

**ATTORNEY GENERAL OF THE STATE OF NEW YORK
HEALTH CARE BUREAU**

**IN THE MATTER OF THE INVESTIGATION BY
ANDREW M. CUOMO, ATTORNEY GENERAL OF
THE STATE OF NEW YORK, OF**

Assurance No. 09-100

**GOOD SAMARITAN HOSPITAL/BON SECOURS
CHARITY HEALTH SYSTEM**

ASSURANCE OF DISCONTINUANCE

In October 2008, the Office of the Attorney General of the State of New York (“OAG”) began to investigate, pursuant to the provisions of Article 22-A of the General Business Law and Executive Law Section 63(12), the patient billing practices of Good Samaritan Hospital/Bon Secours Charity Health System (hereinafter “Good Samaritan”).

This Assurance of Discontinuance (“Assurance”) contains Findings of OAG’s investigation and the relief agreed to by OAG and Good Samaritan (collectively, “the parties”).

FINDINGS

1. Good Samaritan, as part of its standard claims submission and billing procedure for both inpatient and outpatient services, submits claims to HMOs, Health Plans, and Insurers with which it has Participating Provider contracts for patients who identify themselves as enrollees, covered persons, or subscribers of such HMOs, Health Plans, and Insurers (“Members”).

2. During the period August 2003 through approximately October 31, 2008, pursuant to its standard claims submission and billing procedure for both inpatient and outpatient services then in effect, Good Samaritan sent letters to certain Members improperly representing that such Members would be financially liable for claims to which their HMOs, Health Plans, or

Insurers did not respond in a timely manner. Good Samaritan would send the first such letter at a different interval depending on the source of the payor (i.e., sixty (60) days after submitting a claim for an HMO and fifty (50) days for a Health Plan or Insurer).

3. The letters sent regarding claims for both inpatient and outpatient services billed to an HMO stated, in relevant part:

We billed the HMO over 40 days ago from the information supplied to us. We have not received a response from them and must conclude there is no coverage....

Please assist us in getting this account settled quickly. Regrettably, if we do not receive payment within fifteen (15) days, we will assume there is no coverage by the HMO and have no choice but to look to you for the balance.

4. The letters sent regarding claims for both inpatient and outpatient services billed to a Health Plan or Insurer stated, in relevant part:

We have not been reimbursed by the insurance company for its share of the above account although payment under New York law requires payment to be made within 45 days by the insurance company....

Please assist us in getting this account settled quickly. Regrettably, if we do not receive payment within fifteen (15) days, we will assume the carrier is not responsible and have no choice but to look to you for the balance.

5. If an HMO, Health Plan, or Insurer did not respond to a claim within ninety-five (95) days from the date Good Samaritan submitted the claim, Good Samaritan sent a second letter to the Member stating that the Member would be responsible for full payment of the bill if the HMO, Health Plan, or Insurer did not respond to the claim. Additionally, "THIS IS A BILL" was printed on the top portion of these letters, while the bottom portion of these letters served as a detachable payment stub.

6. The letters regarding claims for both outpatient and inpatient services billed to an HMO, Health Plan, and Insurer stated, in relevant part:

The [HMO, health plan, or insurance carrier] was billed over sixty (60) days ago, and although required under New York statute to pay within 45 days, has not paid. Unfortunately, we are now required to look to you for payment in full.

7. If the HMO, Health Plan, Insurer, or Member did not respond with payment or an explanation for the lack of response to the claim within 117 days of submission of the claim, a “final notice” was sent to the Member. Additionally, “THIS IS A BILL” was printed on the top portion of these letters, while the bottom portion of these letters served as a detachable payment stub.

8. The final notice letters regarding claims for both outpatient and inpatient services billed to an HMO, Health Plan, and Insurer stated, in relevant part:

We wish to inform you that your account is seriously DELINQUENT! If we do not receive the balance in full within fifteen (15) days, we will recommend that the account be referred to a professional collection agency. You will be responsible for the unpaid balance plus reasonable cost of collection, including attorney fees.

9. If there was no response or any payment from the HMO, Health Plan, Insurer or Member within one hundred and twenty-eight (128) days of initial billing Good Samaritan would send the account to Bad Debt.

STATUTORY AND REGULATORY VIOLATIONS

10. Under New York State regulations governing HMOs and applicable to their contracts with Participating Providers, such contracts must “include express conditions indicating that the provider shall hold MCO [managed care organization] enrollees harmless from liability, and shall not bill enrollees under any circumstances for the costs of covered services rendered by the contracting provider, except that nothing herein shall prevent collection

of applicable co-payments or co-insurance or permitted deductibles” (10 NYCRR 98-1.5[b][6][ii]).

11. Under New York State regulations governing financial risk transfer agreements between an Insurer and a Participating Provider, no Insurer may enter into such an agreement unless all agreements between such Insurer and any Participating Provider contain “a ‘hold harmless’ provision that prohibits a participating provider from collecting or attempting to collect from a subscriber any amounts owed to such participating provider for covered services, but excluding any amounts owed by the subscriber to the provider pursuant to the subscriber’s contract ...” (11 NYCRR 101.4[a][2]).

12. New York State Department of Health guidelines applicable to HMOs and to Independent Practice Associations (“IPAs”) under contract with HMOs require that all Participating Provider contracts include a Hold Harmless Provision, as follows:

Enrollee Non-liability. Provider agrees that in no event, including, but not limited to, nonpayment by the MCO or IPA, insolvency of the MCO or IPA, or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a subscriber, an enrollee or person (other than the MCO or IPA) acting on his/her/their behalf, for services provided pursuant to the subscriber contract or Medicaid Managed Care contract or Family Health Plus contract and this Agreement, for the period covered by the paid enrollee premium... This provision shall not prohibit the provider, unless the MCO is a managed long term care plan designated as a Program of All-Inclusive Care for the Elderly (PACE), from collecting copayments, coinsurance amounts, or permitted deductibles, as specifically provided in the evidence of coverage, or fees for uncovered services delivered on a fee-for-service basis to a covered person provided that provider shall have advised the enrollee in writing that the service is uncovered and of the enrollee’s liability therefor prior to providing the service. Where the provider has not been given a list of services covered by the MCO, and/or provider is uncertain as to whether a service is covered, the provider shall make reasonable efforts to contact the MCO and obtain a coverage determination prior to advising an

enrollee as to coverage and liability for payment and prior to providing the service. This provision shall survive termination of this Agreement for any reason, and shall supersede any oral or written agreement now existing or hereafter entered into between provider and enrollee or person acting on his or her behalf.

(New York State Department of Health Standard Clauses For Managed Care Provider/IPA Contracts, § C. 1., revised January 1, 2007).

13. Article 22-A of the New York State General Business Law prohibits “deceptive acts and practices in the conduct of any business, trade or commerce or in the furnishing of any service in this state ...” (General Business Law § 349[a]).

14. Article 29-H of the General Business Law prohibits any creditor or agent of a creditor from attempting or threatening to enforce a right with knowledge or reason to know that the right does not exist. (General Business Law § 601[8]).

15. Accordingly, a hospital cannot bill a patient who is an eligible enrollee or subscriber of an HMO (other than for applicable deductibles, co-insurance and amounts designated by the HMO as the enrollee’s or subscriber’s responsibility in his or her subscriber contract or certificate of coverage) if: (1) the hospital is a Participating Provider with the enrollee’s or subscriber’s HMO; (2) the enrollee or subscriber met all contractual obligations under his or her subscriber contract or certificate of coverage with the HMO; (3) the services rendered by the hospital were provided pursuant to the enrollee’s or subscriber’s subscriber contract or certificate of coverage with the HMO; and (4) the hospital did not inform the enrollee or subscriber prior to rendering the service that the service was not covered and the enrollee or subscriber would be financially liable for such services. If these four conditions are met, the hospital must seek payment for services (other than applicable deductibles, co-insurance and amounts designated by the HMO) solely from the HMO. To bill an enrollee or subscriber, or represent that an enrollee or subscriber may or will be billed, when these four conditions are met,

constitutes an improper billing practice under New York State regulations, a deceptive and fraudulent business practice under General Business Law Article 22-A and an improper collection practice under General Business Law Article 29-H.

16. A hospital cannot bill a patient who is an eligible covered person of a non-HMO Health Plan (“Insurer”) or self-insured Health Plan (other than for applicable deductibles, co-insurance and amounts designated by the Insurer or self-insured Health Plan as the covered person’s responsibility in his or her subscriber contract or certificate of coverage) if: (1) the hospital is a Participating Provider with the covered person’s Insurer or self-insured Health Plan and the contract between the hospital and the Insurer or self-insured Health Plan contains a Hold Harmless Provision that preclude the hospital from billing such patient other than for applicable deductibles and co-insurance amounts, similar in substance and effect to that in paragraph 12 above; (2) the covered person met all contractual obligations under his or her subscriber contract or certificate of coverage with the Insurer or self-insured Health Plan; (3) the services rendered by the hospital were provided pursuant to the covered person’s subscriber contract or certificate of coverage with the covered person’s Insurer or self-insured Health Plan; and (4) the hospital did not inform the covered person prior to rendering the service that the service was not covered and the covered person would be financially liable for such services. If these four conditions are met, the hospital must seek payment for services (other than applicable deductibles, co-insurance and amounts designated by the Insurer or self-insured Health Plan as the covered person’s responsibility in his or her subscriber contract or certificate of coverage) solely from the Insurer or self-insured Health Plan. To bill a covered person, or represent that the covered person may be financially liable, for any other reason constitutes a deceptive and fraudulent business practice

under General Business Law Article 22-A and an improper collection practice under General Business Law Article 29-H.

17. Based on these Findings, the Attorney General has determined that Good Samaritan's has (1) improperly billed Members of HMOs, certain Health Plans, and Insurers in violation of 10 NYCRR 98-1.5(b)(6)(ii), 11 NYCRR 101.4(a)(2) and General Business Law Article 22-A and (2) engaged in improper debt collection in violation of General Business Law Article 29-H.

PROSPECTIVE RELIEF

WHEREAS, Good Samaritan neither admits nor denies OAG's Findings, paragraphs 1 – 17;

WHEREAS, OAG is willing to accept the terms of this Assurance pursuant to New York Executive Law § 63(15) and to discontinue its investigation;

WHEREAS, the parties each believe that the obligations imposed by this Assurance are prudent and appropriate;

WHEREAS, Good Samaritan fully cooperated with the OAG throughout this investigation; and

IT IS HEREBY UNDERSTOOD AND AGREED, by and between the parties that:

18. In consideration of the making and execution of this Assurance and within 10 business days thereafter, Good Samaritan shall pay by wire transfer, certified or bank check payable to the State of New York \$25,000 in costs.

19. Any payments and all correspondence related to this Assurance must reference Assurance No. 09-100.

20. All checks issued pursuant to paragraph 18 of this Assurance as agreed payment of the Attorney General's costs shall be made out to: "State of New York Department of Law."

A. Good Samaritan Shall Not Improperly Bill Patients

21. Good Samaritan shall not permit or institute any billing policy, practice, or procedure that authorizes or constitutes balance billing in violation of the Hold Harmless Provision of any Participating Provider contract.

22. Good Samaritan shall not bill a Member of an HMO with which Good Samaritan is a Participating Provider (other than for applicable deductibles, co-insurance and amounts designated by the HMO as the Member's responsibility in his or her subscriber contract or certificate of coverage) to which it has submitted a claim but not received a response, unless and until Good Samaritan is notified that the Member is not actually enrolled in or eligible for benefits from the HMO.

23. Good Samaritan shall ensure that any written communications it sends, or telephone calls it makes, to Members of HMOs, Insurer or self-insured Health Plans will not improperly represent financial responsibility for services rendered by Good Samaritan, in accordance with paragraphs 15 and 16 above. When Good Samaritan has language in its Participating Hospital Agreement with the Health Plan, Insurer or self-insured Health Plan that obligates Good Samaritan to hold the Member harmless or if it is an HMO Member, written correspondence shall state clearly and conspicuously (in bold letters) "THIS IS NOT A BILL" and "MAKE NO PAYMENT."

24. Good Samaritan shall not bill an eligible Member of an HMO (other than for applicable deductibles, co-insurance and amounts designated by the HMO as the Member's responsibility in his or her subscriber contract or certificate of coverage) if (1) Good Samaritan is a Participating Provider with the Member's HMO, (2) the Member met all contractual obligations under his or her subscriber contract or certificate of coverage with the HMO, (3) the

services rendered by Good Samaritan were provided pursuant to the Member's subscriber contract or certificate of coverage with the HMO, (4) Good Samaritan did not inform the Member prior to rendering the service that the service was not covered and the Member would be financially liable for such services.

25. Good Samaritan shall not bill an eligible Member of an Insurer or self-insured Health Plan (other than for applicable deductibles, co-insurance and amounts designated by the Insurer or self-insured Health Plan as the Member's responsibility in his or her subscriber contract or certificate of coverage) if (1) Good Samaritan is a Participating Provider with the Member's Insurer or self-insured Health Plan and the Participating Hospital Agreement between Good Samaritan and the Insurer or self-insured Health Plan precludes sending a bill to such Member, (2) the Member met all contractual obligations under his or her subscriber contract or certificate of coverage with the Insurer or self-insured Health Plan, and (3) the services rendered by Good Samaritan were provided pursuant to the Member's subscriber contract or certificate of coverage with the Insurer or self-insured Health Plan.

B. Restitution

26. Within five (5) business days of the effective date of this Assurance, Good Samaritan shall provide the OAG with a list of all Good Samaritan patients and the amounts collected as a result of the collection process described in paragraphs 2 – 9 for the period from August 1, 2003 to the effective date of this Assurance..

27. Good Samaritan shall pay restitution to each patient in the list described in paragraph 26. Restitution shall include patient's payment amount plus twelve (12) percent interest per annum.¹

28. Within thirty (30) days of the effective date of this Assurance Good Samaritan shall send a check for the restitution amount to each patient.

29. Good Samaritan shall include a cover letter explaining the reason for the restitution. The letter shall advise patients that they can object in writing to the restitution amount and submit supporting documentation if they believe they are not fully reimbursed for their payment/s made to Good Samaritan. The letter shall also advise the patients that they may contact the Health Care Bureau of the OAG at (800) 428-9071, or Health Care Bureau, The Capitol, Albany, NY 12224-0341, for assistance if they disagree with Good Samaritan's determination. Good Samaritan shall provide a copy of the cover letter to the OAG for prior approval.

30. If the patient objects in writing within thirty (30) days of when restitution was made, Good Samaritan shall review the objection and any supporting documentation submitted. Good Samaritan shall notify the patient and the OAG of its determination, and provide any applicable restitution payment within ten (10) days of receipt of the objection.

31. In the event Good Samaritan is unable to distribute any restitution due to its inability to locate the patient, Good Samaritan shall reach an agreement with the OAG to pay or contribute a sum equal to the total restitution that would have been paid pursuant to the

¹ Restitution need not, but at Good Samaritan's discretion may, include appropriately billed co-pays, deductibles other co-insurance obligations, and patient responsibility amounts so designated by the applicable subscriber contract or certificate of coverage and billed as such by Good Samaritan.

Assurance for those claims had the patients been located. The terms of such agreement shall be consistent with the intent of this Assurance.

32. Within ninety (90) days of the effective date of this Assurance, Good Samaritan shall send the OAG a report detailing the results of the restitution process outlined in paragraphs 26 – 31.

C. Other Remedial Measures

33. Good Samaritan shall ensure that all staff training manuals and conferences relating to patient billing practices conform to the requirements of this Assurance and all New York State laws and regulations.

D. Independent Monitor

34. Within thirty (30) days from the effective date, Good Samaritan shall nominate, subject to approval by the Attorney General, a third- party monitor (“Monitor”).

35. Good Samaritan shall bear all the costs associated with hiring and retaining the Monitor.

36. The Monitor shall within one hundred and eighty (180) days review and report to the OAG all aspects of Good Samaritan’s compliance with this Assurance, including but not limited to modifications in Good Samaritan’s billing policies, practices, and procedures; staff training enhancement; and patient restitution efforts as applicable to the issues raised in this Assurance.

37. OAG will review the Monitor’s report and take any necessary action to ensure Good Samaritan’s further compliance with the terms of this Assurance.

MISCELLANEOUS

38. Good Samaritan hereby accepts the terms and conditions of this Assurance and waives any right to challenge it in a proceeding pursuant to Article 78 of the Civil Practice Law and Rules or in any other action or proceeding.

39. OAG has agreed to the terms of this Assurance based on, among other things, the representations made to OAG by Good Samaritan and their counsel and OAG's own factual investigation as set forth in paragraphs 1 - 9 above. To the extent that any material representations are later found to be inaccurate or misleading, this Assurance is voidable by the OAG in its sole discretion.

40. No representation, inducement, promise, understanding, condition, or warranty not set forth in this Assurance has been made to or relied upon by Good Samaritan in agreeing to this Assurance.

41. Good Samaritan represents and warrants, through the signatures below, that the terms and conditions of this Assurance are duly approved, and execution of this Assurance is duly authorized. Good Samaritan shall not take any action or make any statement denying, directly or indirectly, the propriety of this Assurance or expressing the view that this Assurance is without factual basis. Nothing in this paragraph affects the Good Samaritan's (i) testimonial obligations or (ii) right to take legal or factual positions in defense of litigation or other legal proceedings to which OAG is not a party. This Assurance is not intended for use by any third party in any other proceeding and is not intended, and should not be construed, as an admission of liability by Good Samaritan.

42. This Assurance may not be amended except by an instrument in writing signed on behalf of all the parties to this Assurance.

43. This Assurance shall be binding on and inure to the benefit of the parties to this Assurance and their respective successors and assigns, provided that no party, other than OAG, may assign, delegate, or otherwise transfer any of its rights or obligations under this Assurance without the prior written consent of OAG.

44. In the event that any one or more of the provisions contained in this Assurance shall for any reason be held to be invalid, illegal, or unenforceable in any respect, in the sole discretion of the OAG such invalidity, illegality, or unenforceability shall not affect any other provision of this Assurance.

45. To the extent not already provided under this Assurance, the Company shall, upon request by OAG, provide all documentation and information necessary for OAG to verify compliance with this Assurance.

46. All notices, reports, requests, and other communications to any party pursuant to this Assurance shall be in writing and shall be directed as follows:

If to Good Samaritan to:

Good Samaritan Hospital
255 Lafayette Avenue
Suffern, New York 10901
Attention: Chief Executive Officer

If to the OAG, to:

Brant Campbell, Assistant Attorney General
Office of the Attorney General
Health Care Bureau
120 Broadway
New York, New York 10271

47. Acceptance of this Assurance by OAG shall not be deemed approval by OAG of any of the practices or procedures referenced herein, and Good Samaritan shall make no representation to the contrary.

48. Pursuant to Executive Law § 63(15), evidence of a violation of this Assurance shall constitute prima facie proof of violation of the applicable law in any action or proceeding thereafter commenced by OAG.

49. If a court of competent jurisdiction determines that Good Samaritan has breached this Assurance, Good Samaritan shall pay to OAG the cost, if any, of such determination and of enforcing this Assurance, including without limitation legal fees, expenses, and court costs.

50. The OAG finds the relief and agreements contained in this Assurance appropriate and in the public interest. The OAG is willing to accept this Assurance pursuant to Executive Law § 63(15), in lieu of commencing a statutory proceeding. This Assurance shall be governed by the laws of the State of New York without regard to any conflict of laws principles.

51. Nothing contained herein shall be construed as to deprive any person of any private right under the law.

EFFECTIVE DATE

52. The effective date is the date that the OAG signs this Assurance.

IN WITNESS THEREOF, the undersigned subscribe their names:

Dated: New York, New York

~~June~~, 2009

July 7, 2009

ANDREW M. CUOMO

Attorney General of the State of New York

TIMOTHY A. CLUNE

Health Care Bureau Chief

By: 

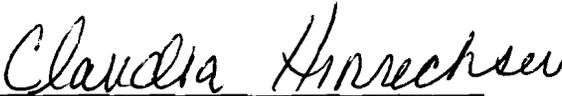
Brant Campbell, Esq.

Assistant Attorney General

Health Care Bureau

Dated: New York, New York

June 25, 2009

By: 

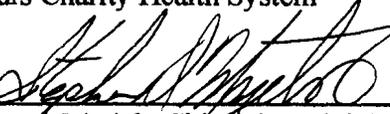
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Abrams, Fensterman, Fensterman, Eisman

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Counsel for Good Samaritan Hospital/Bon

Secours Charity Health System

By: 

Stephen Majetich, Chief Financial Officer

Good Samaritan Hospital/Bon Secours

Charity Health System