HEALTH LAW SECTION NEWSLETTER

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What's Inside

REVISED GUIDELINES OFFER GREATER FLEXIBILITY FOR PHYSICIAN NETWORKS

By Bruce R. Stewart
Ober, Kaler, Grimes & Shriver

On August 28th, the Antitrust Division of the Department of Justice and the Federal Trade Commission issued revised antitrust guidelines generally applicable to the health care industry. Originally issued in 1993, and first revised in 1994, the Statements of Enforcement Policy and Analytical Principles Relating to Health Care and Antitrust consist of nine separate "statements" that set forth and analyze the agencies' current enforcement policy in areas such as hospital mergers and joint ventures, joint purchasing arrangements, and price and cost information exchanges.

For the most part, the Enforcement Statements have not been controversial and generally apply standard antitrust principles and analysis to the specific context of health care providers. Two Statements, however, have generated considerable controversy -- at least

within the narrow confines of the health care industry and its attorneys -- and it was these two (and only these two) that were the subject of the August 28th revisions.

Statement 8 addresses "physician network joint ventures," and analyzes enforcement policy as it applies to partially integrated, physician-controlled networks (such as an IPA or PPO) in which the otherwise competing physicians collectively agree on the price the network will charge for the physicians' services. Statement 9 addresses all other partially integrated, provider-controlled networks (such as a physician-hospital organization or an integrated delivery system made up of assorted health care providers) as well as physician networks in which the physicians do not collectively agree on prices.

Most of the controversy has stemmed from two "antitrust safety zones" set forth in the earlier version of Statement 8 and a widespread perception of what lay in store for networks in which physicians agreed on price but did not fit into the safety zones. To qualify for safety-zone treatment, a provider-controlled network must (1) consist of no more than 20 percent of the physicians in the relevant market if the network is exclusive (that is, the physicians can essentially contract only through the network) or 30 percent of the physicians in the relevant market if the network is non-exclusive; and (2) consist only of physicians who "share substantial financial risk."

Most significantly, Statement 8's safety zones only explicitly recognized two types of acceptable financial risk sharing: capitation (in which physicians contracting with a health plan are paid a fixed amount per member per month regardless of the volume of services rendered) and withholds (in which a significant percentage of physicians' reimbursement is withheld unless the network as a whole meets pre-determined cost-containment goals). From the perspective of the enforcement agencies, risk sharing of this type is likely to generate procompetitive efficiencies and to lower costs to consumers sufficient to offset the potential anticompetitive effects of the physicians' collective agreement on prices.

Rightly or wrongly, many physicians -- and particularly the American Medical Association, which has sought a legislative solution -- concluded after reading the earlier Statement 8 that any network in which physicians agreed on fees but which did not contract on a capitated or withhold basis ran the serious risk of per se condemnation under Section 1 of the Sherman Act for naked price fixing. This concern is hardly irrational, since conduct subject to per se treatment (rather than rule of reason) cannot be defended on the ground that it has had no anticompetitive consequences and, in extreme cases, may even result in criminal prosecution and loss of professional license.

The problem has been that not all physicians -- and, equally important, not all purchasers of physician services -- either want or are able to contract on a capitated or withhold basis for every contract a network may enter into. Some payers, for example, want to continue to offer a standard fee-for-service indemnity plan and have no interest in building into it a withhold. Others may want to capitate primary care physicians but continue to pay specialists on a fee-for-service basis.

Again from the perspective of physicians, under the earlier guidelines the only "safe" alternative to following the formula of the safety zones was to utilize the so-called

"messenger model" for any network contracts not involving capitation or withholds. Under the messenger model, a non-physician (such as the network administrator) may act as a conduit between the individual members of the network and a payer. However, the messenger may not develop or use a fee schedule, may not negotiate on behalf of the physicians, and may not discuss with any members of the network the terms or conditions offered to or accepted by other members of the network.

With the messenger reduced to essentially an errand boy running between individual network members and a payer, the messenger model has been widely criticized as cumbersome and unworkable. Thus, as far as many physicians were concerned, the only choice they had was to contract on a financial risk-sharing basis through capitation or withholds or put up with the inefficiencies of the messenger. Anything else, it was feared, risked per se condemnation, and so, physicians argued, they were at a disadvantage vis a vis non-provider controlled networks and generally inhibited from developing new forms of provider relationships.

The August 28th revisions to Statements 8 and 9 take a modest but real step toward alleviating these concerns. Significantly, the two safety zones of Statement 8 have been changed only slightly. They still require the sharing of substantial financial risk (although three additional "approved" forms of risk sharing have been added) and they still limit the participation percentages to 20 and 30 percent of physicians in the relevant market for exclusive and non-exclusive networks, respectively.

However, while the safety zones remain essentially unchanged, Statement 8 now explicitly recognizes that substantial clinical integration can be an alternative to financial risk sharing in justifying rule of reason (rather than per se) treatment of a network in which the physicians collectively agree on prices. Put differently, otherwise competing physicians can now feel far more comfortable jointly developing a fee schedule and collectively negotiating prices with payers -- in other words, fixing prices -- if through their network they have reached some reasonable threshold of nonfinancial, clinical integration.

Statement 8 does not make explicit what the threshold is. It does make clear, however, that what the agencies will be looking for is an integration that provides genuine incentives to physicians to lower costs, reduce utilization, and increase quality. In other words, physicians who want to agree on prices in the absence of substantial financial risk sharing must be sure their network has achieved a level and type of integration that is likely to produce efficiencies that benefit consumers.

Far less significant than this change to Statement 8 is a slight loosening of the restrictions regarding what a messenger may and may not do. Revised Statement 9 makes clear for the first time (although this has been suggested in earlier agency pronouncements) that a messenger may obtain from each provider the minimum acceptable price for that provider's services and then contract on the provider's behalf if the payer offers at least that amount. Statement 9 now also makes clear that a messenger may bind a provider to contract offers as good or better than earlier ones he or she has accepted and can also construct a schedule that will show a payer the number of providers who would agree to a contract at particular price levels.

All in all, these revisions to the Enforcement Statements should

make it somewhat easier for physicians (as well as other health care providers) to form and implement networks, as is evidenced by the generally positive reaction of the AMA. However, given that the Health Care Enforcement Statements have now been initially issued and revised three times in just four years, we should not be surprised if yet another revision lies down the road.

PRESIDENT SIGNS HEALTH CARE LEGISLATION: FRAUD AND ABUSE LAWS, MANAGED CARE AFFECTED

By Greg Wellins, Mary Lou Liewinko, Venel Brown, and Marie Berliner of Garder, Carton & Douglas

On August 21, 1996, President Clinton signed into law the Health Insurance Portability and Accountability Act of 1996 (the "Act"). Among the provisions included in the Act are reforms to health insurance coverage for individuals covered under employer-based plans; new Medicare fraud and abuse controls; increased deductions for health insurance for the self-employed; a pilot program for medical savings accounts; and rules regarding tax treatment of long-term care insurance contracts. The discussion below focuses on the provisions of the Act regarding fraud and abuse and reviews the health insurance market reforms.

FRAUD AND ABUSE PROVISIONS

The new fraud and abuse controls are designed to expand and strengthen the federal arsenal against fraud and abuse in the health care industry. The Act extends the familiar anti-kickback provisions and their criminal penalties for fraud and abuse violations to include all Federal health care programs, including state health care programs, Medicaid, and CHAMPUS.

Advisory Opinions. One of the criticisms of the so-called anti-kickback law has been that its language has had a chilling effect on legitimate business arrangements. As the health industry grows, a new generation of relationships among providers is being developed, raising new issues under the anti-kickback laws. In response to industry concerns, the Act makes several significant modifications to the fraud and abuse laws. An important new provision requires the Secretary to issue advisory opinions, upon request, regarding the following issues:

- What constitutes prohibited "remuneration";
- Whether an arrangement satisfies the criteria set forth in the Social Security Act for activities which do not result in prohibited remuneration;
- Whether an arrangement satisfies the criteria set forth in the "safe harbor" regulations which the Secretary has established or shall establish for activities which do not result in prohibited remuneration;
- What constitutes an inducement to reduce or limit services to individuals; and
- Whether any activity or proposed activity constitutes grounds for the imposition of a sanction under the Social Security Act.

The following matters will not be subject to advisory opinions:

- The fair market value of goods, services or property for the purposes of determining safe harbor compliance; and
- Whether an individual is a bona fide employee.

Advisory Opinions are not intended to have precedential effect. They will only be binding on the Secretary and applicable to the party requesting the opinion. The failure of a party to seek an advisory opinion may not be introduced into evidence to prove that the party intended to violate the fraud and abuse laws. The Secretary must issue an Advisory Opinions 60 days from the request, and is also required to issue governing regulations within 180 days of the enactment of the legislation. The advisory opinion provisions of the legislation are applicable for 4 years from the date of enactment.

The provision is expected to play a significant role in preventing health care fraud and, utilized properly, may serve as an important tool for physicians, providers, suppliers, and manufacturers. Providers will now have notice and guidance that previously was unavailable.

Fraud and Abuse Control Program. To coordinate the enforcement effort among the entities charged with ferreting out health care fraud, new fraud and abuse provisions require the Secretary of HHS and the Attorney General to establish a joint program to coordinate federal, state and local law enforcement programs to limit and control health care fraud and abuse. The Fraud and Abuse Program will be responsible for conducting investigations, audits, evaluations, and inspections and will also facilitate the enforcement of the fraud and abuse laws; provide for the modification and establishment of new safe harbors; and issue advisory opinions and special fraud alerts. This joint effort should alter the current environment that has Carriers serving two masters: the Department of Justice and HHS' Office of Inspector General ("OIG"). It will also assist the government in seeking out, investigating and prosecuting private health care fraudulent activities. Although the Act permits the OIG to subpoena private health plans for information pertaining to fraud, it does not provide it with the power to sue providers for submitting false claims to private plans.

Health Care Fraud and Abuse Sanctions - Guidance. The Act requires the Secretary to publish a notice in the Federal Register soliciting proposals for modifications to existing safe harbors, new safe harbors, and special fraud alerts to be issued pursuant to the legislation. The Secretary's initial notice soliciting proposals must be published not later than January 1, 1997. Proposals will be accepted during a 60-day period.

Special Fraud Alerts. Under the Act, health care providers may request that Special Fraud Alerts be issued. Upon the receipt of such a request, the Inspector General will investigate the subject matter to determine whether a Special Fraud Alert should be issued. All Special Fraud Alerts are to be published in the Federal Register. The Inspector General will consider whether the practices would result in violations of the fraud and abuse laws.

Mandatory and Permissive Exclusions. The Act includes stricter penalties for health care fraud offenses. The law now requires the Secretary to exclude individuals from Medicare for a minimum of five years upon any felony conviction involving

health care fraud. If the health care fraud offense is a misdemeanor, the Secretary may (but not must) exclude the individual or entity. For these "permissive" exclusions, the length of time varies depending upon the offense. In addition, a person who has an ownership or control interest, or is an officer or managing employee of a sanctioned entity, may also be excluded from Medicare or Medicaid participation if the person knew or should have known of the basis for the exclusion.

New Health Care Fraud and Abuse Data Collection Program. The Act requires the Secretary to create a health care fraud and abuse data collection program by January 1, 1997. Under this program, government agencies and health plans will be required to report to the Secretary "final adverse actions" against providers, physicians and suppliers. A "final adverse action" will include civil judgments, federal or state criminal convictions, and adverse licensing and certification determinations by federal or state agencies that relate to health care fraud. Agencies required to report this information include the Departments of Justice and Health and Human Services, state law enforcement agencies and Medicaid fraud units, and Federal or state licensing and certification agencies.

Civil Monetary Penalties. The Act extends the Medicare and Medicaid civil monetary penalty provisions to include violations involving any Federal health care program, including CHAMPUS. The amount of civil monetary penalties has been increased from $2,000 to $10,000 for each item or service involved. Additionally, a violator may be assessed damages of three times (increased from two times) the amount claimed for each item or service involved. Further, individuals excluded from Medicare participation that retain a direct or indirect interest in a Medicare-participating entity, or who remain as an officer or a managing employee, must sever their relationships with these entities. Failure to do so subjects these individual to fines of up to $10,000 for each day the prohibited relationship occurs. These changes are clearly intended to prevent fraudulent operations and individuals from participation in Medicare.

The Act makes two additional practices subject to civil monetary penalties: (1) upcoding (i.e., engaging in a pattern of presenting claims using codes to seek higher reimbursement); and (2) engaging in a practice of submitting claims for payment for medically unnecessary services. Although these practices were covered under the prior law, they are now specifically articulated in the Act. It is expected that such provisions will significantly affect Carrier operations.

New Penalty for False Home Health Certifications. Of interest to home care providers is a new provision that penalizes physicians who certify that an individual is eligible for home health services, if that physician has knowledge that the individual does not qualify for such services. Currently, a Medicare beneficiary cannot receive covered home care benefits without physician certification of the need for skilled care and the patient's homebound status. The Act would penalize a physician making an invalid certification the greater of $5,000 or three times the amount of Medicare payments made on behalf of the ineligible individual.

The provision is expected to decrease the number of intermediary inquiries into false certifications, currently a time and resource drain, freeing up resources to focus fraudulent activities in other sectors of the health care market.

The Medicare Integrity and Beneficiary Incentive Programs. The Act also creates the "Medicare Integrity Program." Under this Program, the Secretary is charged with promoting the integrity of the Medicare program by entering into contracts with qualified entities to carry out such activities as cost report audits, payment determinations, provider education, and provider review activities.

The Secretary is also required to provide beneficiaries with an explanation of benefits under the Medicare program with respect to each item or service covered by Medicare.

NEW MANAGED CARE SAFE HARBOR

Among other changes, the managed care portion of the Act includes a provision that creates a new statutory "safe harbor" to the fraud and abuse laws for certain risk arrangements. This provision is broadly worded, contains no definitions and, therefore, should not be viewed as a blanket exception to the fraud and abuse laws for all risk-sharing arrangements.

The "Safe Harbor". The provision purports to except from the definition of "remuneration" those payments between an organization and a provider of items or services, if (1) the organization is an "eligible organization" under section 1876 of the Social Security Act or (2) the organization and the provider have a written, risk-sharing arrangement that puts the provider at "substantial financial risk" for the cost or utilization of the items or services that the provider is obligated to provide under the arrangement.

The language is extremely broad and, if taken literally, would protect any remuneration between an organization and a provider simply because the organization and the provider have a risk sharing arrangement. The protection is not limited to the terms of the risk-sharing arrangement itself. Thus, for example, this statutory provision could be interpreted to protect a physician's investment interest in an organization, lease arrangement, or other relationship with the organization without that aspect of the arrangement having to meet the applicable safe harbor simply because the physicians and the organization shared risk. It could also be construed as allowing remuneration in exchange for referrals in the form of bonuses or preferred shares of stock to top referral sources, if the relationship between the parties is otherwise a risk sharing arrangement. It appears unlikely that Congress intended to protect payments that would otherwise be illegal simply because an organization has a risk-sharing arrangement.

Implementing Regulations. The Secretary (of HHS) is charged by the Act with establishing an expedited negotiated rulemaking process to promulgate implementing regulations to this new safe harbor. In developing the regulations, the Secretary will take into account: (1) the level of risk appropriate to the size and type of arrangement; (2) the frequency of assessment and distribution of incentives; (3) the level of capital contribution; and (4) the extent to which the risk-sharing arrangement provides incentives to control the cost and quality of health care services.

It seems clear from this directive that Congress intended to except from the definition of "remuneration" the payment structure and mechanisms, and the payments that comprise those risk-sharing

arrangements, and not any remuneration between the parties. It is also likely that certain withhold and risk-pools will be protected in the context of the overall risk-sharing arrangement. Previously, HCFA had expressly declined to extend such protection in the final rule on the managed care safe harbor for capitation arrangements.

In the interim, organizations should be cautioned not to rely on the statutory language as creating a broad exception from the fraud and abuse laws, and would be wise to wait for regulations to be published before drawing any conclusions about their arrangements.

HEALTH INSURANCE MARKET REFORMS

The cornerstone of the Act are the provisions affecting the employer-based insurance market. Similar changes on a more far reaching scale were proposed during the 1994 health care reform debate but were met with stiff opposition from the insurance industry and many employers. The Act takes an incremental approach to insurance market reform by focusing only on insurance for working Americans. It does not address insurance coverage for the millions of Americans currently without coverage.

Market Reforms. Included in the Act are provisions establishing federal requirements that address availability, access, portability, and renewability of insurance coverage for group health plans and for health insurance issuers. Health insurance issuers include traditional insurance companies, as well as HMOs.

Portability. Among the provisions included in the Act are limitations on preexisting condition exclusions which allow for increased portability of coverage in the event an individual changes jobs. Preexisting conditions exclusions may be imposed only if the exclusion relates to a condition for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period prior to the enrollment date. The Act generally limits this period to 12 months from the date of enrollment in the plan. The preexisting condition exclusion period is reduced if an individual had continuous health insurance coverage prior to enrollment in the plan.

Access. The Act also increases access to health insurance by prohibiting group health plans or health insurance issuers from establishing eligibility rules that would exclude individuals based on the following health-related factors: health status; medical condition; claims experience; receipt of health care; medical history; generic information; and evidence of insurability or disability.

Small Employers. With some exceptions, the Act requires every health insurance issuer offering insurance coverage in a State small group market to accept a small employer that applies for coverage in that market and all employees that enroll under such plans, if they enroll for coverage when first eligible. A small group employer is defined as one who has 2 to 50 employees on a typical business day.

Cancellation. The Act also provides that a health insurance issuer may not arbitrarily cancel the policy of a large or small employer. However, a policy may be canceled for nonpayment of premiums, fraud, violation of participation or contributions rules, termination of coverage in the market, and termination of all coverage.

Individuals. For individuals, the Act provides guaranteed

availability and renewability of health insurance coverage to qualified individuals who were previously covered by a group health plan. Exceptions similar to those for group health plans apply. The Act will also allow States to develop alternative mechanisms to provide access to health insurance coverage for individuals.

SECTION HOLDS TELEMEDICINE LUNCHEON

By James V. Schuster
Reed Smith Shaw & McClay

As part of the D.C. Bar's Summer Series Luncheon Program, section members were recently updated on the emerging field of telemedicine. Speaking at the June 20, 1996, luncheon "Telemedicine In Cyberspace," were **Dr. Leroy Buckler** of the Federation Of State Medical Boards; **Michael Williams** of Hogan & Hartson; and **Lynn Frendt Shotwell** of Arent, Fox, Kintner, Plotkin & Kahn. The session was moderated by **Venel Brown** and **Lisa Vanston**. By the conclusion of the luncheon, section members left with a taste of a major legal aspects of telemedicine, including cross-state licensure issues, contracting and commercial considerations, third-party reimbursement issues, and privacy and confidentiality concerns.

Cross-State Licensure Issues: According to Dr. Buckler, the interstate nature of telemedicine has given the states compelling reasons to enact special laws to regulate the practice of medicine across state lines.

"Currently, physicians who practice medicine across state lines without physically being located in the state where the patient encounter occurs, are either required to have a full and unrestricted license in that state or are unregulated," according to the Federation Of State Medical Boards. In an effort to strike a balance between the need for patient protection and physician licensure burdens, Dr. Buckler outlined model legislation calling for a special purpose license -- "an abbreviated but effective licensure process for physicians who will not physically be practicing within a state's jurisdiction, but wish to provide services to patients located within that jurisdiction."

Under the model legislation, a physician holding a valid, unrestricted license in one state would be permitted to obtain a medical license limited to the practice of medicine across state lines in other states. A physician would still need a valid, unrestricted license to practice within the state. According to Dr. Buckler, the term, "practice of medicine across state lines," would be based on where the patient, as opposed to the physician, is physically located. Such an approach would ensure that the full resources of the patient's state would be available for the protection of that patient.

Other provisions of the Act would require physicians holding a special purpose license to abide by the confidentiality requirements of the state in which the patient resides and permit state medical boards to approve patient-granted waivers of confidentiality by physicians holding a special purpose license.

Contracting And Commercial Considerations: Michael Williams outlined a number of issues that must typically be addressed in any business transaction involving telemedicine. Such base-line determinations often dictate the

type of transaction and transactional terms to be agreed upon by the parties.

Mr. Williams noted that there are diverse transactional terms that must be specified in telemedicine agreements, including those on: ownership and use of telemedicine equipment and technical services; who provides professional medical services; reimbursement, billing, and financial terms; responsible for confidentiality and data security; and regulatory compliance. Williams cautioned against using boilerplate provisions to frame a telemedicine transaction. Instead, he advised that terms to any telemedicine transaction be carefully drafted to capture the unique aspects of telemedicine.

Other Telemedicine Issues: In her presentation, **Lynn Frendt Shotwell** outlined a potpourri of legal issues on telemedicine. In addition to the licensure issues described by Dr. Buckler, two issues of particular mention that Shotwell addressed were malpractice and reimbursement considerations.

On malpractice, Ms. Shotwell presented the possibility that, in addition to traditional health care providers, telecommunications vendors may also soon find themselves involved in malpractice disputes. For example, if disruptions in the transmission of treatment data adversely affected patient care, a patient might proceed against both the health care on telecommunications providers.

On the Medicare and Medicaid program reimbursement issue, Ms. Shotwell indicated that such programs currently lack an overall policy on telemedicine reimbursement and are hesitant to reimburse for telemedicine-related services, as patient utilization of services might increase. As a result, Medicare carriers exercise discretion in considering claims for telemedicine-related services. However, federal demonstration projects and legislative initiatives require HCFA to propose new policies for telemedicine reimbursement. In addition, some states (e.g., Louisiana) have enacted laws that prohibit payment discrimination against telemedicine services.

Other issues outlined by the presentation included licensure and certification, privacy and confidentiality, fraud and abuse, and intellectual property.

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UPDATE ON SECTION COORDINATION WITH D.C. MEDICAL SOCIETY CORRECTIONAL HEALTH TASK FORCE

Since March 1996, at the invitation of D.C. Medical Society, Steering Committee member Paul Nolan has been serving on the Medical Society's Correctional Task Force. The Steering Committee views the Medical Society's invitation as a way to increase member awareness of public health concerns affecting the District of Columbia and to expand its community presence.

D.C. Jail - The Medical Society has monitored efforts to reform medical services at the D.C. Jail, which is currently operating a court appointed receiver. Dr. John May, Assistant Chief Medical Officer for the D.C. Jail has given the Committee monthly updates that demonstrate improved medical systems at the jail. The jail has hired full time health personnel, including an internist, family practitioner, and additional staff for the medical records department. Dr. May is considering acquiring computers to automate prisoner medical records. The jail's new medical staff has implemented new protocols to ease prisoner access to urgent care and to improve the process for identifying, caring for, and following patients with AIDS, tuberculosis and chronic medical problems. The D.C. Jail has also improved the coordination of prisoner health care with D.C. General Hospital and Lorton. The Task Force has contacted representatives of the D.C. City Counsel and Control Board to help insure that future budgets will meet prisoner health needs.

Oversight Systems For Correctional Facilities - The Task Force has discussed several ways to improve quality care at District correctional facilities. It invited a representative from Delmarva Health Foundation to explain how a quality assurance program for the D.C. Jail could be developed. The Task Force has also considered whether the District will privatize the management of the District's correctional facilities. Task Force members are working to insure that a District Request for Proposals contain criteria to insure that any private contractor will meet generally recognized correctional health accreditation standards. One of the Task Force's members will serve as a resource to the District in designing correctional health care terms of a possible RFP. Finally, the Task Force has discussed the possibility of creating a private correctional health

association, such as those in Georgia and California, to develop a program of accreditation for jails, prisons and juvenile detention centers in the District. A correctional health oversight committee could either be developed as a private association or as a public commission. The latter option would involve drafting legislation to specify the mission and authority of the commission.

Women's Jail Project - The Task Force is encouraging the District to develop a "bonding" program that would permit unwed teenagers to care for their infants while in jail. Medicaid is not a likely source of funds for this project because the operation of a nursery for well children would probably not qualify as a reimbursable health service. The Task Force has had its chair meet with a representative of the Control Board to facilitate consideration of funding for a bonding program. The Health Law Section's representative also suggested that private philanthropic foundations or corporations could serve as an alternative to public funding.

Other Activities - The Task Force has considered several legislative developments that may effect correctional health care including the reorganization of District Health Services into a Public Benefit Corporation and a Drug Rehabilitation Alternative to Prison Act. The Task Force considered whether the Public Benefit Corporation will substantively change the organization and finding of correctional health care. The Task Force also believes that the District's shortage of funding will preclude any serious consideration of legislation that would provide drug rehabilitation programs as an alternative to prison.

D.C. HEALTH LAW UPDATE

By John Brennan
Michaels, Wishner & Bonner

The District government continues to reorganize in order to dealt with its fiscal crisis and to seek more efficient ways of providing health care services. To this end, the following actions have taken place and/or will soon occur:

- Prior to its summer recess, the D.C. City Council and the D.C. Financial Control Board approved the establishment of the D.C. Public Benefit Corporation ("PBC"). Congress is expected to approve this law in early 1997. The PBC will be responsible for managing and operating all the District's public health clinics and D.C. General Hospital. The Corporation will receive a specific, direct subsidy from the government with which to operate these services; it will not be permitted to draw down on the District's general revenues. It is hoped that by integrating D.C. General with the clinics in this model that D.C. General can remain a viable facility, and that health services within the District will be better coordinated.

  At this time, the 12-member Board which will operate the Public Benefit Corporation has not been appointed. Once appointed, the Board is required to develop an implementation plan for transferring the health facilities involved to its jurisdiction and for the ongoing operation of the PBC itself.

- The District has also reorganized the Department of Human Services by establishing a separate Department of Health (DOH). The new DOH will oversee the District's Medicaid Office, and will also control the Commission of Public Health. The District's professional and health facility licensure, environmental control, and health planning agencies will all be organized into this new Department. The reorganization is intended to streamline governmental processes and be more cost efficient.

  In addition to these reorganization initiatives, the D.C. City Council recently passed final Certificate of Need legislation which now also awaits Congressional approval. The key change to the old statute is that health care facility acquisitions may now be reviewed and approved/denied under a streamlined regulatory process. This particular "reviewable activity" has been the focus of great interest due to the persistent rumors of interest in the acquisition of various D.C. hospitals by outside suitors.

  Finally, Bill 11836, the Access to Emergency Services Act of 1996, has recently been introduced in the City Council by Councilmember Brazille. This bill would seek to assure equitable coverage of emergency room treatment by insurers and HMOs. The bill would require that emergency visits be covered by payers if a "reasonable and prudent person" would have sought such treatment, regardless of whether pre-approval from the payor had been obtained. A hearing on this bill will be scheduled for October.

COMMUNITY OUTREACH PLANNING MEETING

The Health Law Section's Community Outreach Committee will hold its annual planning meeting on Tuesday, October 15th in the 6th floor conference room at the D.C. Bar Headquarters, 1250 H Street, N.W. The purpose of this meeting is to develop a community outreach agenda for 1996-1997. As in past years, the Section's goal is to offer a two-pronged program through which its members can aid the D.C. community on a volunteer basis through: (1) one or more opportunities for substantive legal work in a health law area; and (2) one or more group volunteer opportunities that may or may not be related to health law.

Interested Section members are encouraged to give back a little to our shared community by helping us design and implement our 1997 plan. Please contact Community Outreach Coordinator Bill Schmidt at (202-371-9746), or Community Outreach Committee Chair Andrea Sloan at (202-448-9145), if you plan to attend.

Making Medical Decisions: Advance Directives

The Health Law Section ("HLS") is pleased to announce the latest segment in its televised programs on health law issues.

On October 22nd, at 8:30 p.m., D.C. Cable, Channel 25, will air "Making Medical Decisions: Advance Directives," produced by the HLS and Georgetown Television Newtork. The program features HLS Community Outreach Committee Co-Chair Andrea Sloan, R.N., J.D., and Michele Kirby, LICSW, ACSW.

In a straightforward, no-nonsense manner, the program provides a discussion of cases and situations which help demonstrate the need for and efficacy of advance planning for health care decisions. Cases such as Quinlan and Cruzan are included in the discussion. The death of Jacqueline Kennedy Onassis is used as an example of an individual whose careful planning and communication with her family and health care providers allowed her to die with dignity.

The program discusses in detail a form document which combines a living will with a durable power of attorney and which has been adopted by each of the local jurisdictions. After viewing the program, the audience is well equipped with sufficient information to understand the utility of advance directives and to have one executed should they desire to do so.

The HLS wishes to express its appreciation to Andrea Sloan for her assistance and expertise in helping to make this program possible. If you have any questions, comments or suggestions about this program or future programs, please contact Saundra Brown at (202) 806-2650.

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