's liabilities?

The actual agreement transferring the predecessor's assets is most instructive on and important to proving this point. As previously noted, New York courts hold that purchasers failing to expressly assume their predecessors' liabilities in the document governing the transaction will not be deemed to have assumed them. In fact, as noted, this may be similarly true when the purchaser only assumes specific liabilities, in which instance only those specifically referenced liabilities will be assumed. Furthermore, the courts will look to other factors, such as use of the predecessor's name, to decide whether an implied assumption of liability exists. Nonetheless, the courts' decisions thus far seem to evidence a reluctance to find either express or implied assumption of liability without the parties' clear intention otherwise. Therefore, "post-Berger Law" asset–acquisition arrangements by hospitals or nursing homes should strictly specify what, if any, liabilities are transferred to the purchaser and what happens with any that are retained by the seller.

2. Second Exception: Did the entities *de facto* consolidate or merge?

The courts look to four factors to determine whether a *de facto* merger or consolidation occurred. And recall that New York courts have suggested that, minimally, existence of the first two factors is required to prove existence of a *de facto* consolidation or merger.

a. Continuity of ownership

In accordance with *Van Nocker* and *Sweatland*, courts might find *de facto* mergers upon continuity of ownership and/or of management. And what in the health care context constitutes ownership or management continuity? On the taxable side, the criteria for health care *de facto* mergers and consolidations should be no different than for similar taxable businesses: the same, or predominately the same, shareholders and management. On the tax exempt health care side, the answer may be less clear. An acquisition required by the Berger Law that effectuates the seller's prior corporate Member(s), management and/or board members conducting/governing the resulting business just as they did prior to the transaction, risks vulnerability to claims of being a *de facto* merger or consolidation, merely a continuation of the seller's former business. A surviving provider's acquisition of another facility's assets under a Berger Law mandate, without continuing that other facility's prior management, ownership and/or control, should emphasize the transaction's lack of ownership continuity.

b. Cessation of the seller's ordinary business operations and its dissolution immediately following the transaction

A health care entity that sells its assets to another provider under the Berger Law likely would cease operations, return its operating certificate to the Department of Health and dissolve—however, not necessarily immediately. In such a circumstance, the non-surviving provider most likely must continue to operate on at least some level while winding up its business affairs and liabilities and awaiting its state and federal funding, even if no longer as a licensed health care company. The longer that the seller remains operational in some capacity, the more tenuous the seller's creditors reliance on this exception becomes.

c. Purchaser's assumption of liabilities ordinarily necessary to continue the seller's business

As mentioned above, the asset-purchase agreement specifically may limit the purchaser's assumption of any, even minimal, amounts of the seller's liabilities and, without specific language to the contrary, courts are loathe to find liabilities assumed. While the courts have not specifically described what degree of assumed liabilities by the purchaser necessarily constitutes "continuing" the seller's business, and thus responsibility for its liabilities, it should require more materiality than simply using the seller's assets in the context of the same industry. For example, would assuming existing physician leases in an acquired medical office building constitute continuity? Would conversion of a hospital into a nursing home suffice? No definitive conclusion exists.

d. Continuity of the seller's management, personnel, physical location, assets and general business operation

As mentioned above, the courts briefly discuss this factor, noting that simply hiring some of the seller's former employees will not constitute this type of continuity. Thus, an acquiring health care provider employing some

of a seller's personnel is not thereby dispositive whether the acquirer becomes the seller's successor.

Similarly, while a hospital or nursing home acquiring another's assets might maintain the seller's physical location and general business operations, a variety of factual scenarios still could defeat claims that successor liability transfers to the acquirer. For example, does the acquirer use the assets as, or even in the same manner as, the seller? Are the same services provided the same way, at the same location or in the same amount? Do the seller's retained managers and employees perform the same or similar tasks, the same way, in the same capacity or at the same locale? What, if anything, is different and which of these differences constitutes a material change from the seller's former operation?

3. Third and Fourth Exceptions: Is the asset purchase a mere continuation or a fraudulent transaction?

Clearly transactions required by the Berger Law should not be deemed fraudulent. The mere continuation theory is discussed below in the context of the continuity of enterprise theory.

4. Continuity of Enterprise: Does the purchaser purport to continue the original enterprise?

This too will depend upon a situation's particular facts. Nonetheless, to be prudent, an acquiring health care organization should consider emphasizing that it is acquiring the other party's assets in order both to comply with the Berger Commission's mandates and, in the spirit thereof, to expand its services and to augment or to diversify those that it already provides. Courts clearly believe that purchasers alleging to be their sellers successors in order to retain the sellers' business goodwill cannot later claim otherwise to avoid resulting successor liability. As the *Salvati* Court explains, the purchaser should not represent itself as an "unbroken continuation of the original enterprise."[30] Purchasers should be able to avoid a similar continuity claim by convincingly demonstrating that the acquisition, rather than continuing the seller's enterprise, creates a new "whole," that is, unique, different from or merely greater than its original parts: new services, new locations for, or methods of, service provision, different strengths, different business methods, new governance or control.

5. Product Line Exception: Does the successor enterprise continue the same business as the seller, using its name, goodwill and customers?

As the Court of Appeals recently rejected this exception, it will not be further discussed herein.

Conclusion

Asset acquisition under the established New York successor liability rules generally should not cause acquirers to assume their transferees' liabilities absent their affirmative assent otherwise; however, a number of recognized exceptions to this rule could expose purchasers to potential liability. Much of such an analysis will depend upon the particular facts pertinent to the individual transaction.

Still, a hospital or nursing home that acquires another provider's assets in compliance with the Berger Commission's mandates should attempt to guard against inviting such liability by first taking certain actions. For example, compile an asset-purchase agreement clearly stating that the acquiring entity does not assume any of the seller's liabilities or, if it does, clearly reflecting only those specific liabilities being acquired. Second, if possible, the acquirer should avoid maintaining the seller's managers, shareholders/members/managers, ownership, structure or control, the first factor that courts consider when analyzing whether a *de facto* merger occurred. In fact, if possible, the survivor also should encourage the seller to maintain its corporate form and to operate in some capacity for some time after the transaction closes, as this is another key factor that courts examine to determine whether successor liability passes.

Similarly, the surviving entity in a post-Berger asset acquisition should publicly emphasize its continued existence as a separate, independent enterprise, rather than merely as a continuation of the seller's business. In this manner, the survivor also dispels the notion that the transaction in any way constitutes a corporate reorganization, thus further distancing itself from the continuity of enterprise exception to New York's general successor liability rule.

Courts logically should review transactions undertaken in compliance with a legal mandate, like the Berger Law, somewhat differently than they would a similar, but purely market-driven accord. In such legally driven transactions, the parties' actions possibly are not, or at least not entirely, voluntary. Although nothing was found to actually evidence that courts will treat such transactions this way, acquiring a provider's assets compliant with a state law reflecting public policy concerns essential to improving the state's health care infrastructure, finances and, even more important, public health, do deserve special scrutiny. Indeed, in *Sweatland,* the Fourth Department, Appellate Division of the Supreme Court, discussed taking a variety of factors into account case-by-case when analyzing whether successor liability exists:

> It is apparent from the nature of the inquiry required that the court is to make, on a case-by-case basis, an analysis of the weight and impact of a multitude of factors that relate to the corporate creation, succession, dissolution and successorship.[31]

Surely the goal of reforming the state's health care system to secure both its future viability and to ensure that millions of people throughout the state depending on it daily receive enhanced health care services is laudable and worthy of any support that the courts can offer.

Endnotes

1. "What's at Stake 2008: The Impact of New York's Hospitals on the Economy and Our Communities," Healthcare Association of New York State, January 2008, *available at* http://www.hanys.org.
2. New York State Commission on Health Care Facilities in the 21st Century (http://www.nyhealthcarecommission.org).
3. *Schumacher v. Richards Shear Co.*, 59 N.Y.2d 239, 244 (1983).
4. *Rivera v. Anderson United Co.*, 283 A.D.2d 563, 564 (N.Y. App. Div. 2d Dep't 2001).
5. *Kasem v. BNC Stor., LLC*, 30 A.D.3d 469, 470 (N.Y. App. Div. 2d Dep't 2006), citing *Schumacher v. Richards Shear Co.*, 59 N.Y.2d 239, 244 and *Rivera v. Anderson United Co.*, 283 A.D.2d 563, 564.
6. *Id*. at 470.
7. *Id*. at 470–471.
8. *In re Seventh Jud. Dist. Asbestos Litig.*, 788 N.Y.S.2d 579, 581 (Sup. Ct., Ontario Co. 2005).
9. *Van Nocker v. A.W. Chesteron, Co. (In re N.Y. City Asbestos Litig.),* 15 A.D.3d 254 (N.Y. App. Div. 1st Dep't 2005).
10. *Id*. at 256.
11. *Id*., quoting *Cargo Partner AG v. Albatrans, Inc.*, 352 F3d 41, 47 (2d Cir. 2003).
12. *Sweatland v. Park Corp.*, 181 A.D.2d 243, 246 (N.Y. App. Div. 4th Dep't 1992).
13. *Barrack, Rodos & Bacine v. Ballon Stoll Bader & Nadler, P.C.*, 2008 U.S. Dist. LEXIS 22026, 17 (S.D.N.Y. 2008), quoting *New York v. Nat'l. Serv. Indus., Inc.*, 460 F.3d 201, 205 (2d Cir. 2006).
14. *Id*. at 18, quoting *AT&S Transp., LLC v. Odyssey Logistics & Technology Corp.*, 803 N.Y.S.2d 118, 119 (2d Dep't 2005).
15. *Id*. at 19–20.
16. *Id*. at 22, quoting *Kretzmer v. Firesafe Prods. Corp.*, 805 N.Y. S.2d 340, 340 (1st Dep't 2005).
17. *In re Seventh Jud. Dist. Asbestos Litig.*, 788 N.Y.S.2d 579, 581.
18. *See* George W. Kuney, *Successor Liability in New York*, NYSBA Journal 24, pp. 22–27 (September 2007).
19. *Id*., p. 23.
20. *Salvati v. Blaw-Knox Food & Chemical Equipment, Inc*. 497 N.Y.S.2d 242 (N.Y. Sup. Ct. 1985).
21. *Schumacher v. Richards Shear Company, Inc.*, 59 N.Y.2d 239, 245 (1983).
22. *Salvati v. Blaw-Knox Food & Chemical Equipment, Inc.* 497 N.Y.S.2d 242, 244 *citing Turner v. Bituminous Cas. Co.*, 244 N.W.2d 873 (Mich. 1976).
23. *Id*.
24. *Id*.
25. *Id*. at 247.
26. *Ray v. Alad Corp.*, 560 P.2d 3 (Cal. 1977).
27. *Salvati v. Blaw-Knox Food & Chemical Equipment, Inc.*, 497 N.Y.S.2d 242, 244–245.
28. *Id*. at 247.
29. *Sementez v. Sherling & Walden, Inc.*, 7 N.Y.3d 194, 200 (N.Y. 2006), quoting *Fish v. Amsted Indus., Inc.*, 126 Wis. 2d 293, 305–306 (1985).
30. *Salvati v. Blaw-Knox Food & Chemical Equipment, Inc.*, 497 N.Y.S.2d 242, 247.
31. *Sweatland v. Park Corp.*, 181 A.D.2d 243 at 246, quoting *Santa Maria v. Owens-Illinois, Inc.*, 808 F2d 848, 861 (1st Cir. Mass. 1986).

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A Joint State-City Bar Study of Health Care Costs and Their Effects on Access to Care and Relationship to Outcomes: Legal Issues, Barriers and Solutions

NYSBA Public Health and Policy Committee
Health Law Committee of the Bar of the Association of the City of New York

The Public Health and Policy Committee of the Health Law Section of the New York State Bar Association, working together with the Health Law Committee of the Bar of the Association of the City of New York (together the "Committees"), is examining the issue of health care costs, the drivers of such, and the legal issues involved with both health care cost drivers and possible options to reduce such costs. Although there has been substantial recent literature regarding health care costs and drivers of such, there has been nothing in the literature regarding the legal challenges that states or the federal government may face in attempting to reduce such.

Background

The costs involved with the health care system are an ever-increasing drain on the federal budget, the economy, and on employers, particularly small employers. Total health spending in the United States is currently 16% of gross domestic product (GDP), up from 8% in 1975, and projected to reach 20% by 2016. Medicare and Medicaid account for more than 25% of the federal budget. Medicaid alone accounted for approximately 22% of total state spending in fiscal 2007, with a projected spending growth rate of 8% annually for the next decade, according to a report released December 5, 2007 by the National Governors Association. Overall, states' single largest expenditure for fiscal 2007 was health care, accounting for on average nearly one-third of state spending.

Health care costs also have social and public policy consequences. Insurance premiums increase every year, driving down the number of employers that offer health insurance to employees: 61% in 2007 versus 69% in 2000. Uninsurance has costs: the uninsured delay seeking medical care and end up sicker when they do go for care; when hospitalized, the uninsured are likely to be in worse condition and die than the insured, and roughly half of all personal bankruptcy cases are due to medical bills. Increased costs have also been found to not result in better care; in fact, areas of the country with higher costs (which is due in large part to higher utilization) may have worse outcomes.

Drivers of Health Care Costs, and Potential Strategies to Reduce Costs

There are a number of drivers of health care costs. The drivers identified by the Commonwealth Fund in its January 2007 report include (i) overuse, inappropriate or ineffective use of care, (ii) payment incentives that reward delivery of more services, (iii) market power of insurers, providers and the health industry, (iv) a low ratio of primary to specialty care physicians and services, (v) access barriers to preventive and primary care, (vi) a lack of well-coordinated care that leads to unsafe, duplicative or conflicting care, (vii) inadequate information systems and exchange, (viii) high administrative costs, (ix) new technology without comparative information on clinical outcomes or cost-effectiveness to guide decisions on adoption and use, (x) wages and prices of other hospital-purchase goods/services, and (xi) the increasing prevalence of chronic disease. The potential strategies recommended in the Commonwealth Fund report were (i) increasing the effectiveness of markets by improving access to information, promoting competition and developing better information on cost-effectiveness of technology and procedures, (ii) reducing administrative overhead, (iii) providing payment incentives to promote efficient and effective care, (iv) promoting primary care, (v) investing in infrastructure such as IT, and (vi) investing strategically to improve access, affordability and equity.

The Bar Committees have summarized the drivers of health care costs as fitting into four basic buckets: (1) utilization and overutilization (due to a number of different factors, including skewed payer, provider and patient incentives, lack of evidence-based medicine and standards, and fear of litigation), (2) administrative costs, (3) technology and its impact on the definition of standard of care and (4) drugs. Many if not all of these drivers are associated with the commercialism of health care, largely unique to the United States (and perhaps recently to China) and lack of comparative effectiveness of technology and care. To quote the *New England Journal of Medicine*, February 7, 2008, "The dominance of for-profit insurance and pharmaceutical companies, a new wave of investor-owned specialty hospitals, and profit-maximizing behavior even by nonprofit players raise costs and distort resource allocation." To the extent that economic incentives are working in perverse ways, policy, legal and legislative changes may be in order. The commercialism of health care is strongly related to findings of the 2007 McKinsey study ("Accounting for the Cost of Healthcare in the US") that the overriding cause of high US healthcare costs is the failure of the system to (a) provide sufficient incentives to consumers to be value conscious in their demand

decisions, and (b) establish the necessary incentives or mandates to promote rational supply.

Legal Issues Involved with Reducing Health Care Costs

Review of the impediments to restructuring the health care system to provide appropriate incentives and change the above cost drivers raises a large number of legal issues. Legal issues include statutory and regulatory limitations (e.g., the inability of hospitals to pay non-employed physicians for appropriate utilization), rights under existing law, contractual obligations (e.g., confidentiality clauses in provider-payer contracts and effect on transparency), antitrust issues, ERISA, insurance rating systems, ability of payers and employers to change employee/subscriber behavior under existing law, and more. Legal options to address some of the drivers of health care costs may include possible state and/or federal legislation to limit some of the administrative costs (e.g., establishing a brain-damaged baby fund similar to the national vaccine pool or having a single health care adjudicator), incentivizing insurers to keep subscribers healthy and manage care (not just costs) by requiring the insurers to be to responsible for patients' care over the long run, removing regulatory impediments to alignment of incentives among providers, payers and patients, and providing immunity to providers who follow certain delineated standards. The legal community can also explore regulatory involvement with the players involved with health care costs, such as how to level the playing field among providers and requiring that dollars be spent on care and quality rather than administrative costs or profits. Neutralizing the incentive of each player to protect their own position through lobbying and the political system may also best occur through the establishment of a politically immune "health care board" similar to the Federal Reserve Board or the military's base-closing commission. The legal community can assist in formulating and structuring both health care system reform and payment reform.

The Bar Association Committees have as a goal a publication which addresses the legal issues associated with health care costs, their drivers and possible solutions. The Committees are currently are exploring possible avenues of assistance to work with the committees in research and drafting of a publication in this regard.

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Proposed Amendments to the Health Care Practitioner Referrals Law (the "State Stark Law")

NYS "Stark Law" Task Force, Health Law Section
Marcia B. Smith Chair

Last April, the Health Law Section Executive Committee formed a State "Stark" Task Force to develop a proposal to eliminate inconsistencies between the federal Physician Self-Referral law (the "Stark Law")[1] and New York's Health Care Practitioner Referrals statute (the "State Stark Law").[2]

"[W]ith the increased focus on compliance and enforcement, attorneys practicing health law in New York are no longer comfortable relying on this informal guidance and would like to ensure that arrangements that are permitted under the federal law are also permitted under the state law."

In the absence of conformity between the two statutory schemes, many arrangements involving physicians that are permissible under the federal Stark Law are not permitted by the New York statute. Specifically, the New York statute does not contain exceptions for providing electronic medical record systems, donations of items and services to federally qualified health centers, and fair market value arrangements. Also, the New York exception for in-office ancillary services requires an employer/employee relationship, as compared to the Stark exception, which permits an independent contractor relationship.

The New York State Department of Health has informally advised practitioners that it is not enforcing the State Stark Law as written and will not seek to penalize those providers whose arrangements comply with the Stark Law. But with the increased focus on compliance and enforcement, attorneys practicing health law in New York are no longer comfortable relying on this informal guidance and would like to ensure that arrangements that are permitted under the Stark Law are also permitted under the State Stark Law.

The Task Force recommended that N.Y. Public Health Law § 238-a be amended by adding two new paragraphs to Section 2 as follows:

> (h) any arrangement between a practitioner (or immediate family member) and health care provider that, under the federal statutory prohibition on certain referrals codified at 42 U.S.C. § 1395nn and regulations promulgated thereunder:
>
> > (i) would not be a financial relationship if existing between a physician and an entity, as such terms are defined under such federal law or regulations; or
> >
> > (ii) would satisfy the requirements of an exception relating to financial relationships provided under such federal law if existing between a physician and an entity, as such terms are defined under such federal law or regulations;
>
> (i) in the case of a referral for any services excepted under 42 U.S.C. § 1395nn and regulations promulgated thereunder.

On October 31, 2008, the NYSBA House of Delegates approved this proposal. As a result, the Bar Association will make the proposal part of its legislative agenda for 2009.

Endnotes

1. 42. U.S.C. § 1395nn.
2. N.Y. Pub. Health Law Title II-D (§§ 238 *et. seq.*).

Task Force Chair Marcia B. Smith is a partner of Iseman, Cunningham, Reister & Hyde, LLP and practices health law in the firm's Albany office.

Recent Events

- **Fall** Retreat**.** The Fall Retreat was held at the Gideon Putnam Hotel in Saratoga Springs on October 18. The well-attended and well-received program, "Anatomy of an Internal Investigation," was principally organized by Anne Maltz of FOJP Service Corporation (NYC).

Upcoming Programs—Save these Dates

- **Annual Meeting. The Health Law Section's Annual Meeting will be held on January 28, 2008 at the New York Marriott Marquis, in conjunction with the NYSBA Annual Meeting.**

  This year's program is devoted to legal issues in Health Care Reimbursement. The program will cover reimbursement basics, recent changes in payment methodologies, challenges relating to claims denials and rate changes, payment for new technologies, and the role of quality in reimbursement. The program will be co-chaired by Ellen Weissman of Hodgson Russ (Buffalo) and Margaret Davino of Kaufman Borgeest & Ryan (NYC).

Upcoming *Journal* Edition

The upcoming Winter '09 Edition of the *Health Law Journal* will contain articles on a diverse range of topics. Persons wishing to propose an article should send it to the Editor, Robert N. Swidler, at swidlerr@nehealth.com. Guidelines for articles are set forth on the back page of the *Journal.*

Notable Committee Activities

- **Public Health Committee.** This Committee, chaired by Margaret Davino of Kaufman Borgeest & Ryan (NYC), has been actively working on two projects: a public health emergency legal preparedness project, and a health care costs project.

  With respect to public health emergencies, the Committee sponsored a program on May 15, 2008 on the subject in Yonkers, and also commissioned a gap analysis comparing New York State and New York City law with the Model State Emergency Health Powers Act. The Committee now plans to develop a white paper that builds on the work of the gap analysis, combined with the "real world" expertise of legal and non-legal practitioners with responsibility for, and experience with, public health emergencies.

  The Health Care Cost project involves a joint effort with the NYC Bar Association to review the issue of health care costs and related legal issues. The two committees jointly issued a statement regarding the project that appears in this edition of the *Journal*.

New Committees

Section Chair Ross Lanzafame recently created two new committees within the Health Law Section:

- **Medical Legal Partnership—**The committee will focus its efforts on supporting and helping to expand this model of legal service delivery for low-income patients in hospitals and clinics throughout the state. Medical-legal partnerships provide on-site free legal services to patients in areas of law that affect a patient's quality of life and access to health care. Medical-Legal partnerships also train health care professionals on the legal issues affecting their patients. The Committee will provide a liaison to the newly established Coalition of New York State Medical-legal Partnerships, help garner support for legislation by Sen. Hannon to establish a Medical-Legal partnership program within the Department of Health, work on a State Bar resolution supporting these partnerships and finally establish a pro bono committee willing to assist in this effort.

  For more information contact Committee Chair, Randye Retkin, rretkin@nylag.org (212) 613-5080.

- **Special Committee on E-Health and Information Systems**. This new committee intends to:

  - Provide updates on legislation and significant developments involving Health Information Technology.
  - Draft a survey of the law in New York on E-Health and Information Systems.

- Hold telephone conferences on specific areas such as: E-signatures, State and Agency Interpretations; E-Archives and electronic document retention; RHIOs SHIN-NY's; E-Privacy and Confidentiality in the Age of HIPAA, and identify-theft laws.

Persons interested in participating on this new committee should send an email with their full name and contact information to Sections@nysba.org. For further information, contact the committee chair, Raul Tabora, at rtabora@ruffotabora.com.

State Bar Privacy Task Force

The New York State Bar Association recently announced the formation of a Task Force on Privacy that will examine current policies, practices and legislation that threaten attorney-client privacy today, and make recommendations to safeguard this most fundamental legal right. The task force was created by Association President Bernice K. Leber (Arent Fox LLP) and is one of her key priorities.

The Task Force on Privacy will be co-chaired by Kelly M. Slavitt, Corporate Counsel of the American Society for the Prevention of Cruelty to Animals (ASPCA), and Alison Arden Besunder (Arent Fox LLP). The panel will also include members of the Association's Business, Criminal, Health, Labor and Employment, and Intellectual Property law sections.

The Task Force's Health Law Working Group is Co-Chaired by Jo-Ann Marchica, and Jill Steinberg, both of Arent Fox PLLC, and also includes Lauren Fass, of Arent Fox PLLC, Paul Gillan, Jr. of Capital District Physicians Health Plan, and Robert N. Swidler of Northeast Health.

For more information about the Association's Task Force on Privacy, visit its Web site at www.nysba.org/privacytaskforce.

Legislative Matters

The NYSBA House of Delegates recently approved a legislative proposal developed by the Health Law Section to amend New York's Physician Self-Referral Law (the state "Stark Law") so that it includes the same exceptions as those found in the federal Physician Self-Referral Law (the federal "Stark Law"). The proposal and memorandum in support appear in this edition of the *Journal.*

Recent Supraspinatus Blurb Topics:

- DOH Gives $1.5 Million to Long Term Care Quality Improvement
- More on Federal Mental Health Parity
- UCLA Privacy Breaches Rampant
- FDA Science Board Subcommittee on BPA, Scientific Peer Review of FDA's draft assessment of BPA use in food contact applications
- ASC Returns $2.5 Million to State for Waiving Copays
- Some NIH tips on finding reliable health information online
- Placebos Commonplace in Physician Prescribing Practices
- Special Committee on E-Health & Information Systems
- Michelle's Law
- "Probing the genomic basis for cancer" MSK
- Great Lakes Health System of WNY
- "Glowing Proteins—A guiding star for biochemistry," Royal Swedish Academy of Sciences
- NYSBA Creates Privacy Task Force
- New CEO for Helen Hayes Hospital
- Stony Brook Cleared—Again

Supraspinatus, the Health Law Section's blog, may be viewed at http://nysbar.com/blogs/ healthlaw. The most frequent recent contributors have been Paul Gillen and Joan Shipman.

Further information about upcoming programs is always available at www.nysba.org/health. Just click on "Events."

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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2009 Annual Meeting

Health Law Section

Annual Meeting

Getting Paid in a Changing World: The Present and Future of Healthcare Remibursement

Wednesday, January 28, 2009

New York Marriott Marquis

New York State Bar Association

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Persons interested in writing for this *Journal* are welcomed and encouraged to submit their articles for consideration. Your ideas and comments about the *Journal* are appreciated as are letters to the editors.

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Northeast Health
2212 Burdett Avenue
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(518) 271-5027
e-mail: swidlerr@nehealth.com

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