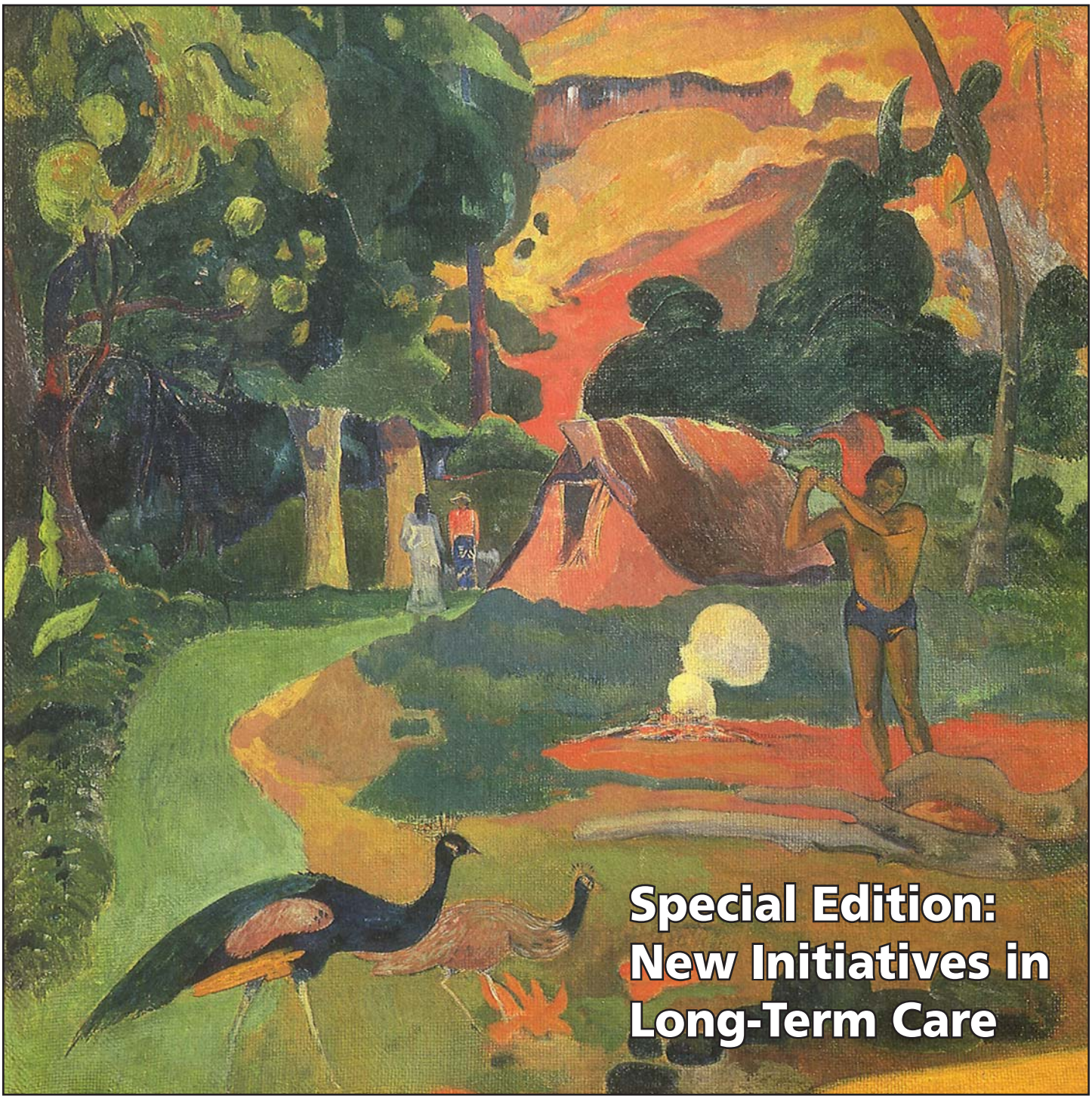
NYSBA SUMMER 2007 | VOL.12 | NO.2

Health Law Journal

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



Special Edition: New Initiatives in Long-Term Care

NYSBA

HEALTH LAW JOURNAL

Summer 2007

Vol. 12, No. 2

THE HEALTH LAW SECTION
NEW YORK STATE BAR ASSOCIATION

© 2007 New York State Bar Association

Table of Contents

Page

A Message from the Section Chair 5
Mark Barnes

Regular Features

In the New York State Courts 6

In the New York State Legislature 14

In the New York State Agencies 17

In the Journals 19

For Your Information 21

Feature Articles

New Initiatives in Long-Term Care

Special Edition Introduction 22
Raul Tabora, Special Edition Editor

F-SHRP: A Strong Note for Reform 23
Mark R. Ustin

Continuing Care Retirement Communities 31
Alyssa M. Barreiro

Assisted Living in New York: Old and Broke, Where Will We Go from Here? 35
Jane Bello Burke

Privacy and Security Solutions for Interoperable Health Information Exchange 39

Editor's Selected Court Decision
McKinney v. Commr. of DOH 49

Section Matters

Newsflash: What's Happening in the Section 56

Cover artwork: *Matamoe* by Paul Gauguin (1892)

Special Edition Editor: Raul Tabora, Ruffo, Tabora, Mainello & McKay, PC, Albany, NY

A Message from the Section Chair

My term as chair of the Health Law Section came to an end in June 2007, and I passed the reins to Peter Millock, who is highly esteemed in our legal circles for his long service as General Counsel of the New York State Department of Health. This past year has been a good one for the Section. We did lose a tough contest with the Trusts and Estates Law Section over its proposal that the State Bar Association support a "living will" statute—which our Section believes is entirely unnecessary given New York State's well-established health care proxy law and clear common law precedents. Lynn Stansell, as our Section representative on the State Bar Executive Committee, fought heartily for us on this issue, and we thank her for her leadership and efforts. The debate over this issue reminds us of how rampant are the misconceptions about this area of law and points out again the need for passage of the Family Health Care Decisions Act, which is more responsive to the real problems of New Yorkers with respect to end-of-life decision making.

We look forward in the next year to our Section's sponsorship of CLE programs on mental illness and the court system, human subjects research law, fraud and abuse issues, and the "Health Law 101" course. On November 3, 2007, we will host a retreat for the Section (and Section spouses/significant others) at the Otesaga in Cooperstown, NY. This year the topic of the retreat will be again the "downsizing" of New York's health facilities. Having a retreat like this is a new tradition in the Section, begun only two years ago when Lynn Stansell served as Chair. This fall event lasts for only one day, but gives us all a chance to bring our spouses and families to settings in which we can meet and talk at a more leisurely pace than that to which we are so unfortunately accustomed. The fruitful conversations and personal introductions that the Fall Meeting makes possible are compelling reasons for all of us to encourage the new junior attorneys in our office to attend.

I am grateful to all of you for your help and assistance over the past year. Our Section spans a broad variety of health law issues, practices and government agencies, and we have managed this year, in our January 2007 program on physician/hospital issues, our November 2007 program on health facility retrenchment, and our CLE programs, to sustain our ongoing collective conversation about the issues that matter so much to all of us, as attorneys and as citizens.

As many of you already know, after completing this year's service as Section Chair and winding up some other client commitments, I am resigning as a partner at Ropes & Gray to move to Memphis (yes Memphis—home of Elvis and blues and barbecue) to serve as chief operating officer at St. Jude Children's Research Hospital. Although supervising the general counsel and regulatory affairs staff there, I will primarily just be running a large pediatric research hospital. The leaving of law practice to do this—and the leaving of all my many daily personal connections to the members of this Section— is bittersweet. But change is good, and it probably makes us, in the end, better health lawyers when we fully understand the operational burdens of our clients. And so a new adventure lies ahead for me, even as I cherish the many fine years of law practice and government service I have had in New York.

My best wishes to the new slate of Section leaders as they take office, and to all members of the Section.

Mark Barnes

Health Law Section

FALL RETREAT

November 3, 2007

The Otesaga • Cooperstown, NY

In the New York State Courts

By Leonard M. Rosenberg

Motion Court Upholds Constitutionality of the Berger Commission's Enabling Legislation Under the Separation of Powers Doctrine

McKinney v. Commissioner of New York State Dep't of Health, 836 N.Y.S.2d 794, 15 Misc. 3d 743, 2007 WL 703119 (Sup. Ct., Bronx County 2007), *aff'd*, 41 A.D.3d 252 (1st Dep't 2007). In 2005, the New York Legislature created the Commission on Health Care Facilities in the Twenty-First Century (the "Berger Commission"), with a mandate to review and make recommendations regarding the structure of New York's health care facilities. In 2006, the Berger Commission recommended that Westchester Square Medical Center ("WSMC") be closed. Upon the approval of the Governor and the inaction of the Legislature, this recommendation became law on January 1, 2007.

Plaintiffs Mary McKinney ("McKinney") and Mechler Hall Community Services, Inc. ("Mechler"), sued the State of New York and the Department of Health, seeking an injunction against implementation of the Berger Commission's recommendation, and a finding that the actions of the Berger Commission were an unconstitutional delegation of legislative power. McKinney was a patient receiving services at WSMC, and Mechler was a not-for-profit corporation serving local senior citizens, many of whom relied on WSMC for health services. Plaintiffs brought suit under common law, and as taxpayers under Section 123-b of the New York State Finance Law, which permits a taxpayer to sue to prevent the improper expenditure of public funds. The motion court issued a temporary restraining order, and subsequently heard Plaintiffs' motion for injunctive relief and Defendants' cross-motion for summary judgment.

The Court denied Plaintiffs' motion for injunctive relief, and granted Defendants' cross-motion for dismissal. Before hearing the merits, the Court made preliminary rulings on joinder and standing. Defendants claimed that the action should be dismissed because WSMC was not a party to the action. The Court held that, to the extent WSMC could maintain a claim of constitutionality, its interests were intertwined with Plaintiffs'. Moreover, WSMC knew of the proceedings and could have intervened to protect its own interests. Finally, Plaintiffs' claims concerned only issues of law. Therefore, WSMC was not a necessary party to the action.

The Court also held that Plaintiffs did not have taxpayer standing under the Finance Law, because the purpose of the Berger Commission's Enabling Legislation was not the expenditure of State funds. To hold otherwise, said the Court, would create an overbroad standard, since most activities arguably have some relationship to expenditures. The Court also held that Plaintiffs did not have common law standing, as they did not have a legal stake or right to WSMC's operating license, and the alleged injury, the potential disruption of health care services, was too speculative and indistinct from the injury the public might face. Moreover, the purpose of the Enabling Legislation reflected legislative policy decisions, and Plaintiffs' injuries did not fall within the zone of interests the legislation sought to protect.

The Court nonetheless considered the action on its merits, finding that "a broader interpretation of the principle of legal standing requires that standing be conferred to a party adversely affected by a decision or regulation of an administrative agency."

Reviewing the merits, the Court held that the Enabling Legislation did not violate the separation of powers doctrine. There must necessarily be overlap between the branches of government to effectively carry out policy, and where it is impractical for the Legislature to lay out specific standards, there is broad flexibility and discretion on the part of the administrative body in determining the proper course of action. As long as the basic policy objective is articulated, the Legislature need not give the administrative body a rigid framework to follow. Because restructuring the health care system is extremely complex, and benefits from specialized input, the Legislature did not err in passing the Enabling Legislation, so long as it provided sufficient guidelines.

To analyze whether the administrative agency had overstepped its approved guidelines, the Court looked to the factors in *Boreali v. Axelrod*, 71 N.Y.2d 1 (1987), which include "whether the agency had to balance competing concerns of public health and economic costs, whether the legislature provided guidelines, whether there was special expertise or technical competence utilized, and whether there was legislative inaction." The Court found that specialized expertise was utilized, and that the guidelines set forth in the Enabling Legislation were sufficient, and general by necessity due to the complexity of the issues involved.

The Court declined to grant weight to the Legislature's inaction, finding that such inaction is not

indicative of disapproval, but rather of the Legislature's decision to defer to the expertise of the administrative body. The Court also found that a balancing of public health with economic concerns was not in and of itself a violation of the doctrine of the separation of powers. In this case, the Legislature explicitly granted the Berger Commission the authority to conduct such a balancing. In the Court's view, the Berger Commission acted rationally and consistently with the legislative policy laid out in the Enabling Legislation, and therefore there was no violation of the separation of powers doctrine.

As a final matter, the Court held that language in the Enabling Legislation that allowed the Berger Commission to make recommendations "notwithstanding" existing laws was within the Legislature's authority, and did not unconstitutionally grant the Commissioner of Health the authority to nullify existing laws. The Court also pointed out that the Commissioner of Health was being charged with no more power than he already possessed, namely, the granting and revocation of hospital operating certificates.

On June 19, 2007, the Appellate Division for the First Department affirmed dismissal of the complaint. The Court first rejected defendant's argument that plaintiffs lacked standing to bring suit under State Finance Law § 123-b, and that Westchester Square Medical Center was a necessary party. The Court then ruled that the enabling statute was not an unconstitutional delegation of the Legislature's lawmaking power to the Executive Branch.

The Court held that once the Legislature made the basic policy choice that some hospitals and nursing homes needed to be closed, resized or restructured, it was permissible for the legislation to authorize the Berger Commission to fill in the details and interstices and make subsidiary policy choices consistent with the enabling legislation.

Appellate Division Upholds Dismissal of Hospital's Constitutional Challenge to Berger Commission's Closure Recommendation

St. Joseph Hospital of Cheektowaga v. Novello, ___N.Y.S.2d ___, 2007 WL 2044870 (4th Dep't July 18, 2007). In 2006, the Commission on Health Care Facilities in the Twenty-First Century ("Berger Commission"), in accordance with its legislative mandate to review and restructure New York's health care system, recommended that Plaintiff St. Joseph Hospital of Cheektowaga ("St. Joseph's") be closed. On January 1, 2007, pursuant to the approval of the Governor and the inaction of the Legislature, the Berger Commission's recommendations became law. Plaintiff Catholic Health System, Inc. ("CHS") is the hospital system in which St. Joseph's operates. Plaintiffs brought suit in the Supreme Court, Erie County, seeking a declaratory judgment and injunctive relief under CPLR 3001, and injunctive relief under 42 U.S.C. § 1983. The motion court denied Plaintiffs' motion for summary judgment, and granted Defendants' cross-motion for summary judgment in its entirety. (15 Misc. 3d 333, 828 N.Y.S. 2d 877). On appeal, the Appellate Division for the Fourth Department vacated the provision dismissing Plaintiffs' request for declaratory judgment, and otherwise affirmed the motion court's order.

The Appellate Division held that, although Plaintiffs had a protectable property interest in St. Joseph's operating license, the Legislature had satisfied due process requirements. Although Plaintiffs had a substantial interest at stake, the State also had a substantial interest in containing rising Medicaid costs and maintaining sufficient health care facilities. Plaintiffs were aware of the Berger Commission's mandate and the possibility that St. Joseph's would be closed. Additional, individualized notice would impose an enormous administrative burden on the State. The notice and hearing opportunities provided to Plaintiffs through public hearings and the submission of documents were sufficient to satisfy procedural due process.

Moreover, substantive due process was not violated, since the State had a legitimate government concern, and its actions were not without legal justification or "outrageously arbitrary."

The Court also held that the Presentment Clause and the separation of powers doctrine were not violated. The Berger Commission's Enabling Legislation included a severability clause. The inclusion of a severability clause creates a presumption that the Legislature intended provisions to be severable unless there is strong evidence to the contrary, which there was not in this case. Therefore, even if the provision of the Enabling Legislation allowing for legislative veto was unconstitutional, it was severable from the rest of the Legislation, which would survive.

In response to Plaintiffs' free exercise clause claims, the Court held that the free exercise clause was not violated because Plaintiffs failed to raise an issue of fact as to whether the Enabling Legislation constituted an unreasonable interference with religious freedom. The Legislation did not target Catholic hospitals and did not in itself restrict religious freedom. Finally, the Enabling Legislation did not violate the contracts clause because the Legislation was reasonable and necessary to accomplish a legitimate public purpose.

One justice dissented from the majority, arguing that the Enabling Legislation violated procedural due process because Plaintiffs did not receive meaningful notice that St. Joseph's was being considered for closure, or an opportunity to be heard, as was their right established by Public Health Law § 2806. The dissent pointed out that Plaintiffs' limited opportunity to speak had been before the Regional Advisory Committee, which made recommen-

dations to the Berger Commission, and not before the Berger Commission itself, despite the fact that the Berger Commission was the ultimate decision-making body.

Additionally, the dissent stated that the separation of powers doctrine was violated, since the process of Governor approval, followed by legislative veto, "inverts the usual procedure utilized for the passage of a bill. . . . [T]he Legislature has in effect assumed the veto powers of the Governor." Although there is a presumption of severability, the dissent argued that this presumption can be discarded in "extraordinary circumstances," as exist in the present case given the "magnitude of the deprivation and the minimal nature of the protection offered . . . to the property interest." Since the veto provision was therefore not severable, the entire Enabling Legislation was unconstitutional. And even if the provision was severable, the dissent argued that the Enabling Legislation nevertheless constituted an improper delegation of legislative authority to the Berger Commission.

Intended Organ Donee Has No Claim to Organ Without Evidence That Organ Will Be Compatible

Colavito v. New York Organ Donor Network et al., 486 F.3d 78, 2007 WL 1462399 (2d Cir. 2007). Plaintiff was the intended recipient of two kidneys from his recently deceased friend, Peter Lucia. The New York Organ Donor Network ("Donor Network") sent one of Lucia's kidneys to Florida for Plaintiff, but contrary to the Lucia family's wishes, the other kidney was designated for a different recipient. In transit to Florida, the kidney intended for the Plaintiff was damaged, and thus could not be successfully transplanted. The Plaintiff's physician attempted to obtain the second kidney from Donor Network, but it was in the process of being transplanted into another donee.

Plaintiff sued Donor Network for fraud, conversion, and violation of New York Public Health Law Articles 43 and 43-A, in the United States District Court for the Eastern District of New York. The district court granted summary judgment in favor of Donor Network, and Plaintiff appealed to the Second Circuit. The Second Circuit affirmed with respect to the fraud claim, and certified several questions to the New York Court of Appeals. Based on the state court's findings, the Second Circuit (J. Sack) found that Plaintiff had neither a common law claim for conversion nor a statutory claim because he could not have derived a medical benefit from the second kidney.

The questions certified to the New York Court of Appeals were whether the intended recipient of an organ donation has a private right of action for common law conversion or a statutory claim under the New York Public Health Law if he does not receive the organ. The state Court of Appeals found that although the intended recipient of a donated organ might have a common law right to it under New York law, no such rights exist for the "specified donee of an incompatible kidney." The state court also decided that whether or not a private right of action exists under New York Public Health Law for disappointed intended recipients, it is available only to those who fall within the statutory term "donee," which the court read to define as "someone who needs the donated organ." The state court assumed that the donated kidneys were incompatible with Plaintiff's immune system based on the language of the Second Circuit's opinion affirming summary judgment of the fraud claim. Neither the district court nor the Second Circuit previously decided if there was a material issue of fact requiring a trial as to whether the donated kidneys and Plaintiff's immune system were compatible.

In light of the state court's assumption that the kidneys were not compatible with Plaintiff's, the Second Circuit opted to decide the issue in the first instance. The Second Circuit considered the district court's finding that the evidence strongly suggested "Lucia's kidneys were . . . useless to Colavito." Plaintiff's contention throughout the litigation was that compatibility was immaterial, and thus presented no evidence that would have raised a genuine issue of fact as to compatibility. Because the notion that the second kidney may have been compatible was only speculative, the Second Circuit concluded that, as a matter of law, Plaintiff could not have benefited from the second kidney, and thus he did not "need" it, as required by the New York Public Health Law. The Court affirmed the district court's grant of summary judgment in favor of Defendants.

Physician Not Civilly Liable for Failure to Report Suspected Abuse of Child by Minor Brother Since Conduct Was Not Knowing and Willful

Page v. Monroe and Adirondack Internal Medicine and Pediatrics, P.C., 02 CV 0526, 2007 WL 1458201 (N.D.N.Y. May 16, 2007). The District Court for the Northern District of New York (J. Kahn) ruled that a physician's failure to report suspected abuse of a minor by her brother, when there was no evidence that the minor's mother was allowing it to take place, was neither a violation of the physician's statutory duty nor a basis for civil liability.

Section 413 of New York Social Services Law ("SSL") requires certain professionals, including physicians, to make a report to the State Central Register when they have reasonable cause to suspect child abuse or maltreatment. SSL § 420(2) provides that a person or institution who knowingly and willfully fails to make a required report of suspected child abuse can bear civil liability.

New York has established a policy of non-intervention when a minor is abusing a sibling, "because such a situation is within the capacity and authority of a fit parent." SSL § 412(4)

provides, however, that a report is properly made against a parent who commits such abuse or allows it to take place.

Catherine Page, the mother of Plaintiffs Brittany and Melissa (ages nine (9) and seven (7) respectively) suspected that Brittany's half brother, Anthony, age 14, had inappropriately touched Brittany. Ms. Page called the New York State Office of Children and Family Services hotline to report the suspected abuse. The hotline staff was not able to register a report, however, because Anthony could not be the "subject" of a report of abuse under the terms of the New York Social Services Law. A "subject" is defined as a parent, guardian, custodian or any other person eighteen years of age or older who is legally responsible for the child.

Ms. Page then called Dr. Monroe, a pediatrician at Adirondack Internal Medicine and Pediatrics, P.C. She apprised Dr. Monroe of her suspicions and recounted her telephone call to Children and Family Services. She informed Dr. Monroe that Brittany would be staying at her aunt's house for the next week, and asked Dr. Monroe to make a report to the State Central Register. Dr. Monroe did not make such a report, and advised Ms. Page not to leave Plaintiffs alone with Anthony.

Approximately six months later, Dr. Monroe was asked to examine Plaintiffs in connection with a State Police investigation into additional and more severe allegations of sexual abuse. After her examination, Dr. Monroe confirmed the allegations, and reported Ms. Page to the State Central Register for failure to supervise the children adequately.

Plaintiffs allege that Dr. Monroe violated her statutory duty by failing to report the abuse when she initially heard about it from Ms. Page, as she allegedly had cause to reasonably suspect that Ms. Page was allowing the abuse to happen.

The Court noted that for Plaintiffs' claims for civil liability to succeed, a reasonable jury must be able to conclude that Dr. Monroe's failure to report Ms. Page was willful and knowing, and that the failure caused Plaintiffs' harm. The Court held that at the time of Dr. Monroe's earlier communication with Ms. Page, there was no evidence that Ms. Page was incapable or unwilling to protect her daughters. Accordingly, Dr. Monroe had no duty to report the suspected abuse at that time.

Federal Court Grants Summary Judgment Dismissal of Deaf Plaintiff's ADA Suit Against Hospital for Alleged Failure to Provide Sign Language Interpreting Services

Loeffler et al. v. Staten Island Univ. Hosp. 2007 WL 805802 (E.D.N.Y. Feb. 27, 2007). Plaintiffs Robert A. Loeffler, his wife, Josephine Loeffler, who are both deaf, and children Kristy and Robert C. Loeffler, who are both hearing individuals, alleged that Staten Island University Hospital (the "Hospital") failed to provide Robert and Josephine with sign language interpreting services necessary to communicate with Hospital staff. Plaintiffs also claimed that Kristy and Robert C., who were fluent in American Sign Language, were forced to miss school to provide interpreting services necessary for Robert's medical care. Plaintiffs sought damages and injunctive relief under the Rehabilitation Act, Title III of the ADA, the New York State Patients' Bill of Rights, the New York State Human Rights Law ("NYSHRL"), the New York City Civil Rights Law ("NYCCRL"), and New York common law negligence.

Section 504 of the Rehabilitation Act prohibits discrimination against disabled persons in the provision of public services by institutions that receive federal financial assistance. To establish a claim for monetary damages under the Rehabilitation Act, the disabled Plaintiff must demonstrate, among other things, that the failure to provide services was due to intentional discrimination. Intentional discrimination, the court held, was a "deliberate indifference" to a potential violation of federally protected rights. The same analysis, the Court held, governed Plaintiffs' NYSHRL and NYCCRL claims.

Here, the Court found no evidence of any "deliberate indifference" that could be submitted to a jury. Rather, the Court found substantial evidence that the Hospital had a policy to provide interpreting services, and that the Hospital's staff made numerous good-faith—albeit unsuccessful—attempts to secure interpreting services. Thus, summary judgment was granted on Plaintiffs' Rehabilitation Act, NYSHRL and NYCCRL claims.

The Court also denied Plaintiffs' request for injunctive relief. To obtain injunctive relief, a plaintiff must be able to show a real and immediate threat that (1) plaintiff will use defendant's services in the future, and (2) plaintiff will suffer from a discriminatory deprivation of interpreting services. Plaintiffs failed to show that Josephine might require future treatment at the Hospital, and the Court found that the Hospital had sufficiently amended its policy of providing interpreting services such that a future occurrence would be unlikely. Accordingly, the Court denied Plaintiffs' request for injunctive relief.

Upon granting summary judgment in favor of the Hospital on all of Plaintiffs' claims except New York common law negligence, the Court refused to exercise supplemental jurisdiction over the common law negligence claim. [Ed. Note—Garfunkel, Wild & Travis, P.C. represented the Hospital in this suit.]

Appellate Division Upholds Term in Physician's Employment Contract That Requires Surrender of Medical Staff Privileges Upon Termination of Employment with Hospital-Based Group

Sandhu v. Mercy Medical Center et al., 35 A.D.3d 479, 828 N.Y.S.2d 91 (2d Dep't 2006). This suit began as an Article 78 proceeding in which a physician sought an order requiring Mercy Medical Center ("Hospital") to conduct a fair hearing concerning the suspension of his medical staff privileges. The physician also asked the Court to declare null and void a clause in his employment contract that deemed his medical staff privileges at the Hospital "resigned" upon termination of his employment by Long Island Emergency Care, P.C. ("LIEC"). The petition further sought a declaration that his entire employment agreement with LIEC was void as a contract of adhesion.

LIEC served as the Hospital's exclusive provider of emergency department physicians, and Petitioner was employed by LIEC as an emergency department physician at the Hospital. His employment agreement with LIEC provided that Petitioner would be deemed to have resigned his Hospital medical staff privileges if LIEC terminated his employment.

The Hospital suspended Petitioner's medical staff privileges after he allegedly assaulted a patient, and advised Petitioner that, pursuant to the Hospital medical staff bylaws, he was entitled to a fair hearing before an ad hoc committee of the medical staff. Petitioner requested a fair hearing to review his suspension. Shortly thereafter, LIEC terminated Petitioner's employment and advised him that, pursuant to his employment agreement, his medical staff privileges were deemed resigned, thereby eliminating any rights Petitioner had to a fair hearing. The Hospital thereafter denied Petitioner's request for a fair hearing based on his termination by LIEC. Petitioner then commenced an Article 78 proceeding.

The Hospital and LIEC moved to dismiss the petition on the grounds that, pursuant to Public Health Law § 2801-b, the physician had to first seek review before the Public Health Council ("PHC") and that the Article 78 proceeding was improper because Petitioner's claims sounded in contract. The Supreme Court, Nassau County, denied the motion and ordered the Hospital to conduct the fair hearing. Upon reargument by the Hospital and LIEC, the Supreme Court vacated its original determination, but concluded that an issue of fact existed as to whether the employment agreement was void as a contract of adhesion, thus rejecting the Hospital's and LIEC's argument that the provisions of the employment agreement rendered moot any request for a fair hearing.

The Appellate Division held that because Petitioner was not seeking reinstatement of his medical staff privileges, but only a fair hearing under the Hospital's medical staff bylaws, Petitioner was not required to first seek review before the PHC.

Next, the Appellate Division found that the dispute was improperly brought as an Article 78 proceeding because it concerned the enforcement of Petitioner's contract with LIEC. Accordingly, the Court converted the proceeding into a civil action for a declaratory judgment seeking to void Petitioner's entire employment agreement, or the applicable portion thereof which required him to surrender his medical staff privileges upon his employment termination by LIEC.

The Appellate Division then dismissed the petition. Citing to *Gelbfish v. Maimonides Med. Ctr.*, 184 A.D.2d 614, 584 N.Y.S.2d 651 (2d Dep't 1992), and *Del Castillo v. Bayley Seton Hospital*, 172 A.D.2d 796, 569 N.Y.S.2d 168 (2d Dep't 1991), the Court found no merit to Petitioner's argument that the clause of his employment agreement deeming his medical staff privileges "resigned" if terminated by LIEC should be found unenforceable. [Ed. Note—In both *Gelbfish* and *Del Castillo*, the court upheld similar contract terms that led to loss of privileges upon termination of the physician's association or employment with a professional corporation that provided services at the hospital.]

Further, the Court declined to declare the employment agreement void as a contract of adhesion, as Petitioner did not claim he was unable to read or understand his employment agreement, nor did he claim he was unable to find employment elsewhere.

Court Affirms Dismissal of Claims for Termination of Hospital Privileges, Breach of Employment Agreement, Breach of the Implied Covenant of Good Faith and Fair Dealing, and Tortious Interference with Contract and Prospective Business Relations

Lobel v. Maimonides Med. Ctr., 835 N.Y.S.2d 28, 39 A.D.3d 275 (1st Dep't 2007). Plaintiff physician sued her employer, Maimonides Medical Center ("Hospital") and another physician, claiming improper termination of her hospital privileges, breach of her employment agreement, breach of the implied covenant of good faith and fair dealing, tortious interference with contract, and tortious interference with prospective business relations.

The Supreme Court, New York County, granted Defendant's motion to dismiss claims of improper termination of Plaintiff's hospital privileges, breach of employment agreement, breach of the implied covenant of good faith and fair dealing, tortious interference with contract, and tortious interference with prospective business relations. The Appellate Division affirmed.

The Court held that once Plaintiff's employment agreement expired, she became an at-will employee, and that the Hospital's letter extending Plaintiff's Hospital privileges did not constitute an extension of her

employment agreement. As for letters from Defendant physician to his attorney and to the Hospital's vice president, those were not sufficient to satisfy the statute of frauds. They failed to state all the material terms of a complete agreement, which terms were clearly left to be included in an anticipated restructured contract. Because of the lower court's proper determination that Plaintiff was an at-will employee at the time she was released, the claim for breach of the implied covenant of good faith and fair dealing was also properly dismissed.

Plaintiff's claims for tortious interference with contract and tortious interference with prospective contract relations were also properly denied. Because Plaintiff was an at-will employee, she had no cause of action based on a co-employee's allegedly tortious interference with her employment. Plaintiff's allegations concerning Defendant physician's statements purportedly defaming her did not set forth grounds for a tortious interference claim because it was clear that he was motivated by economic self-interest, rather than by a desire to harm her.

The Appellate Division also affirmed the Supreme Court's decision to dismiss Plaintiff's claim that the Hospital improperly terminated her staff privileges, noting that there is no common-law cause of action based upon a denial of staff privileges by a private hospital. The Court noted that a physician's only remedy for an alleged wrongful denial of hospital privileges is an injunctive action under Public Health Law ("PHL") § 2801-c, and that prior to seeking such relief, a physician is required to exhaust her administrative remedy with the New York State Public Health Council pursuant to PHL § 2801-b, which Plaintiff failed to do. The Court also noted that as a matter of law, in the absence of a clearly written contract by which a hospital grants privileges for a fixed period of time and agrees not to withdraw those privileges without cause, any claim for damages is legally insufficient.

Physician's Suit Over Loss of Hospital Privileges Dismissed for Failure to Pursue Administrative Remedy with Public Health Council

Eden v. St. Luke's-Roosevelt Hosp. Ctr., 39 A.D.3d 215, 833 N.Y.S.2d 433 (1st Dep't 2007). Plaintiff physician was terminated from his employment as an attending physician in a hospital's Department of Obstetrics and Gynecology. Plaintiff sued the hospital for wrongful termination of employment and withdrawal of his staff privileges. He also sought recovery of unpaid compensation allegedly earned during his employment.

The Supreme Court, New York County, granted Defendant's motion to dismiss the complaint for lack of subject matter jurisdiction and denied Plaintiff's cross-motion for leave to amend the complaint. The Appellate Division unanimously affirmed the lower court's decision, holding that whether Plaintiff sought reinstatement or damages, the Court lacked subject matter jurisdiction, as those claims had not yet been reviewed by the Public Health Council under the grievance procedure provided by Public Health Law § 2801-b.

The other claims pertaining to recovery of unpaid compensation, even if not subject to Public Health Council review, were intermingled with the claims barred by Section 2801-b rather than separately pleaded. The Court declined to parse the pleadings to separate the cognizable claims from the prematurely pleaded ones, and dismissed the entire suit.

Hospital-Wide Layoffs Constitute a Legitimate and Nondiscriminatory Basis for Terminating Assistant Vice President of Nursing

Bailey v. New York Westchester Square Medical Center et al., 38 A.D.3d 119, 829 N.Y.S.2d 30 (1st Dep't 2007). In this employment discrimination action brought under Executive Law § 296 and New York City Administrative Code § 8-107, Plaintiff, an African-American female nurse over the age of 60, alleged age, race and gender discrimination based upon termination of her employment with Defendant hospital. Plaintiff also alleged breach of contract for failure to provide severance pay, and intentional infliction of emotional distress. Defendants moved for summary judgment, asserting that Plaintiff was terminated as part of hospital-wide layoffs, motivated by the hospital's decline in revenues and its need to significantly reduce expenses. The motion court denied the motion, finding Plaintiff had set-forth a *prima facie* case for discrimination and determining there were genuine issues of material fact as to whether Defendants' grounds for terminating Plaintiff were a pretext for discrimination.

At the time of her discharge, Plaintiff was employed by Defendant hospital as the Assistant Vice President of Nursing ("AVP") in the medical-surgical unit. Defendant hospital also employed a second AVP in the critical care unit, who was a white female and 10 years younger than Plaintiff.

Due to the hospital's declining financial situation, the hospital decided to downsize, which necessarily included a review of the two AVP positions. The AVP position for the critical care unit was essential to maintain because of the hospital's recent "911" designation from the New York City Fire Department, which required the hospital to employ an experienced emergency room staff. The AVP position for the medical-surgical unit, however, could be eliminated without affecting the hospital's quality of care. Because Plaintiff lacked the educational background and the emergency room experience required for the position of AVP of the critical care unit, she was terminated, her AVP position was eliminated and she was not replaced.

In their appeal to the Appellate Division, First Department, Defendants maintained that Plaintiff's termination was part of a hospital-wide layoff plan, which was a legitimate business decision motivated by the hospital's declining financial position. The Appellate Division agreed.

The Court stated that Plaintiff, an African-American female over the age of 60, was unquestionably part of a protected class. It further stated, however, that "[t]he downsizing of a company's employment rolls, due to business failings and economic setbacks, constitutes a sustainable rebuttal and explanation for the decision to terminate a particular employee . . ." particularly since her position was eliminated and she was not replaced. As the facts demonstrated, because Defendants had hospital-wide layoffs, including male and female employees of various races and ages, a cause of action for discrimination could not be maintained.

In addition, the Court found there was no inference of discrimination on the part of Defendants' decision to eliminate the AVP position in the medical-surgical unit, as well as Defendants' decision to terminate the Plaintiff. As Plaintiff admitted, the AVP of the critical care unit was more important for the hospital to maintain. More so, Plaintiff did not have the education or emergency room experience to qualify her for the remaining position.

Accordingly, the Appellate Division reversed the motion court's decision and granted Defendants' motion for summary judgment.

The Court found Plaintiff's other causes of action to be without merit. First, absent a written agreement or evidence to support that the hospital maintained a severance benefits policy, Plaintiff had to demonstrate that the hospital had a regular practice of making severance payments to terminated employees and that she relied upon this practice during her employment. Plaintiff failed to present such evidence to support a breach-of-contract claim.

The Court also found that Plaintiff failed to produce any evidence that Defendants' actions were so outrageous in character and so extreme in degree that they went beyond the bounds of decency and were utterly intolerable in a civilized community; as such, Plaintiff failed to demonstrate a cause of action for intentional infliction of emotional distress.

Court Upholds Revocation of Physician's License for Gross Incompetence, Negligence, Creation of a False Report, Failure to Maintain Accurate Medical Records, and the Fraudulent Practice of Medicine

Ostad v. New York State Dep't of Health, 837 N.Y.S.2d 364, 2007 WL 1362637 (3d Dep't 2007). In an Article 78 proceeding, a physician sought review of a determination of the Hearing Committee of the State Board for Professional Medical Conduct (the "Hearing Committee") that revoked his license to practice medicine in New York.

The Bureau of Professional Medical Conduct (the "Bureau") brought seven separate charges of professional misconduct. After receiving testimony and reviewing the physician's records, the Hearing Committee sustained charges of physician's gross incompetence, negligence, creation of a false report, failure to maintain accurate medical records, and the fraudulent practice of medicine. The Appellate Division upheld the Hearing Committee's determinations.

First, the Appellate Division found no merit in the physician's initial contention that the charges against him lacked specificity. The record confirmed that the physician was given sufficient supplemental information prior to the hearing to prepare an adequate defense.

In reviewing the Hearing Committee's determinations, the Appellate Division's scope of review was limited to whether the determination was supported by substantial evidence. To support allegations of negligence, gross incompetence, and the failure to maintain accurate medical records, the Bureau presented both evidence and an expert. The evidence showed that the physician repeatedly prescribed antibiotics for children with sore throats without recording adequate medical histories or doing throat cultures, even though antibiotics were an improper remedy for the physician's diagnosis. The expert established the standard of care for diagnosing throat ailments in children and explained the adverse consequences of the improper prescription of antibiotics. The physician failed to offer an expert witness. He acknowledged that his notes did not reflect the patients' medical histories. He further admitted that he prescribed the antibiotics because his patients demanded them and because the antibiotics were a more appropriate remedy for low income patients, who could not afford more expensive medications or be expected to return for follow-up visits. In addition to finding the Bureau's expert testimony credible, the Hearing Committee also found that the physician believed that a lower standard of medical care was justified by his patients' lower economic status. This evidence established that the physician failed to exercise the care that a reasonably prudent physician would exercise under the circumstances and his conduct was sufficiently egregious to constitute gross incompetence.

The Court further confirmed the Hearing Committee's determination of the physician's fraudulent practice of medicine. A finding that a physician is guilty of fraud requires proof of either an intentional misrepresentation or concealment of a known fact and the intent or knowledge, which may be inferred from surrounding circumstances. Rejecting the physician's claim that his false answer on a hospital Medical Staff

application was a mistake, the Court found that the physician did have the intent to deceive because at the time because he was actively participating in ongoing disciplinary hearings, the very subject of the question on the application.

Finally, the Appellate Division concluded that, based on the physician's prior professional misconduct, revocation was not a penalty so disproportionate to his conduct that it would shock someone's fairness. The fraudulent conduct alone would be sufficient to uphold a revocation penalty. Furthermore, the physician was disciplined twice in the past and convicted for receiving Medicare kickbacks. The Court noted that the physician lacked contrition for his past errors and the necessary insight to avoid future misconduct.

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

You're a
New York State
Bar Association member.

You recognize the value and relevance of NYSBA membership.

For that we say,

thank you.

The NYSBA leadership and staff extend thanks to you and our more than 72,000 members — from every state in our nation and 109 countries — for your membership support in 2007.

Your commitment as members has made NYSBA the largest voluntary state bar association in the country. You keep us vibrant and help make us a strong, effective voice for the profession.

Kathryn Grant Madigan
President

Patricia K. Bucklin
Executive Director

NYSBA

In the New York State Legislature

By James W. Lytle

In what may just be a temporary respite from Albany, the New York State Legislature concluded its regular session during the third week of June, leaving a number of issues to be further debated and theoretically decided later this summer. A number of high profile issues, including campaign finance reform, Mayor Bloomberg's congestion reduction plan, and legislative and judicial pay raises have been deferred, with the possibility of a return to Albany as soon as mid-July.

In the health care arena, many of the larger policy and fiscal issues were, as is often the case, decided as part of the State Budget. Among the more significant bills passed by the Legislature after the passage of the Budget was a managed care reform bill that had been the subject of prolonged negotiations between providers and payors, a Family Health Plus "buy-in" proposal, bills relating to hospice care and a host of other proposals, described below.

Among the "near-misses" was a bill that would limit nurses' overtime in hospitals, diagnostic and treatment centers, nursing homes, home care agencies and mental hygiene facilities. In addition, disagreements over legislation to extend the authority of industrial development agencies to finance health care facilities and other civic facilities were not resolved. Despite much debate within and without the Legislature, no bill that sought to override the Berger Commission recommendations was passed by both houses, nor was a late-starter that would have provided some additional funding for workers displaced by the implementation of those recommendations. The Legislature was also unable to agree on legislation to legalize the medical use of marijuana or to expand HIV testing in certain health care settings. And, once again, no agreement was reached on legislation that would enact a Family Health Care Decisions Act to address health care decision-making by persons without health care proxies or decision-making capacity. These issues and other health care items may be reconsidered when the Legislature reconvenes at various times during the balance of 2007, but the contentiousness of the final weeks and post-recess period may not bode well for a successful resolution of these issues.

Whether or not the Legislature returns to address health care issues, interested parties should pay attention to developments in the Executive Branch over the next several months. With the new Spitzer team in place, work is being undertaken in many of the state agencies to place the new Administration's stamp on New York State policy. The Governor has pledged to begin budget negotiations over the 2008–9 State Budget as soon as late fall. In addition, the development of a health coverage expansion initiative, Medicaid reimbursement reform, more aggressive enforcement from the new Medicaid Inspector General, and new program initiatives from the Office of Mental Health, the Office of Mental Retardation and Developmental Disabilities and the Office of Alcoholism and Substance Abuse Services should be carefully monitored in the months ahead.

Selected highlights from the Legislative session include the following**:**

- **Family Health Plus Buy-In for Employers and Benefit Plans (A.5919B/S.6344):** Passed by both houses in the final days of the legislative session, this legislation would allow employers and Taft-Hartley benefit funds to offer FHPlus as a health insurance option for employees and members. Under existing law, individual families may "buy-in" to Child Health Plus ("CHPlus"), even if their income exceeds the eligibility limits, by paying full premium for coverage. This new legislation would create a similar option for employers and Taft-Hartley plans through FHPlus, while authorizing the State to contribute to the employee's share of the premium, if the employee is otherwise eligible for coverage under Medicaid, FHPlus, or CHPlus. This bill was already signed into law.
- **Healthy NY Labor-Management Benefit Fund Demonstration Project (S.6316/A.4859D):** This bill, which is very similar to a bill that was vetoed last year, would allow labor-management benefit funds to offer Healthy NY coverage to their members. The bill was advanced by SEIU 1199 and other unions as a means of addressing the challenges they face in funding health coverage for low-wage workers. The Executive Branch has questioned the adequacy of the Healthy NY stop loss funds to cover losses associated with benefit fund members. Accordingly, they advanced the FHPlus Buy-In bill as a vehicle for supporting the benefit funds. It is unclear at this point whether the Governor will sign this legislation into law.
- **Managed Care Reform (A.8128-A/S.3986-A):** This legislation imposes new requirements on health care payors and providers. It was passed by both houses and is expected to be signed into law. Specifically, the bill**:** requires out-of-network providers of services to Medicaid, FHPlus, and CHPlus beneficiaries to submit claims to plans within 15 months from the date of service; requires Preferred Provider Organization

(PPO) products to provide HEDIS quality data to the Department of Health; imposes a two-month "cooling off period" after the expiration of a contract between a hospital and a plan, during which the terms of the terminated contract would remain in place; expands the scope of the external review process to include denials of treatments that are not approved by a physician participating in the plan's network and are to be provided by an out-of-network practitioner; prohibits plans from denying claims for preauthorized services, except under certain circumstances.

- **Medicaid/FHPlus:** The following bills, passed by both houses, relate to Medicaid and FHPlus eligibility, fraud recoveries, and reimbursement:
  - **Disregard of Depreciated Assets (A.1301/S.1108):** Provides for a disregard of depreciation of assets in calculating the gross household income of self-employed farmers for purposes of determining FHPlus eligibility.
  - **Special Needs Trusts (A.1462A/S.5521):** Clarifies that income deposited in special needs trusts for people with disabilities is not countable in determining Medicaid eligibility.
  - **Continued Medicaid Eligibility for Inmates (S.5875A/A.8356A):** Continues the Medicaid eligibility of inmates of State and local corrections facilities. Although inmates may not access Medicaid-funded services (other than inpatient hospital care) while imprisoned, this bill would allow for immediate access to services upon release.
  - **Amendments to Medicaid Inspector General Legislation (A.4964/S.2801):** Clarifies that modifications of advisory opinions by the Commissioner of Health shall operate only prospectively and shall not result in retroactive recovery of overpayments made as a result of a provider's reliance on the original opinion.
  - **Hospital Rate Adjustment Based on Cost Report Correction (S.6168/A.9065):** Authorizes public hospitals outside of New York City and voluntary hospitals in New York City to receive a specified high Medicaid volume rate adjustment based on a revised cost report, provided that they had filed the initial report in a timely manner and that the correction was received by June 1, 2007.
- **Hospice Reimbursement and Establishment:** The Legislature passed several bills related to hospice and palliative care services:
  - **Hospice Palliative Care Program Reimbursement (A.7676/S.4518):** Repeals a provision of law that bars government reimbursement of services provided under the hospice palliative care program.
  - **Palliative Care Teaching (A.8081/S.5340):** Authorizes the use of palliative care teaching grants to train medical students in certified home health care agencies, long-term home health care programs, and AIDS home care programs.
  - **Hospice Residence Pilot Program (A.8082/S.5017):** Expands the hospice residence pilot program from three to ten sites.
- **Health Care Providers:** The following bills relate to the regulation of various health care professions and providers:
  - **Oversight of Office-Based Surgery (S.6052A/A.7948A):** Prohibits office-based surgery except in accredited settings and requires reporting of adverse events. The bill also classifies a violation of these requirements as professional misconduct. This bill was proposed by the Department of Health and is expected to be signed by the Governor.
  - **Publicly Traded Dialysis Centers (S.3987A/A.8100A):** Authorizes publicly traded dialysis companies to operate in New York. Under current law, publicly traded entities are prohibited from operating facilities licensed under Article 28 of the Public Health Law (e.g., hospitals, nursing homes, and clinics). However, publicly traded dialysis providers have been allowed to enter into management arrangements with New York dialysis providers that are not publicly traded. This bill would provide clear statutory authority for publicly traded dialysis companies to operate in New York.
  - **Pandemic Flu and Emergency Preparedness (S.4021A/A.8098A):** Requires clinical laboratories to make reports of diseases and health conditions directly to the State Department of Health in electronic form in accordance with standards to be promulgated by the Commissioner of Health consistent with national health information standards adopted by the federal Centers for Disease Control and Prevention and the Department of Health and Human Services. This bill was proposed by the Department of Health and will likely be signed by the Governor.
  - **Prescription of Controlled Substances by Physician Assistants (A.8456-A/S.4793-A):** Expands the scope of practice for physician assistants to allow for them to prescribe controlled substances for patients under the care of the physician responsible for the physician assistant's supervision.

- **The Elderly and People with Disabilities:** The following are some of the bills, passed by both houses, that relate to the elderly and people with disabilities:
  - **Cash and Counseling Program (A.1469/S.4440):** Establishes a "cash and counseling" program consistent with the federal Deficit Reduction Act provisions. Under this program, which would be established in up to 12 counties, self-directing Medicaid beneficiaries who require personal care services would be allocated a fixed budget with which to purchase the necessary personal care and other home- and community-based services, consistent with an assessment and service plan. Beneficiaries would be authorized to hire close family members to provide personal care services.
  - **Access for People with Disabilities (A.4932B/S.5670B):** Expands the scope of State Human Rights Law protections against discrimination on the basis of disability in public accommodations to conform to the Americans with Disabilities Act.

Vision Care (A.897/S.522): Authorizes the State Office for the Aging (SOFA) to establish a program to distribute grants to not-for-profit corporations to provide senior vision services to elderly persons with a visual impairment that interferes with their ability to perform daily living skills and tasks.

Geriatric Chemical Dependence Act (A.1453A/S.2902A): Establishes a geriatric chemical dependence demonstration program within the Office of Alcohol and Substance Abuse Services and an Interagency Council on Geriatric Chemical Dependence Services. Under the program, grants would be made to providers of chemical dependency services to the elderly within amounts to be appropriated.

- **Veterans Geriatric Mental Health Act (A.5154/S.5170):** Establishes a demonstration program to be administered by the Office of Mental Health in cooperation with the Division of Veterans' Affairs, the State Office for the Aging (SOFA) and any other agencies deemed necessary to operate the program, to provide grants to providers of mental health care for elderly veterans.
- **Naturally Occurring Retirement Communities (NORCs) (S.5911/A.8542):** Makes permanent the NORCs program.

Mr. Lytle is a partner in the Albany office of Manatt, Phelps & Phillips, LLP. **Please note that the author appreciates the assistance of Karen Lipson, Mark Ustin, Barbara Lee Steigerwald and Vanessa Wisniewski in the preparation of this article.**

In the New York State Agencies

By Frank Serbaroli

HEALTH DEPARTMENT

Neonatal Herpes Reporting and Laboratory Specimen Submission

Notice of adoption. The Department of Health amended §§ 2.1 and 2.5 of Title 10 N.Y.C.R.R. in order to enable diagnosis, prevention, and effective management of neonatal herpes and to call public attention to this disease. Filing date: January 30, 2007. Effective date: February 14, 2007. *See* N.Y. Register, February 14, 2007.

Expansion of the New York State Newborn Screening Panel

Notice of emergency rulemaking. The Department of Health amended §§ 69-1.2 and 69-1.3 of Title 10 N.Y.C.R.R. to add Krabbe disease to the New York State Newborn Screening Panel and to clarify the requirement for timely specimen transfer. Filing date: February 20, 2007. Effective date: March 7, 2007. *See* N.Y. Register, March 7, 2007.

Criminal History Record Check

Notice of emergency rulemaking. The Department of Health added Part 402 to Title 10 N.Y.C.R.R. to implement Chapter 769 of the Laws of 2006 and a chapter of the Laws of 2006 (Section 6630) by requiring nursing homes, certified home health agencies, licensed home care services agencies, and long-term home health care programs to request criminal background checks of certain prospective employees. Filing date: February 26, 2007. Effective date: February 26, 2007. *See* N.Y. Register, March 14, 2007.

Licensure and Practice of Nursing Home Administration

Notice of emergency rulemaking. The Department of Health amended Part 96 of Title 10 N.Y.C.R.R. to refine and streamline the existing regulations and ensure their consistency with the policies and directives of the Board of Examiners of Nursing Home Administrators. Filing date: March 6, 2007. Effective date: March 21, 2007. *See* N.Y. Register, March 21, 2007.

SPARCS Definition of Ambulatory Surgical Procedures

Notice of adoption. The Department of Health amended § 400.18 of Title 10 N.Y.C.R.R. to improve reporting to the Statewide Planning and Research Cooperative System ("SPARCS") of surgical procedures performed in freestanding and hospital based ambulatory surgery centers. Filing date: March 9, 2007. Effective date: March 28, 2007. *See* N.Y. Register, March 28, 2007.

Assisted Living Residence

Notice of proposed rulemaking. The Department of Health gave notice of its intent to add Part 1001 to Title 10 N.Y.C.R.R. to further the goals of the Assisted Living Reform Act by creating the regulatory framework necessary for implementation of the provisions therein. *See* N.Y. Register, March 28, 2007.

Federally Qualified Health Centers 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 Medicaid billing for individual psychotherapy services provided by certified social workers in article 28 Federally Qualified Health Centers. Filing Date: March 16, 2007. Effective Date: March 16, 2007. *See* N.Y. Register, April 4, 2007.

Criminal History Record Check

Notice of proposed rulemaking. The Department of Health gave notice of its intent to repeal § 400.23 and amend §§ 763.13(b) and 766.11(f) of Title 10 N.Y.C.R.R. and to amend § 505.14(d)(4)(i) of Title 18 N.Y.C.R.R. because these sections were repealed and amended by operational law. *See* N.Y. Register, April 18, 2007.

Serialized Official New York State Prescription Form

Notice of emergency rulemaking. The Department of Health added Part 910 and amended Parts 85 and 80 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: April 9, 2007. Effective date: April 9, 2007. *See* N.Y. Register, April 25, 2007.

INSURANCE DEPARTMENT

Healthy New York Program

Notice of adoption. The Department of Insurance added § 362-2.7 and amended §§ 362-2.5, 362-3.2, 362-4.1, 362-4.2, 362-4.3, 362-5.1, 362-5.2, 362-5.3, and 362-5.5 of Title 11 N.Y.C.R.R. to reduce Healthy New York premium rates to enable more uninsured businesses and individuals to be able to afford health insurance and generally improve the Healthy New York Program. Filing date: January 16, 2007. Effective date: January 31, 2007. *See* N.Y. Register, January 31, 2007.

Minimum Standards for the Form, Content, and Sale of Health Insurance

Notice of emergency rulemaking. The Department of Insurance amended Part 52 (Regulation 62) of Title 11 N.Y.C.R.R. to clarify when plans may exclude coverage for cosmetic surgery. Filing date: February 5, 2007. Effective date: February 5, 2007. *See* N.Y. Register, February 21, 2007.

Arbitration

Notice of emergency rulemaking. The Department of Insurance amended Sub-part 65-4 (Regulation 68-D) of Title 11 N.Y.C.R.R. to provide procedures for the administration of the special expedited arbitration for disputes regarding the designation of the insurer for first part benefits. Filing date: February 23, 2007. Effective date: February 23, 2007. *See* N.Y. Register, March 14, 2007.

Healthy New York Program

Notice of emergency rulemaking. The Department of Insurance added §§ 362-2.7(d)-(f) and 362-2.8 to Title 11 N.Y.C.R.R. to create additional health insurance options for qualifying small employers and individuals by requiring health maintenance organizations and participating insurers to offer high deductible health plans in conjunction with the Healthy New York Program. Filing date: March 9, 2007. Effective date: March 9, 2007. *See* N.Y. Register, March 28, 2007.

Rules Governing Individual and Group Accident and Health Insurance Reserves

Notice of proposed rulemaking. The Department of Insurance gave notice of its intent to repeal Part 94 and add new Part 94 (Regulation 56) to Title 11 N.Y.C.R.R. to prescribe rules and regulations for valuation of minimum individual and group accident and health insurance reserves including standards for valuing certain accident and health benefits in life insurance policies and annuity contracts. *See* N.Y. Register, April 25, 2007.

Compiled by Francis J. Serbaroli. Mr. Serbaroli is a partner in Cadwalader, Wickersham & Taft LLP's 17-attorney health law department. He is the Vice Chairman of the New York State Public Health Council, writes the "Health Law" column for the *New York Law Journal*, and serves on the Executive Committee of the New York State Bar Association's Health Law Section. He is the author of "The Corporate Practice of Medicine Prohibition in the Modern Era of Health Care" published by BNA as part of its Business and Health Portfolio Series. The assistance of Jared L. Facher and Ariel Gordon of Cadwalader, Wickersham & Taft LLP, in compiling this summary is gratefully acknowledged.

Available on the Web
Health Law Journal
www.nysba.org/HealthLawJournal

Back issues of the *Health Law Journal* (1996-present) are available on the New York State Bar Association Web site

Back issues are available in pdf format at no charge to Section members. You must be logged in as a member to access back issues. Need password assistance? Visit our Web site at www.nysba.org/pwhelp. For questions or log-in help, call (518) 463-3200.

***Health Law Journal* Index**

For your convenience there is also a searchable index in pdf format.

In the Journals

American Journal of Bioethics, Vol. 7, No. 3 (March 2007)

- *Determining Risk in Pediatric Research with No Prospect of Direct Benefit: Time for a National Consensus on the Interpretation of Federal Regulations*, C.B. Fisher, S.Z. Kornetsky & E.D. Prentice
- *Difficult Hospital Inpatient Discharge Decisions: Ethical, Legal and Clinical Practice Issues*, R.N. Swidler, T. Seastrum & W. Shelton
- *Compelled Authorizations for Disclosure of Health Records: Magnitude and Implications*, M.A. Rothstein & M. K. Talbott

American Journal of Law and Medicine, Vol. 32, No. 4 (2006)

- *My Computer, My Doctor: A Constitutional Call for Federal Regulation of Cybermedicine*, C.E. Lewis
- *The Mental Health Paradigm and the MacArthur Study: Emerging Issues Challenging the Competence of Juveniles in Delinquency Systems*, D.R. Katner

Indiana Health Law Review, Vol. 3, No. 2 (2006)

- *Pay-for-Performance in Central Indiana*, David E. Kelleher & J. Marc Overhage

Journal of Health Care Law and Policy, Vol. 9, No. 2 (2006)

- *The Role of Medicare in Medical Malpractice Reform*, W.M. Sage
- *A New Prescription for America's Medical Liability System*, P.J. Barringer III
- *Medical Liability and Patient Safety Reform: Are Health Courts and Medicare the Keys to Effective Change?*, R.R. Bovbjerg
- *Health Court and Malpractice Claims Adjudications Through Medicare: Some Questions*, T.S. Jost
- *An Advocate's Response to Professor Sage*, T.S. Edelman
- *The Patient-Physician Relationship and Its Implications for Malpractice Litigation*, D. Roter, Dr. P.H.
- *"But I'm an Adult Now . . . Sort Of": Adolescent Consent in Health Care Decision-Making and the Adolescent Brain*, P. Arshagouni
- *The Increasing Necessity of the Tort System in Effective Drug Regulation in a Changing Regulatory Landscape*, A.E. Haffner.
- *Time for Plan B: Increasing Access to Emergency Contraception, and Minimizing Conflicts of Conscience*, E.S. Mellick.

Journal of Law, Medicine and Ethics, Vol. 34, No. 4 (Winter 2006)

- *Meeting the Growing Demands of Genetic Research*, R. Gibbs & A.L. McGuire
- *To Tell or Not to Tell: Disclosing Medical Error*, W. Winslade & E.B. McKinney
- *The Devil's Choice: Re-Thinking Law, Ethics, and Symptom Relief in Palliative Care*, R.S. Magnusson
- *The Marginally Viable Newborn: Legal Challenges, Conceptual Inadequacies, and Reasonableness*, S.A. Sayeed
- *When Doing the Right Thing Means Breaking the Law—What Is the Role of the Health Lawyer?* R. Schwartz

Widener Law Review, Vol. 12, No. 1 (2005)

- *Making Patient Safety and a "Homelike" Environment Compatible: A Challenge for Long Term Care Regulation*, M.B. Kapp
- *To HIPAA, a Son: Assessing the Technical, Conceptual, and Legal Frameworks for Patient Safety Information*, N.P. Terry
- *Can Adhesive Labels Prevent Wrong Site Surgery and Reduce Liability Risk?*, J.W. Saxton & M.M. Finkelstein
- *Collaborating on Patient Safety: Legal Concerns and Policy Requirements*, B.A. Liang.
- *Combating Those Ugly Medical Errors—It's Time for a Regulatory Makeover!*, J.D. Blum

Yale Journal of Health Policy, Law, and Ethics, Vol. 7, Issue 1 (Winter 2007)

- *Pay-for-Performance: Is Medicare a Good Candidate?*, M.F. Cannon
- *The Three Faces of Retainer Care: Crafting a Tailored Regulatory Response*, F. Pasquale
- *Fluconomics: Preserving Our Hospital Infrastructure During and After a Pandemic*, V.J. Williams
- *Mortality, Equality, and Bioethics*, E. Cohen
- *The Medical Resident Working Hours Debate: A Proposal for Private Decentralized Regulation of Graduate Medical Education*, A. Ciolli

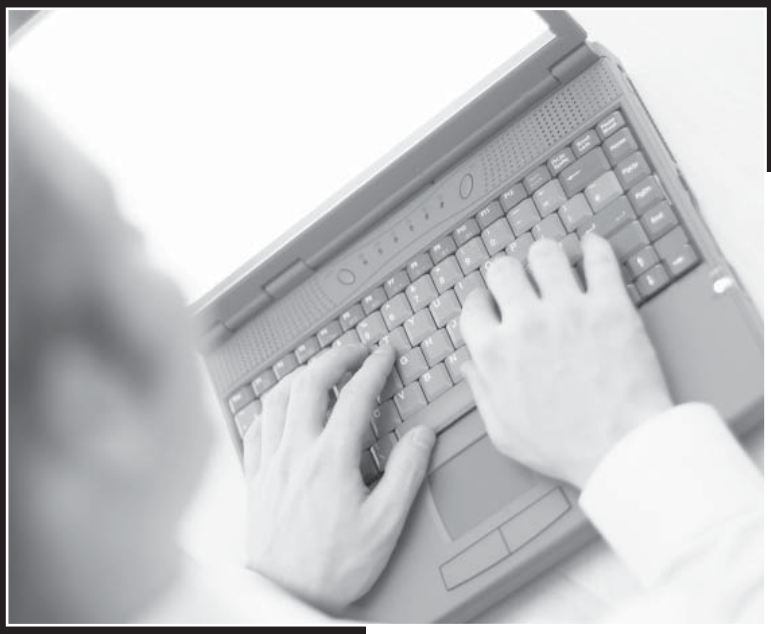
Other Journals

- *Ancillary Service and Self-Referral Arrangements in the Medical and Legal Professions: Do Current Ethical, Legislative and Regulatory Policies Adequately Serve the Interests of Patients and Clients?*, B. P. Falit, 58 S. Carolina L. Rev. 371 (Winter 2006)
- *Consumer-Defined Health Plans: Emerging Challenges to Tort and Contract*, E. H. Morreim, 39 J. of Health L. 307 (Summer 2006)

- *Data Mining and Substandard Medical Practice: The Difference between Privacy, Secrets and Hidden Defects*, B. R. Furrov, 51 Villanova L. Rev. 803 (2006)
- *Difficult Hospital Inpatient Discharge Decisions: Ethical, Legal and Clinical Practice Issues*, R. Swidler, T. Seastrum & W. Shelton, 7 Am. J. Bioethics 23 (March 2007)
- *Disability and the End of Life*, A. Ouellette, 85 Oregon L. Rev. 123 (2006).
- *Dishonest Medical Mistakes*, M.J. Mehlman, 59 Vanderbilt L. Rev. 1137 (May 2006)
- *Don't Ask, Don't Tell: HIPAA's Effect on Informal Discovery in Products Liability and Personal Injury Cases*, D.M. Roche, 2006 Brigham Young Univ. L. Rev. 1075
- *The Impact of the War over the Corporate Attorney-Client Privilege on the Business of American Health Care*, S.H. Duggin, 22 J. of Contemporary Health L. and Policy 301 (Spring 2006).
- *Not Just a Minimum Income Policy for Physicians: The Need for Good Faith and Fair Dealing in Physician Deselection Disputes*, S.D. Coppolo, 48 William and Mary L. Rev., 677 (2006)
- *Patients and Biobanks*, E.W. Clayton, 51 Villanova L. Rev. 793 (2006)
- *Prescribing the Best Facilities for Our Nation's Health Care: Physician-Owned Facilities vs. Community Hospitals*, K. E. Ericksen, 8 J. L. and Family Studies 449 (2006)
- *Rethinking Peer Review: Detecting and Addressing Medical Malpractice Claims Risk*, I.N. Moore et al., 59 Vanderbilt L. Rev., 1175 (May 2006)

The Editor thanks Eric J. Swidler for his assistance in compiling this list of recent journal articles.

A Pro Bono Opportunities Guide For Lawyers in New York State *Now Online!*



Looking to volunteer? This easy-to-use guide will help you find the right opportunity. You can search by county, by subject area, and by population served. A collaborative project of the Association of the Bar of the City of New York Fund, New York State Bar Association, Pro Bono Net, and Volunteers of Legal Service.

powered by probono.net

NYSBA
NEW YORK STATE BAR ASSOCIATION

You can find the Opportunities Guide on the Pro Bono Net Web site at **www.probono.net/NY/volunteer**, through the New York State Bar Association Web site at **www.nysba.org/volunteer**, through the Association of the Bar of the City of New York Web site at **www.abcny.org/volunteer**, and through the Volunteers of Legal Service Web site at **www.volsprobono.org/volunteer**.

VOLS
Volunteers of Legal Service

For Your Information

By Claudia O. Torrey

According to the Medicare website,[1] long-term care is defined as a variety of services that include both medical and non-medical care to people who have a chronic illness or disability.[2] It is estimated that approximately nine million men and women over the age of 65 will need long-term care this year; by 2020, the estimate increases to twelve million.[3]

Most scientists do not believe that our life spans are inherited.[4] "After all, for most of our hundred-thousand-year existence—all but the past couple of hundred years—the average life span of human beings has been thirty years or less. . . . Today, the average life span in developed countries is almost eighty years. If human life spans depend on our genetics, then medicine has got the upper hand. We are, in a way, freaks living well beyond our appointed time."[5]

All humor aside, this country has a dearth of geriatricians. "It is a specialty of little interest to medical students because geriatricians are paid relatively poorly and are not considered superstars in an era of high-tech medicine. In fact, the credo of geriatric medicine is 'less is more.'"[6] Given this stark reality, it was prudent that in February 2007, President Bush signed legislation restoring federal funding to the Title VII Geriatrics Health Professions Programs (federal initiatives that train a wide array of healthcare providers to better meet the unique health care needs of older adults) for the remainder of fiscal year 2007;[7] the $31.5 million earmarked for this legislation restored funding to fiscal 2005 levels, since Congress had eliminated funding for the programs in fiscal year 2006 with disastrous results.[8] Hopefully, lessons learned will prevent elimination of these federal funds in the 2008 fiscal year budget.

Ironically, effective June 2007, for the first time ever, the Centers for Medicare and Medicaid Services ("CMS") plans to post a broad comparison of hospital death rates for both heart attack and heart failure.[9] Once a closely guarded secret, CMS "will name the high-risk hospitals along with all the others, . . . but does not plan to take corrective action. Instead . . . they hope to shame them into doing better."[10] This type of available information could not have come at a better time, given the earlier stated estimated future numbers of people who will need long-term care.

Medicine may be on the edge of a future transformation into pay-for-performance. That is, physicians and hospitals will be financially rewarded for the quality of their professional performance.[11] Last year, Congress authorized CMS to develop a pay-for-performance plan by 2009.[12] The three-year pilot project implemented as a result of this authorization has so far done so well that it has been extended for an additional three years.[13] Who knows? With this potential trend, at least in the area of geriatric medicine, "less is more" may finally be financially rewarded.

Endnotes

1. Http://www.medicare.gov/LongTermCare (last viewed on May 24, 2007).
2. *Id*.
3. *Id*.
4. Reported in *The New Yorker*, www.newyorker.com/reporting/2007/04/30/070430fa_fact_gawande, from Atul Gawande, *The Way We Age Now*, Annals of Medicine (April 30, 2007) (last viewed on May 24, 2007).
5. *Id*.
6. Jane Gross, *Geriatrics Lags in Age of High-Tech Medicine*, New York Times, www.nytimes.com/2006/10/18/health/18aged.html (last viewed on May 25, 2007).
7. *Washington Update: Title VII Funding, MedPAC Report, DHHS and Medicare Drug Prices, Hospital Pay-for-Performance Pilot Program*, 15 Annals of Long Term Care 16-18 (April 2007).
8. *Id*.
9. Http://www.usatoday.com/news/health/2007-05-22-death-rates_N.htm (last viewed on May 24, 2007); *see also* hospitalcompare.hhs.gov.
10. *Id*. This author notes that of the hospitals highlighted in this article, the facility with the best numbers against the national averages regarding both heart attack and heart failure mortality is located in New York State!
11. *Supra* note 6.
12. *Supra* note 8.
13. *Supra* note 6.

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

Catch Us on the Web at WWW.NYSBA.ORG/HEALTH

Special Edition Introduction

By Raul Tabora, Special Edition Editor

The past two years in the field of long-term care have brought about significant proposals for change within the system as it concerns those in need of chronic care and those suffering from disabilities. One of the goals of the Committee on Long Term Care of the Health Section is to focus on this time of planning and transition by contributing to the educational mission of NYSBA.

The current edition of the *Health Law Journal* brings together articles regarding new developments within assisted living and continuing care while also providing a summary of the Federal-State Health Reform Partnership, or F-SHRP, within the area of long-term care. As the LTC system and policy makers move toward a complete overhaul of funding and the methods of delivering services in this area, we hope to heighten the level of education, analysis and advocacy which will be needed for attorneys who serve all of the stakeholders in this area.

Among our objectives for the coming fall and winter is to plan three teleconference presentations for our committee meetings during the year to include CLE credits. The sessions will be posted and information provided through the Bar Association but will focus on assisted living programs (ALPs) and assisted living residences (ALRs) for an October 10, 2007 teleconference in Albany; an October 22, 2007 teleconference in Rochester on managed care in the LTC world; and a teleconference focusing on developments on Medicare-expedited determinations in November of 2007 in Lake Success. Our work will also seek to involve other committees and possibly associations to plan a CLE program on assisted living and other integrative housing models in addition to a conference on LTC issues. Lastly, we hope to explore the development of a white paper or other appropriate submission on state and federal initiatives and plans for long-term care.

Raul Tabora is a member of the firm of Ruffo, Tabora, Mainello & McKay, PC, of Albany, New York, a firm focusing on health care in general and long-term care in particular.

F-SHRP: A Strong Note for Reform

By Mark R. Ustin

On March 16, 2005, Secretary of Health and Human Services (HHS) Mike Leavitt announced conceptual support for an innovative proposal to fund a broad spectrum of health care reform in New York State.[1] Proposed by Governor George Pataki 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), the Federal-State Health Reform Partnership (F-SHRP) represented a potential investment of $1.5 billion of federal funds. The mere possibility of such a significant investment changed health care policy making in New York State before the agreement was even finalized. The final agreement, and particularly the conditions placed on the funding by the federal government, have driven further policy changes, and can be expected to effect permanent modifications to health care delivery in the State.

This article will briefly recount the history of the F-SHRP initiative and examine the conditions placed on it by HHS, with a particular emphasis on the agreement's impact on long-term care. It will then examine the current status of the initiative, and provide some sense of the next steps to be taken in its implementation.

History and Basic Terms of Agreement

The March 16, 2005, HHS announcement represented only the beginning of what proved to be an arduous process of negotiation between the New York State Department of Health (DOH) and HHS's Centers for Medicare and Medicaid Services (CMS). F-SHRP is technically a Medicaid Section 1115 Demonstration, and its approval was tied to the renewal of the State's existing 1115 waiver. That waiver was originally set to expire on March 31, 2006. However, the negotiation of the F-SHRP initiative made that renewal unusually difficult, necessitating a total of ten extensions over a period of six months before a final agreement was reached on September 29, 2006.

During that time, the mere possibility of F-SHRP funding itself had a profound effect on state policy making. In fact, many would credit it with providing the impetus for legislative agreement to the Commission on Health Care Facilities in the Twenty-First Century (known colloquially as the "Berger Commission"), the State commission charged with recommending substantial, enforceable changes to the hospital and nursing home industries in the State, with which the F-SHRP initiative is still closely linked.[2] Similarly, the finalization of the agreement on September 29, 2006, could be credited with persuading the Legislature not to reject the Berger Commission's final report issued on November 29, 2006,[3] as it was authorized to do, prior to January 1, 2007.[4] Certainly, the agreement's terms and conditions concerning Medicaid fraud and abuse have driven, and will continue to drive, policy decisions on that front. Similarly, those terms and conditions carry substantial implications for the State's ongoing policy regarding long-term care.

At its core, F-SHRP is an agreement that CMS will provide federal Medicaid matching funds for certain identified State programs that previously were ineligible for such funding, in return for the State meeting certain identified terms and conditions, including minimum spending thresholds, specific performance benchmarks and a specific level of Medicaid program savings. The F-SHRP agreement is embodied in a series of documents available on the DOH website,[5] including the CMS approval letter, a statement of Special Terms and Conditions (STCs), a list of the Medicaid requirements formally waived in connection with the program, and a list of the State expenditures previously ineligible for federal financial participation that provide the vehicle for transferring F-SHRP funds to the State. The STCs, and the program in general, are effective from October 1, 2006, through September 30, 2011, and, unlike other waiver programs, F-SHRP may not be extended beyond its expiration date.

The STCs identify three "reform initiatives that the State will pursue under this Demonstration":[6]

1. "Rightsizing Acute Care Infrastructure": The STCs specifically note that F-SHRP is intended to assist the efforts of the Berger Commission to reduce future Medicaid inpatient hospital costs by reconfiguring the State supply of hospital beds to better account for the migration of patients to outpatient settings.

2. "Improvement in Primary/Ambulatory Care": Logically, the STCs also identify the expansion of primary care and disease management services, and the collection of additional data concerning outpatient services, as goals to be supported by F-SHRP funds.

3. "Reforming Long Term Care": Finally, the STCs also state that F-SHRP funds are intended to be

used to assist in "rightsizing" the State's long-term care system (another Berger Commission objective), and implementing the State's single point of entry (SPOE) system, a "home modification program to enable recipients to stay at home" (the State's "Access to Home Program"[7]), and a telehome care program.

This list really represents only the philosophical foundation of the F-SHRP initiative. In fact, the list of reform programs which will benefit from the F-SHRP initiatives is much broader.

The mechanism by which this will occur is complex. As noted, under the F-SHRP demonstration, CMS will provide federal financial participation (FFP) for certain State programs that previously were ineligible for such funding, in return for the State meeting certain minimum spending thresholds, specific performance benchmarks and a specific level of Medicaid program savings. Each of these will be examined in turn.

Medicaid Managed Care Provisions

As an initial matter, however, it must be recalled that the STCs occur within the context of the State's existing 1115 waiver. Consequently, several of its provisions relate directly to the State's Medicaid managed care program, and do not obviously mesh with the rest of the agreement directly governing the transfer of the new federal funds. Nonetheless, these provisions are important to an overall understanding of the agreement. Specifically, the STCs:

1. Require mandatory managed care enrollment in the 14 counties that had not previously implemented mandatory programs;[8]
2. Require, in the counties previously participating in mandatory managed care, the enrollment of two groups for which managed care was not previously mandatory, namely, (i) individuals over age 65 and (ii) Supplemental Security Income (SSI) recipients; and
3. Allow voluntary enrollment in Medicaid managed care of two new groups, namely (i) individuals who are HIV+ and (ii) individuals with severe and persistent mental illness and children with serious emotional disturbances, except those individuals whose benefits are provided through Medicaid fee-for-service.[9]

Moreover, the State is subject to a "budget neutrality cap" on its expenditures on Medicaid managed beneficiaries, whereby it cannot spend more on those beneficiaries, on a per capita basis, than it would have spent without the F-SHRP demonstration.[10] The cap is calculated annually. If the State exceeds the annual cap by more than a specified percentage (ranging from 1 percent in year one of the demonstration to 0 percent in year five), then the State must submit a corrective action plan to CMS for approval. If, at the end of the demonstration period, the cumulative five-year cap has been exceeded, the excess federal funds must be returned.

This cap is distinct from State spending and the overall Medicaid savings threshold imposed by the STCs, and it is less important to the overall F-SHRP agreement than the actual expansion of mandatory managed care. The latter is likely to be of pivotal importance when evaluating whether the State has achieved the required overall savings threshold, which will be discussed in more detail below.

Spending Thresholds

The STCs require the State to meet two spending thresholds in order to receive the $1.5 billion in federal funding. In short, the State must annually invest $600 million in "approved reform initiatives" and $600 million in "designated state health programs" in order to receive $300 million in annual federal financial participation (FFP). However, these numbers are deceptive, and oversimplify the complex web of obligations established by the STCs.

In general, the State must meet certain minimum investments in the approved reform initiatives in order to qualify for the federal funds, which can only be drawn down as FFP for the designated State health programs.[11] Some identified State programs are both approved reform initiatives and designated State health programs, but not all. In order to understand fully the relationship between the approved reform initiatives and designated State health programs, it is useful to examine each of them in turn, as well as how State and federal funds flow between them.[12]

Approved Reform Initiatives

The list of approved reform initiatives includes those initiatives identified above, but is broader. In fact, the STCs essentially divide such initiatives into two separate lists: certain general initiatives, or types of initiatives, that *must* be funded in order to receive FFP, and other more specific initiatives that *may* be funded for that purpose.

The State *must* invest in the same general initiatives that provide the underlying rationale for F-SHRP in the first place, namely, (i) reducing excess capacity in the acute care system, (ii) improving ambulatory and primary care services, and (iii) shifting emphasis in long-term care from institutional-based to community-based settings. The State must also invest to "expand the use of e-pre-

scribing, electronic medical records and regional health information or organizations" and, more generally, invest in "programs that will promote the efficient operation of the State's health care system."[13]

These investments *may* include investments in (i) reform activities "consistent with the goals of [the] Health Care Efficiency and Affordability Law for New Yorkers (HEAL NY)," pursuant to which the State is expending $1 billion over four years to "encourage improvements in the operation and efficiency of the health care delivery system," (ii) the Department of Health's indigent care payments to diagnostic and treatment centers, (iii) the State Office for the Aging's Expanded In-home Services for the Elderly Program (EISEP), (iv) the Office of Mental Health's Community Support Services and Residential Services Program and New York University Child Studies Center, and (v) the Office of Alcoholism and Substance Abuse Services' Prevention and Treatment Program. Any additional investments in programs that the State wishes to consider approved reform initiatives require an amendment to the STCs.[14]

Designated State Health Programs

The following programs (not including administrative costs) qualify as "designated state health programs":

1. Health Care Reform Act programs, including:
   a. Healthy New York;
   b. AIDS Drug Assistance Program (ADAP);
   c. Tobacco Use Prevention and Control;
   d. Health Workforce Retraining;
   e. Recruitment and Retention of Health Care Workers;
   f. Telemedicine Demonstration; and
   g. Pay for Performance Initiatives.
2. Office for the Aging programs, including:
   a. Community Services for the Elderly (CSE);
   b. Expanded In-home Services for the Elderly Program (EISEP).
3. Office of Mental Health: Community Support Services and Residential Services Program.
4. Office of Mental Retardation and Developmental Disabilities: Residential and Community Support Services.
5. Office of Alcoholism and Substance Abuse Services: Prevention and Treatment Program.
6. Office of Children and Family Services: Committees on Special Education Direct Care Programs.
7. Department of Health: Early Intervention Program.[15]

As noted, the relationship among the approved reform initiatives, designated state health programs and the federal funds is complex. The STCs specifically require the State to invest $3 billion in approved reform initiatives to receive the $1.5 billion of F-SHRP funding.[16] On its face, this seems a lot like traditional FFP. However, while the State explicitly cannot draw down the federal funds until such time as corresponding expenditures are made on these approved reform initiatives,[17] and those federal funds are technically FFP, they are not directly tied to such expenditures. Rather, they are directly tied to State expenditures on the designated state health programs.[18] Thus, sufficient investment in the approved reform initiatives is a condition for receipt of that FFP, but does not make those initiatives automatically eligible for FFP. In fact, the only time an expenditure on an approved reform initiative would be eligible for FFP is where that initiative is also a designated state health program.

In this regard, it is instructive to compare the list of approved reform initiatives and the list of designated state health programs. While overlapping, they are not identical, and in fact are conceptually distinct—the approved reform initiatives are programs in which the State must invest in order to continue to receive F-SHRP FFP, whereas the designated state health programs are programs by means of which the State will receive F-SHRP FFP. Thus, for example, the State's obligation to invest in the approved reform initiatives can be satisfied by investment in EISEP, and that investment can in turn draw down FFP. In contrast, the State's investment in indigent care payments for diagnostic and treatment centers will satisfy the requirement to invest in approved reform initiatives without it drawing down FFP, and any investment in the Early Intervention Program will draw down FFP without qualifying as investment in an approved reform initiative.

The implication of this arrangement is obvious: Even though, in contrast to the approved reform initiatives, there is technically no minimum State investment in the designated State health programs, in effect the State must invest at least $600 million per year in the designated State health programs, in addition to the $600 million per year investment in approved reform initiatives, in order to draw down the full $300 million per year in FFP. While in practice there will be substantial overlap, since several programs are both approved reform initiatives and designated state health programs, these are actually distinct obligations. This distinction is bound to have a substantial

impact on future funding decisions made by the State during the pendency of the F-SHRP initiative.

Annual Cap

Also significant is the overall cap on FFP. Across the duration of the program, FFP is limited to the lesser of $1.5 billion or half the money expended by the State on approved reform initiatives.[19] Even more significant, however, is the fact that this is actually an annual cap—on an annual basis, FFP is limited to the lesser of $300 million or half the money expended by the State on approved reform initiatives in that year, and State expenditures cannot be carried over from year to year for accounting purposes.[20] Thus, if the State expends $500 million in year one ($100 million less that it is required to expend in order to receive the full $300 million in federal financial participation), and $700 million in year two ($100 million more than it is required to spend), thus achieving its spending goal of $1.2 billion over two years, federal financial participation will be limited to $550 million ($250 million for year one plus $300 million for year two), rather than the expected $600 million. This requirement has significant implications for the implementation of approved reform initiatives, which must be structured to ensure sufficient expenditures in each federal fiscal year.

Performance Milestones

As noted, the STCs also require the State to meet several performance milestones.[21] The milestones include:

1. *Fraud and Abuse:* The State must increase its Medicaid fraud and abuse recoveries from less than 1% of its Medicaid expenditures in 2005 ($42.9 billion) to 1.5% of its 2005 expenditures ($644 million) by September 30, 2011. This is to be accomplished on an incremental basis, with the State filing a fraud and recovery plan with CMS by October 31, 2006, and making the following minimum annual fraud recoveries:

	% of 2005 Medicaid Expenditures	Dollar Amount
September 30, 2008	.5%	$215 million
September 30, 2009	.75%	$322 million
September 30, 2010	1.0%	$429 million
September 30, 2011	1.5%	$644 million

   While these anticipated recoveries are ambitious, recent additions to the State's arsenal of enforcement tools, including the enactment of a State False Claims Act and additional staff for the Office of the Medicaid Inspector General, help to make them achievable.

2. *Preferred Drug List:* DOH was required to implement a preferred drug list for Medicaid mandatory, optional and expansion populations, with the exception of enrollees in Family Health Plus, by February 1, 2007.

3. *Reporting:* DOH was required to report to CMS by November 30, 2006, certain data concerning hospitals, nursing homes, and managed care, including (i) total hospital discharges, Medicaid discharges, expenditures and debt; (ii) total nursing home days, Medicaid days, expenditures and debt; (iii) total fee-for-service and managed care expenditures and enrollment for Temporary Assistance to Needy Families (TANF) and Supplemental Security Income (SSI) enrollees, including the aged. In addition, such data is required to be reported quarterly and annually on an ongoing basis.

4. *Employer Sponsored Insurance:* Subject to CMS approval, the State must implement a program to increase private health insurance coverage among employed but uninsured New Yorkers by January 1, 2008, and document the impact of that program by January 1, 2009.

5. *Cost Containment Initiatives:* By October 31, 2006, the State was required to implement various previously enacted cost containment initiatives, including:
   a. Restructuring the Family Health Plus benefit package;
   b. Increasing Medicaid drug co-payments;
   c. A one-year freeze on managed care premiums and an administrative cost cap;
   d. Mandatory managed care enrollment for SSI recipients;
   e. Expanding the managed long-term care program;
   f. A "collaborative multiple payer Pay for Performance demonstration."

   In addition, the State was required to implement "at least one new Medicaid cost efficiency initiative," either by February 1, 2007 (if done administratively), or January 1, 2008 (if requiring legislative approval; in addition, such approval must have been granted by July 1, 2007).

6. *ADA Compliance:* By March 31, 2007, the State was required to submit a report outlining the State's plan for updating its on-site reviews of ADA compliance, and an evaluation of possible incentives for managed care organizations to improve accessibility at beneficiary point-of-service.

7. *Single Point of Entry:* Subject to CMS approval, by April 1, 2008 the State must implement "a program to create a single-point-of-entry for Medicaid recipients needing long-term care in at least one region of the State."

8. *Berger Commission:* Finally, among the performance milestones are two related to the Berger Commission. By January 31, 2007, the State was required to submit a report to the federal government that included:

    a. Certification that there are "no State statutory impediments to implementation of the Commission's recommendations on reconfiguring the State's general hospital and nursing home bed capacity";

    b. The "steps taken to implement the recommendations"; and

    c. A "timeline for implementation."

    By July 15, 2008, the State must submit a report to the federal government that includes:

    a. Certification that "each of the Commission's recommendations has been acted upon, as well as the strategy and timeline for full implementation"; and

    b. "[H]ow the implementation of the Commission's recommendations will impact the provision of primary/ambulatory care services in affected communities."

9. *Reporting:* The State must make several different sorts of progress reports to CMS, including monthly conference calls, quarterly reports, and more expansive annual reports.[22]

10. *Compliance:* Finally, the performance milestones include a general requirement of "compliance with Administration policy."[23]

Thus far, the State has apparently met all necessary deadlines. Failure to meet any of these milestones will result in termination of the demonstration, with one exception[24]—if the State does not meet its fraud targets in any given year, the State must pay the federal government the lesser of the difference between the actual and target recoveries or total claimed FFP for designated state health programs for that year, not to exceed $500 million over the five-year demonstration period.[25]

Several of these performance milestones, like the fraud recovery targets, impose easily ascertainable benchmarks. Others may be subject to interpretation. For instance, in many cases, where the STCs require the creation of a State program, they also specify that the State must maintain such program throughout the term of the F-SHRP initiative. In other cases, however, that is not explicitly required. It remains to be seen whether that inconsistency is intentional, or (perhaps more immediately) whether the State will even test that issue. However, it is clear that the performance milestones in the STCs may be subject to interpretation.

Demonstrated Savings

Finally, in what the STCs refer to as a "sub cap" to the Medicaid neutrality otherwise required of the demonstration, F-SHRP must also generate at least $3 billion in gross Medicaid savings, including at least $1.5 billion in federal savings, over the life of the demonstration.[26] That savings is to be measured by two factors: (1) the savings generated through the Medicaid managed care expansions and (2) the savings generated by decreased hospital utilization resulting from eliminating excess acute care capacity.

The savings generated through the Medicaid managed care expansions will be calculated by examining the difference between what is spent on the applicable beneficiaries and what would have been spent absent the expansion. The savings generated by decreased hospital utilization will be calculated by examining the difference between the cost of Medicaid hospital discharges before implementation of the demonstration and the cost of such discharges after implementation. Both will be calculated on an annual basis, but no reconciliation will occur until the end of the demonstration, at which point the State must return the difference between the actual and planned federal savings.[27]

As it is still only the first year of the demonstration, it remains to be seen whether the State will be able to meet its obligations under the STCs, including not only the savings threshold, but also the spending thresholds and performance milestones. Certainly, the required State investments, performance milestones, and savings threshold place a substantial burden on the State. DOH itself acknowledges that there is no guarantee that it will be able to access the full amount of available federal funding.[28] However, the sheer magnitude of that funding creates an enormous incentive for the State to meet its obligations under the agreement.

Current Status of F-SHRP Initiative: HEAL NY

The State has already identified potential specific uses for the funding, thus far confining it to activities "consistent with the goals of [the] Health Care Efficiency and Affordability Law for New Yorkers (HEAL NY)."[29] HEAL NY is a capital grant program established in 2005 to "en-

courage improvements in the operation and efficiency of the health care delivery system" in New York State.[30] 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.[31] In addition, awards must be "consistent with objectives and determinations" of the Berger Commission.[32]

Funding under the program is expected to total $1 billion over four years, including $750 million in proceeds from DASNY bonds, of which $10 million will be directed to community health centers. The debt service on such bonds will be paid by the State pursuant to a service contract.[33] The remaining $250 million is subject to State appropriation.

Thus far, there have been four iterations of HEAL NY funding. The first three were competitive Requests for Grant Applications (RGAs). Phase 1 offered approximately $53 million for investment in health information technology; those awards were announced on May 24, 2006.[34] Phase 2 offered approximately $268 million for institutional restructuring; those awards were announced on November 17, 2006.[35] Phase 3 offered approximately another $53 million for health information technology.[36] Phase 3 also marked the first appearance of potential F-SHRP funding; specifically, the RGA notes that "Phase 3 grant awards are anticipated to total $52,875,000, although if additional funding becomes available, this amount may be increased."[37] That RGA has since been withdrawn, and the contemplated $53 million in funding is slated to be combined with an additional $53 million for the same purpose; it is unclear whether F-SHRP will be a source of that additional funding.

The most recent iteration of HEAL NY, Phase 4, explicitly includes F-SHRP funding.[38] Phase 4, unlike the previous iterations, is not structured as a fully competitive RGA. While it is generally competitive, potential applicants are limited to those facilities that are subjects of the recommendations of the Berger Commission, which were included in the Commission's final report released on November 28, 2006.[39] In contrast to traditional applicants for State funding, these applicants are at liberty to work with DOH to refine their applications, which were technically due, at least in initial form, on July 16, 2007.

Phase 4 is offering up to $550 million, which is explicitly to be composed of both HEAL NY and F-SHRP funds. The precise breakdown of that funding between HEAL NY and F-SHRP is undetermined. In fact, it is dependent on the nature of the applications received—DOH staff has noted that the two sources will be used on a "mix and match basis" depending on the extent to which a particular application qualifies as a capital investment eligible for HEAL NY funding or requires the greater flexibility of F-SHRP funding.[40] For the same reason, DOH has asked applicants to distinguish which elements of an application can be considered capital investments.[41]

Also driving this determination is the need to maximize approved reform initiative expenditures during the federal fiscal year ending September 30, 2007, so that the State will have access to the full $300 million in federal funding. Accordingly, DOH is explicitly encouraging applicants to maximize their F-SHRP-appropriate expenditures prior to October 1, 2007.[42]

It is by no means certain that the State will make the investments in approved reform initiatives necessary to qualify for the full amount of FFP in this federal fiscal year. However, it should be remembered that HEAL NY Phase 4 is only the first vehicle for F-SHRP funding; more are coming, either via HEAL NY or other mechanisms. HEAL NY itself promises to continue to offer further opportunities for F-SHRP funding. DOH staff has identified a few likely investments, including:

1. *Primary Care:* A consistent theme of Governor Spitzer's administration in general, and of the HEAL NY and F-SHRP programs in particular, is that the State desperately needs substantial, coordinated investment in primary care infrastructure. In fact, DOH staff has explicitly confirmed that "building primary care capacity" is a likely target for future investment.[43]

2. *Health Information Technology:* Similarly, DOH's continuing focus on health information technology issues, including the creation of a new "Office of Health Information Technology Transformation," along with the stated purposes of HEAL NY and F-SHRP, suggest additional funding for health information technology initiatives, and in fact such additional funding has been announced.[44]

3. *Institutional Restructuring:* There is also likely to be additional HEAL NY and F-SHRP funding for institutional reform of the type recommended by the Berger Commission.[45]

4. *Long-Term Care:* It is virtually certain that there will be additional HEAL NY and F-SHRP funding in this area. The likely nature of this funding will be discussed below.

Implications of F-SHRP for Long-Term Care

The implications of the F-SHRP program for long-term care are significant. Clearly, among existing State initiatives in the long-term care area, EISEP and Single Point of Entry, which are approved reform initiatives, will be targets for F-SHRP investment. In addition, the State is likely to invest additional funds in institutional restructuring along the lines of the Berger Commission recommendations, which in regard to long-term care focus much more on conversion to home- and community-based care than on the closure or downsizing that characterize the Commission's acute care recommendations. That is not to say the further downsizing of the nursing home industry is unlikely—in fact, in this year's budget, $30 million was added to the HEAL NY program to be distributed on a discretionary basis for the purpose of restructuring nursing homes to "achieve a reduction in certified inpatient bed capacity."[46] And once again, DOH has offered strong indications that substantial funding for long-term care reform will be available in the very near future (and may even have been announced by the time you are reading this), both through the establishment of a new Office of Long Term Care and through affirmative statements by staff.[47]

The exact nature of this potential investment is uncertain; however, DOH is even now working in collaboration with the State Office for the Aging, other key State agencies, and stakeholders from across the State to explore options to "rebalance" the elements of the State's $10 billion long-term care service system to improve the opportunities for home and community based alternatives. This effort, known as the Long Term Care Restructuring Initiative,[48] has involved several elements that shed some light on potential future F-SHRP funding. In May 2006, DOH established a fifteen-member Long Term Care Restructuring Advisory Council and a network of stakeholder workgroups to focus on specific elements of reform.[49] Throughout the spring of 2006, DOH conducted a series of collaboration sessions around the State, attended by over one thousand stakeholders, to elicit comments on the development of a comprehensive 1115 waiver (in addition to the F-SHRP waiver) to provide community-based services as an element in the State's effort to restructure the overall long-term care system.[50] This was followed on July 5, 2006, with a Request for Information (RFI) seeking more formal public input on the same subject.[51]

Two hundred eighteen responses to this RFI were received from advocates, consumers, service providers, professional organizations, other State agencies, and local governments representing forty-seven counties and the City of New York. These responses and the collaboration sessions reflected several themes, including the need for the State to:

1. Explore options to support and improve existing programs as an alternative to a new comprehensive waiver;
2. Strengthen family and informal caregiver supports;
3. Update and simplify regulations, documentation requirements, and provider reimbursement rate-setting methodologies;
4. Ensure consistency of program administration across geographic areas;
5. Institute a single standardized assessment tool;
6. Enhance educational efforts to increase awareness of all the programs and services;
7. Improve affordable and accessible housing opportunities, workforce recruitment and retention, and transportation systems; and
8. Ensure standardization of case management and service coordination throughout the LTC system.[52]

The work of the Long Term Care Restructuring Initiative is ongoing (e.g., on June 21, 2007, it hosted a symposium entitled "Planning Today for Tomorrow," that updated participants on restructuring activities, examined the special needs of the long-term care population, and reviewed best practices and successful innovations in long-term care[53]), and there is no clear time line for final decisions. However, it is likely that any future F-SHRP funding for long-term care will reflect the themes identified by this initiative.

Conclusion

Thus, while the F-SHRP initiative holds great promise for driving substantial reforms in the delivery of health care, including long-term care, in New York State, it also imposes substantial obligations on the State, which the State may or may not be able to meet. Nonetheless, the State and federal funding available via F-SHRP is already impacting both the long-term care and acute-care delivery systems, and, regardless of the State's ability to meet the mandatory terms and conditions of the F-SHRP agreement, is likely to continue to impact those systems for many years into the future.

Endnotes

1. United States Department of Health & Human Services Press Release, March 16, 2005 (http://www.hhs.gov/news/press/2005pres/20050316.html).
2. *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.
3. *See* http://www.nyhealthcarecommission.org/final_report.htm.
4. 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, § 9(b)(ii).
5. http://www.health.state.ny.us/health_care/managed_care/appextension/health_reform_partnership/.
6. Centers for Medicare & Medicaid Services Special Terms and Conditions (CMS STCs) No. 11-W-00234/2, § II, pp. 1-2.
7. *See* http://www.dhcr.state.ny.us/ocd/progs/acc/ocdacc0.htm.
8. Allegany, Cortland, Dutchess, Fulton, Montgomery, Putnam, Orange, Otsego, Schenectady, Seneca, Sullivan, Ulster, Washington and Yates.
9. *See* CMS STCs No. 11-W-00234/2, § IV(18-20), pp. 5-7.
10. *See* CMS STCs No. 11-W-00234/2, § IX(56-61), pp. 22-24.
11. *See* CMS STCs No. 11-W-00234/2, § VI(27)(b), p. 11.
12. It should be noted that any annual calculations under the STCs are based on the federal fiscal year.
13. CMS STCs No. 11-W-00234/2, § VI(26)(a), p. 10.
14. CMS STCs No. 11-W-00234/2, § VI(26)(c), p. 10.
15. CMS STCs No. 11-W-00234/2, § VI(28), p. 12.
16. CMS STCs No. 11-W-00234/2, § VI(26), pp. 9-10.
17. *See* CMS STCs No. 11-W-00234/2, §§ VI(27)(b)(iii), p. 11; (29)(b), p. 12.
18. *See* CMS STCs No. 11-W-00234/2, § VI(27), pp. 10-11.
19. CMS STCs No. 11-W-00234/2, § VI(27)(a)(i), p. 10.
20. CMS STCs No. 11-W-00234/2, § VI(27)(b)(i), p. 11.
21. *See generally*, CMS STCs No. 11-W-00234/2, § VI(30-37), pp. 13-16.
22. *See* CMS STCs No. 11-W-00234/2, §§ VI(30—introductory paragraph), p.13); VII, pp. 16-17.
23. *See* CMS STCs No. 11-W-00234/2, § VI(30—introductory paragraph), p. 13.
24. CMS STCs No. 11-W-00234/2, § VI(30—introductory paragraph), p. 13.
25. CMS STCs No. 11-W-00234/2, § VI(30)(f), p.14.
26. *See* CMS STCs No. 11-W-00234/2, § X, pp. 24-25.
27. CMS STCs No. 11-W-00234/2, § VI(27)(a)(iv), pp. 24-25.
28. Transcript of HEAL NY Phase 4 Information Conference, May 24, 2007 (http://www.health.state.ny.us/funding/rfa/0705141214/), p. 109.
29. CMS STCs No. 11-W-00234/2, § VI(26)(b)(i), p. 10.
30. Public Health Law § 2818(1); *see generally*, Public Health Law § 2818, Public Authorities Law § 1680-j.
31. 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).
32. Public Health Law § 2818(1).
33. Public Authorities Law § 1680-j.
34. *See* http://www.health.state.ny.us/funding/rfa/0508190240/; *see also* http://www.health.state.ny.us/technology/awards/.
35. *See* http://www.health.state.ny.us/funding/rfa/0604261035/; *see also* http://www.dasny.org/dasny/news/2006/061124HEALstem.php.
36. *See* http://www.health.state.ny.us/funding/rfa/0610100951/.
37. *See* Request for Grant Applications, HEAL NY Phase 3 (http://www.health.state.ny.us/funding/rfa/0610100951/0610100951.pdf), §1.2, p. 5.
38. *See* http://www.health.state.ny.us/funding/rfa/0705141214/.
39. *See* http://www.nyhealthcarecommission.org/final_report.htm.
40. Transcript of HEAL NY Phase 4 Information Conference, May 24, 2007 (http://www.health.state.ny.us/funding/rfa/0705141214/), p. 11. In general, HEAL NY funding is confined to capital expenditures, while F-SHRP has no such limitation.
41. Transcript of HEAL NY Phase 4 Information Conference, May 24, 2007 (http://www.health.state.ny.us/funding/rfa/0705141214/), p. 107.
42. *See* Request for Applications, Implementation of Commission Mandates, May 16, 2007 (http://www.health.state.ny.us/funding/rfa/0705141214/0705141214.pdf), p. 2; *see also* Transcript of HEAL NY Phase 4 Information Conference, May 24, 2007 (http://www.health.state.ny.us/funding/rfa/0705141214/), pp.17, 48.
43. Transcript of HEAL NY Phase 4 Information Conference, May 24, 2007 (http://www.health.state.ny.us/funding/rfa/0705141214/), p. 66; *see also* p.58.
44. *See* http://www.nyhealth.gov/press/releases/2007/2007-08-08_health_it.htm.
45. Transcript of HEAL NY Phase 4 Information Conference, May 24, 2007 (http://www.health.state.ny.us/funding/rfa/0705141214/), pp. 54, 57-58, 65-66.
46. *See* Public Health Law § 2818(3).
47. Transcript of HEAL NY Phase 4 Information Conference, May 24, 2007 (http://www.health.state.ny.us/funding/rfa/0705141214/), pp. 54, 58, 66.
48. *See* http://www.nyhealth.gov/facilities/long_term_care/.
49. *See* http://www.nyhealth.gov/facilities/long_term_care/restructuring/advisory_council/.
50. *See* http://www.nyhealth.gov/facilities/long_term_care/restructuring/index.htm.
51. *See* http://www.nyhealth.gov/funding/rfi/ltc_restructuring/.
52. *See* http://www.nyhealth.gov/funding/rfi/ltc_restructuring/executive_summary_of_responses.pdf, p. 3.
53. *See* http://www.nyhealth.gov/events/planning_today_for_tomorrow/.

Mark R. Ustin is of counsel to the firm of Manatt, Phelps & Phillips, LLP, and located in Albany, New York. His practice focuses primarily on advising institutional providers and insurers on regulatory and legislative matters. He was previously Deputy Director and General Counsel to the Commission on Health Care Facilities in the 21st Century, and is a frequent speaker on issues surrounding health care reform in New York State.

Continuing Care Retirement Communities

By Alyssa M. Barreiro

Introduction and Overview

Article 46 of the Public Health Law, the legislation authorizing continuing care retirement communities, was created by Chapter 689 of the Laws of 1989 and signed into law on August 8, 1989.[1] Lawmakers recognized that "the dramatic increase in the numbers of elderly people, especially those seventy-five years of age and older, coupled with the special housing and health care needs of this growing segment of the population, requires the development of new and creative approaches to help ensure the care of older people in residential settings of their own choice."[2]

The original CCRCs were "life care communities" that offered contracts for unlimited long-term care with residential, assisted living, nursing, dining, recreational and other services within one setting for one monthly fee (after a substantial entrance fee). In 1997, amended legislation allowed operators to offer modified contracts in Article 46 communities that include only a limited number of skilled nursing days.[3] Further legislation created the Fee-for-Service Continuing Care Retirement Community (FFSCCRC), authorizing up to eight (8) demonstration projects in which residents pay only for the services used.[4]

Carl S. Young, President of the New York Association of Homes and Services for the Aging (NYAHSA) testified in 2002 that "Americans age 50 and older control[ ] two-thirds of all household wealth in the nation in 1998, up from 56 percent in 1983. With an anticipated increase in New York's senior population (age 60 and above) by 37 percent, from 3.0 million in 2000 to 4.4 million in 2025, there is a strong economic incentive to develop policies and legislation that would encourage seniors to retire in New York."[5] One way to accomplish that goal is by offering more CCRCs that "combine the best of all worlds—independent living, adult care facility (ACF), and skilled nursing care—within one community."[6]

It was not intended that CCRCs "become or be perceived as primarily medically-oriented facilities," but "that such communities be viewed as an attractive and innovative residential alternative for older New Yorkers who are seeking to maintain, to the extent possible, an independent and active life in a community in which their long-term care needs will be met."[7]

While the public may view these communities as integrated residential "all-in-one" alternatives, the State still regulates CCRCs as multiple, primarily medically oriented facilities that happen to be located on the same campus. Developers and Operators of CCRCs complain that New York's regulations are too strict and duplicative, costing extra time and money that increases costs to residents. A frequently cited example of this are DOH's multiple surveys for different components of a given CCRC campus which can entail surveys of consecutive floors of the same building on different days. There is no mechanism in the State's rules and regulations to allow for centralized approval of operating certificates or for one inspection to serve more than one level of care. In short, the State views each component of a CCRC as an independent entity—it does not treat CCRCs as integrated facilities. Developers and Operators are thus required to pound the square peg of all-in-one retirement communities into many round holes required by the State.

Continuing Care Retirement Community: Current Models

As it has evolved, the law recognizes the following models for retirement communities in New York State:

1. Life care (Type A) contracts. These include unlimited enriched housing or assisted living care and unlimited skilled nursing facility (SNF) services, along with independent housing and residential services and amenities. The resident's monthly fee is fixed (except for normal operating costs and inflation adjustment) but cannot vary due to care needs. The resident pays the same monthly fee in the SNF as he or she paid in independent housing. These residents will never be Medicaid eligible. Only Type A contracts can be called "life care communities."

2. Modified (Type B) contracts. These include independent housing and residential services, but limit the number of SNF days available to residents. The total number of days may vary by contract but must include at least 60 days of SNF coverage (exclusive of Medicare days). Modified contracts may also include an enriched housing/assisted living benefit if this level of care is offered in the community. The monthly fee cannot change due to level of care during the covered benefit period. The resident pays a market rate (per diem) once the contracted days have been exhausted, should the resident require additional SNF/enriched housing/assisted living days.

3. Fee-for-service (Type C) contracts. FFSCCRCs include independent housing, residential amenities such as scheduled transportation and social activities, and access to a continuum of long-term care services. The long-term care services, enriched housing/assisted living and skilled nursing facility care are available on a fee-for-service or per diem basis. There is no long-term care benefit included in the contract; the resident pays for long-term care if and when needed.
4. Equity Models (Types A, B, C). These allow residents to own a condominium or cooperative shares within a CCRC.

In addition to the CCRCs, there are "look-alike" models, many of which require an entrance fee and offer various levels of care, but with no guarantee of admission to the next level of care when a resident's needs increase. There is no Department of Health (DOH) or Insurance Department (DOI) oversight. Look-alikes cannot market themselves as "continuing care retirement communities."[8]

Development and Operation of CCRCs in New York State

Not all states regulate CCRCs like New York does, and not surprisingly, developers favor the states with less regulation. Pennsylvania, for instance, has over two hundred and forty (240) "continuing care retirement communities" in operation.[9] In contrast, in New York there are twelve (12) continuing care retirement communities that have received a Certificate of Authority from the Commissioner of Health. Eight (8) of these communities are open and are accepting residents.[10]

In New York, the consumer protections built into the CCRC system include: escrow of resident entrance fees, character and competence review of the project sponsor and manager, determination of the financial feasibility of the community through required presales prior to construction, a rigorous procedure for approval and monitoring of projects by DOH for both CCRCs and FFSCCRCs, and DOI for CCRCs. Equity models are also reviewed by the Attorney General's office.

In addition, a Continuing Care Retirement Community Council, consisting of representatives from the departments of Health, Insurance, Aging and the Attorney General's Office, and eight public members appointed by the Governor with the advice and consent of the Senate (and at least two continuing care retirement community residents as members), has the power to approve or reject applications to obtain a certificate of authority.[11] Council approval is also required for Industrial Development Agency (IDA) financing.[12]

"The development of these projects is a long-term commitment. Typically, a new project can take up to four years from inception to completion."[13] Funding is available through the New York State Dormitory Authority (DA), but the Public Authorities Control Board (PACB) requires that organizations have investment grade credit ratings for DA financing. Legislation in 1997 permitted IDA financing, but with sunset provisions.[14]

The application procedure alone to obtain a certificate of authority is cumbersome. The approval process is spread throughout various offices and agencies. Within DOH, the Bureau of Continuing Care takes in the applications, but then doles the pieces out to other departments for various CON approvals: Hospital Review and Planning, Public Health Commission, Home and Community based services, etc. Results are then routed back to the Bureau of Continuing Care for consideration of the CCRC Council for approval of the Certificate of Authority. As a result, the paperwork is duplicative and the process is long and unwieldy.

The requirements are often counter-intuitive. One developer gave the following example: A proposed CCRA involves a structure that would house both ACF and SNF levels of care. Each CON application will be scrutinized by a different set of reviewers. Special care must be taken with cost allocations to meet the SNF equity requirement of 10%, while no similar equity requirement exists for an ACF. But in a model with the ACF on the first floor and SNF on the second, "what happens to the second floor if the first floor goes belly-up?"

Once a CCRC manages to obtain all necessary approvals and pass muster with the CCRC Council, few efficiencies of scale exist in their operation. Both Article 46 and Article 28 continue to define operations. The State of New York "licenses, regulates and surveys [CCRCs] in a discontinuous, disintegrated . . . inefficient and . . . costly . . . manner. There is no mechanism in the state to allow the Department of Health to look at [CCRCs] holistically—regulators are forced to treat our nursing home as if it were a free standing facility, and likewise our Enriched Housing unit, and likewise our Resident Care Clinic, and likewise our Home Care Agency . . . and so on.[15]

Rubbing salt into an existing wound, established CCRCs that market themselves as providing "assisted living" must now apply for a license under the Assisted Living Reform Act, Article 46-b, or cease marketing. [16]

Room for Improvement

Chapter 700 of the Laws of 2006, which amended Article 46 of the Public Health Law, also required DOH to conduct a review of duplicative requirements in CCRCs and to report its findings and recommendations for

eliminating such duplication to the Governor and Legislature.[17] DOH sought input from the industry. Relying heavily on a December 1, 2006 letter from NYASHA, DOH issued a report, identifying a number of areas where the Department agreed with NYASHA and proposed further review:

- Allowing clinical staff to practice within their scope of practice at all levels of care within a CCRC. Current New York State laws and regulations prohibit clinical staff, including registered nurses, licensed practical nurses, rehabilitation therapists and certified nurse aides, employed by the CCRC skilled nursing facility from providing services to adult care facility and independent residents. Operators know that residents desire continuous and integrated health care provided by familiar clinical staff and believe that such an arrangement would offer residents better care.
- Providing for consolidated medical records for residents within a CCRC. Currently, separate medical records are required at the ACF and SNF levels, resulting in delays in availability of information when residents are transferred to a higher level of care within a community. Consolidation of medical records would improve care and reduce costs. A consolidated medical record would ensure better outcomes for residents while reducing the possibility of medical and medication errors.
- Clarification of policies for continuous treatment and medications for CCRC residents at all levels of care.
- Consolidated surveillance activities for the physical plant and related matters. Various components—SNF, ACF, Home Care, etc., are generally regulated as separate individual entities. This is particularly true for oversight of physical plants. Surveys for dietary facilities and services, physical plant, alarms, and sprinklers and generators are conducted independently for each level of care by state surveyors, possibly the same surveyor within weeks, and involve much redundancy.
- Clarification of the rule that the life care contract will serve as the admission agreement for all levels of care within a CCRC for contract holders. Previously, DOH determined that the continuing care contract is the only agreement signed by the resident, but surveyors continue to cite facilities for lack of SNF or ACF admission agreements. (Assisted Living Residences also require a separate admission agreement with no clear exemption under Article 46-B.)
- Potential reduction or elimination of the requirement for the ACFs, home care agency and diagnostic and treatment center to file cost reports with the Department when they will not be billing Medicaid or other government entities, provided, however, that these providers would then be closed to all outside admissions and would be able to serve only resident contract holders.

DOH specifically rejected industry recommendations to (1) allow a CCRC to transfer contract holders between levels of care without completing patient assessments, (2) reduce the required CCRC licensure and inspection fee or exemption from ALR fees since such fees support different activities and purposes, and (3) exempt CCRCs from the timing of the refund provisions at Section 4609 for cooperative model CCRCs (one year) as a requirement not otherwise imposed on cooperatives and condominiums.

NYAHSA continues to promote legislative change in these areas in its 2007 legislative proposal that promotes:

- **Approving the use of entrance fees for construction**. Currently, Article 46 permits release of residents' CCRC deposits for up to 15 percent of the total cost of acquiring, constructing, and equipping the proposed CCRC. Deposits in excess of the 15 percent threshold cannot be used and must be kept in escrow. This increases the cost of these projects and, according to NYAHSA, is not supported by experience.
- **Making Industrial Development Agency (IDA) financing authority permanent** for CCRCs along with retirement communities and nursing homes.
- **Allowing Article 46 CCRCs to enter into fee-for-service contracts**. This proposal seeks to rectify what was likely an unintended consequence of the 2004 legislation that created a fee-for-service model. Since Article 46 was first enacted, subsequent amendments have made admission to CCRCs more affordable by shifting the cost of SNF care from private to public funds. Type A contracts involve no public funding—admission and maintenance fees fund all SNF costs. Type B contracts include a limited SNF benefit, lowering admission fees and maintenance fees, and shifting a portion of the burden of SNF care back to the Medicaid program. Finally, Type C contracts anticipate the bare minimum of SNF coverage through refund of the housing deposit. Medicaid becomes an anticipated source of payment, thus lowering admission fees and maintenance fees substantially when compared to Type A and B contracts. This sets up what is seen by some as an unfair marketing advantage in

favor of FFSCCRCs that has led to a push to allow Article 46 CCRCs to offer 46-A fee-for-service type contracts without the need for a separate certificate of authority.

- **Allowing life care contracts to serve as admission agreements**. Article 46 specifically exempts CCRCs from the adult care facility admission agreement requirement contained in Social Services Law, but there is no exemption for CCRCs applying for an assisted living residence (ALR) licensure under Article 46-B of the Public Health Law to use the CCRC contract as the only contract.
- **Amending the one-year entrance fee refund requirement**. CCRC financing includes the practice of collecting entrance fees from residents when the CCRC contract is signed. These fees must be held in an interest-bearing account with a New York bank, New York savings and loan association, or New York trust company. If a resident cancels the CCRC contract, or upon death, the provider is required to return any entrance fee amount owed to the resident or their estate no later than one year after the apartment/cottage has been vacated. No such one-year refund requirement exists for look-alike facilities with condominiums/co-ops regulated by the Attorney General's Office, and CCRC operators seek to even the playing field.

Conclusion

Given the development hurdles and regulatory environment, the question arises, "Why bother?" From an economic standpoint, operators may be attracted to the younger client base for whom the fee-for-service option allows for escrow of resident assets as a buffer against disqualifying transfers, and if actuarially sound, the Type A and B contracts eliminate or limit the problem of patients in nursing home beds with no source of payment. Mostly, however, CCRCs exist because providers of long-term care see such arrangements as a means of coordinating levels of service to better respond to client needs and to improve the quality of services and care provided.

From a policy standpoint, if properly administered, these communities can encourage seniors to remain in the State. But DOH must first address the gap between what seniors want in integrated housing and what they actually get in New York State. Developers need a more fluid approval process and operators must be permitted to develop efficiencies across care levels. If not, it seems unlikely that CCRC development will have impact in New York on a significant scale.

Endnotes

1. Laws of 1989, chap. 689, eff. July 22, 1989.
2. NY CLS Pub. Health Law § 4600.
3. Laws 1997, chap. 659, eff. Sept. 24, 1997.
4. Laws 2004, chap. 519, eff. Jan. 1, 2005.
5. Carl S. Young, in testimony May 20, 2002, before New York State Assembly Standing Committee on Local Governments (NYASHA Doc. ID # 14505201) *citing* AARP, "A Report to the Nation on Economic Security, 2001," and NYS Office of the Aging, "Demographic Projections 1995–2025," May 1999.
6. 2007 CCRC Legislative Proposal, The Center for Senior Living & Community Service, New York Association of Homes & Services for the Aging.
7. NY CLS Pub. Health Law § 4600.
8. NY CLS Pub. Health Law § 4604(1).
9. http://www.retirementhomes.com/homes/Continuing_Care/USA/Pennsylvania/index.html.
10. New York State Department of Health website/Continuing Care Retirement Communities, http://www.health.state.ny.us/facilities/long_term_care/retirement_communities/continuing_care/index.htm.
11. NY CLS Pub. Health Law § 4602.
12. NY CLS Pub. Health Law § 4604-a.
13. 2007 Legislative Proposal, *supra* note 6.
14. CLS NY Gen. Mun. Law § 854.
15. Patricia A. Doyle, Executive Director/CEO of Kendal on Hudson in testimony November 22, 2005 before the New York State Assembly Committee on Health hearing on Continuing Care Retirement Communities. From a Compilation of Testimony (NYAHSA Document ID# 32912501).
16. Laws of 2004, chap. 2, eff. Feb. 23, 2005.
17. Laws of 2006, chap. 700, eff. Sept. 13, 2006.

Alyssa M. Barreiro is a partner in the Binghamton area law firm of Levene, Gouldin & Thompson, LLP. She received her JD from Syracuse University College of Law and her MBA from Binghamton University. **The author is grateful for the assistance of Michael J. Keenan, CEO of Good Shepherd Village at Endwell (Article 46-A FFSCCRC), Daniel Governanti, Executive Director Kendal at Ithaca (Article 46 CCRC), and Ken Harris, Director, The Center for Senior Living and Community Services, NYAHSA.**

Assisted Living in New York: Old and Broke, Where Will We Go from Here?

By Jane Bello Burke

Introduction

The Assisted Living Reform Act, Article 46-B of the Public Health Law (the "ALR Act"),[1] offers the illusion of reform, rather than an effective and affordable alternative to placement in a nursing home or hospital. Enacted in 2004, but still not implemented as of mid-2007, the statute creates a framework for the establishment of a new type of adult care facility: the "assisted living residence" or "ALR." With "enhanced" certification, the ALR gives individuals the opportunity to age in place by allowing them to remain in the same residence as their needs for care and assistance increase.

In March 2007, the Department of Health proposed regulations to implement the ALR Act.[2] The proposed regulations impose extensive requirements which greatly increase the expense of operating an Enhanced ALR. The added expense will adversely affect the affordability of care and services and undermine access to the benefits of aging in place for moderate- and low-income individuals. Disturbingly, the proposed regulations do not envision any source of public funding to help pay for extended care in an Enhanced ALR.

Funding is fundamental to the success of the Enhanced ALR program. Without a source of funding, the opportunity to age in place in an Enhanced ALR will be financially out of reach for moderate- and low-income individuals. This will thwart the legislative intent to develop affordable assisted living and to ensure that the indigent have adequate access to a sufficient number of assisted living residences.[3]

Will New York's low- and moderate-income residents realize the promise of aging in place in an Enhanced ALR? When their money is gone, where will they go? These and other important policy questions should be resolved before the ALR Act goes into effect, to ensure that the opportunity to age in place will be available to all.

The Existing Statutory Structure: Adult Care Facilities

Assisted living residences are adult care facilities, not nursing homes. Adult care facilities provide temporary or long-term residential care and services to adults.[4] Their residents are individuals who do not require continual medical or nursing care, but due to physical or other limitations associated with age, physical or mental disabilities or other factors, are unable or substantially unable to live independently.[5] Adult care facilities provide non-health care services, such as room, board, meals and direction and some assistance with activities of daily living, such as grooming, dressing, bathing, toileting and the self-administration of medications.[6]

A "nursing home," in contrast, provides "nursing care to sick, invalid, infirm, disabled or convalescent persons in addition to lodging and board or health-related service, or any combination of the foregoing," as well as "nursing care and health-related service, or either of them, to persons who are not occupants of the facility."[7] Nursing homes care for frail, ill or disabled persons who cannot care for themselves and have many health care requirements. Adult care facilities offer an intermediate level of services, more supportive than an individual home, but less restrictive than a nursing home.

To operate as an ALR, an operator must be licensed, either as an adult home or an enriched housing program, and in addition obtain licensure as an assisted living residence.[8] Under the Social Services Law, an adult home provides long-term residential care, room, board, housekeeping, personal care, and supervision to five or more adults.[9] An enriched housing program provides long-term residential care to five or more adults (generally age 65 or older), in community-integrated settings resembling independent housing units, and must provide or arrange for room, board, housekeeping, personal care, and supervision.[10]

The regulations governing adult care facilities impose limitations on the type of residents who can live in adult homes and enriched housing programs.[11] Among other things, these facilities may not accept or retain a person who needs continual medical or nursing care or requires continual skilled observation of symptoms and reactions for the purpose of reporting a medical condition to the resident's physician. They may not accept or retain a person who is chronically bedfast or chairfast, or chronically requires the physical assistance of another person to walk or to climb or descend stairs (unless assigned to a floor with ground-level egress). They also may not accept or retain a person who suffers from a communicable

disease or health condition which constitutes a danger to others or who is cognitively, physically, or mentally impaired to the point that the resident's safety or safety of others is compromised. It is a ground for involuntary transfer and termination of a resident's admission agreement if the resident requires continual medical or skilled nursing care that the adult care facility is not licensed to provide.[12]

When a resident's condition deteriorates to the point that he or she is no longer suitable for the adult home or enriched housing program, the facility generally must transfer the resident to an alternative setting, such as a nursing home or hospital, which can meet the increased needs. The goal of the ALR Act is to provide an alternative to transfer when the resident's needs increase beyond the point where continued retention would be appropriate.

The ALR Act: The Promise of a New Era

The ALR Act defines "assisted living" and "assisted living residence" as "an entity which provides or arranges for housing, on-site monitoring, and personal care services and/or home care services (either directly or indirectly), in a home-like setting to five or more adult residents unrelated to the assisted living provider."[13] The operator holding an ALR license can apply for certification as an "enhanced" ALR. This certification allows the ALR to provide "aging in place" services to individuals who otherwise would not qualify, due to their deteriorating physical condition, to continued retention in the home.

With an Enhanced ALR certification, if the resident's needs increase to the point where he or she requires 24-hour skilled nursing or medical care, the ALR need not necessarily discharge the resident to a nursing home, hospital, or other facility which can meet the resident's needs. Instead, the resident may stay in the ALR, but only if the several conditions as set forth in the statute are met. These are as follows: first, the resident hires appropriate nursing, medical or hospice staff to meet the increased needs; second, the resident's physician and home health agency agree that the resident's additional needs can be met safely and appropriately at the residence; third, the residence agrees to retain the resident and to coordinate the additional care; and fourth, the resident is otherwise eligible to reside there.[14] Through this arrangement—with the resident hiring the additional nursing, medical or hospice care and the operator coordinating the additional care with the other care and services provided in the ALR—the Enhanced ALR certificate allows for aging in place by permitting the facility to retain individuals who otherwise would not meet the retention standards for the adult home or enriched housing program.

The ALR Regulations: A Day Late and a Dollar Short

In March 2007, the Department of Health proposed regulations implementing the ALR Act. The proposed regulations impose extensive and expensive new requirements upon the Enhanced ALR. Perhaps most significantly, they require the Enhanced ALR to provide "health care" services and to hire and pay for licensed nurses to provide staffing coverage in the facility.[15] This must include, at a minimum, a licensed nurse (either a registered nurse or a licensed practical nurse) on duty and on-site for 16 hours a day, seven days a week. In addition, an RN must be on duty and on-site at least eight of those 16 hours, five days a week, and an RN must be on call and available for consultation on a 24/7 basis. Under the proposed regulations, the nurse staffing requirement is a prerequisite to certification as an Enhanced ALR, regardless of whether any individual resident has a specific need for skilled staffing.

Does the Department of Health have the statutory authority to require nurse staffing in the ALR? The scope of an agency's authority is limited by its role as an administrative rather than legislative body.[16] An administrative agency, as a creature of the Legislature within the Executive branch, can act only to implement statutes in accordance with the Legislature's direction.[17] Thus, an agency cannot create rules that the Legislature did not contemplate or authorize.

Significantly, the ALR Act does not itself require nurse staffing in an Enhanced ALR. Under the statute, the responsibility for hiring additional skilled nursing care is on the individual resident requiring such services, not on the ALR. Under the statute, the ALR's obligation, if it chooses to accept it, is to coordinate the care provided by the Enhanced ALR and other provider staff.

The ALR Act, as distinguished from the proposed regulations, does not mandate minimum staffing requirements. With respect to staffing, the statute states only that "an operator of enhanced assisted living may hire care staff directly pursuant to standards developed by the department or contract with a home care services agency which has been approved to operate pursuant to article thirty-six of this chapter."[18] Nothing in the statute itself requires ALRs to hire nurses directly, much less to staff the facility with nurses on a 24/7 basis. If the Legislature had intended to require ALRs to hire skilled nursing staff as a prerequisite to obtaining "enhanced" certification, then it would have expressly so stated in the text of the

statute. The fact that it did not suggests strongly that it intended no such result.

Why is this important? According to recent studies, the New York consumer pays a base rate average of from $2,914 to $3,423 a month for the "assisted living" level of care.[19] Actual costs vary widely depending on the size of the living areas, services provided, type of help needed, and where the facility is located. The base rate includes room and board, assistance with activities of daily living, medication assistance, case management services, 24-hour monitoring, structured activities, housekeeping and laundry. It does not include nursing care. The average cost in facilities offering such care can be considerably higher.

The mandatory nurse staffing requirement will result in increased costs across the board for assisted living, even for those individuals who have no skilled nursing needs at all. Take, for example, a 150-bed Enhanced ALR, in which only 10 residents have skilled nursing needs. The other 140 residents will subsidize the care provided to these few. For many individuals—those with moderate or negligible income and assets—the increased costs will make enhanced assisted living prohibitively expensive. Many of these individuals will be unable to avail themselves of the benefits of aging in place in an Enhanced ALR. For those that do, the increased costs will cause them to spend down and deplete their assets much more quickly. When that happens, where will they go?

After the Money Is Gone, Who Pays?

Medicare does not cover the costs of an assisted living residence. Medicare will pay for a skilled nursing facility—up to 100 days—if the individual has had a qualifying three-day hospital stay and requires skilled care, such as skilled nursing services and/or physical or other types of therapy. After day 100, the individual is responsible for paying 100% of the costs for each additional day of skilled nursing facility care. Medicare does not pay for most long-term care, including the costs of an assisted living facility.

Medicaid is the primary funding mechanism of long-term care services for low-income seniors in skilled nursing facilities. In New York, however, the Medicaid program will not cover the costs of an assisted living residence. Consequently, once a resident spends down his or her assets in the Enhanced ALR, transfer to a skilled nursing facility may be the only option. But how will this further the goal of aging in place? And what will be the effect on nursing homes? After Enhanced ALRs have cherry-picked the most affluent private-pay residents and depleted the assets of the rest, will this leave skilled nursing facilities with nothing but Medicaid to fund the cost of care?

Nationally, New York is in the minority of states that do not cover assisted living under their Medicaid programs. Under Medicaid, each state sets its own income eligibility standards within broad federal parameters, as well as the mix of services and products for which it will provide reimbursement. According to the National Center for Assisted Living, in 2006,[20] about a third of the states made changes to their assisted living regulations, about seven made major regulatory changes, and three began covering assisted living under Medicaid waivers. As a result of these changes, "[o]nly a handful of states now do not provide Medicaid coverage for assisted living." New York is in that handful of states that do not provide Medicaid coverage for assisted living residences.

It need not be this way. Under the ALR Act (as distinguished from the proposed regulations), the obligation to hire nurses is on the individual resident requiring such care, not the residence. This is an important difference. Medicaid pays for medically necessary care for needy individuals who meet income and eligibility qualifications, and medically necessary nursing care is a Medicaid-covered benefit.[21] Thus, if the resident requiring skilled nursing care were to hire the nurse directly—as the ALR Act contemplates—Medicaid could be available to qualified recipients as a potential source of funding for the medically necessary nursing services that they would need to be able to age in place. The Department's proposed regulations, in shifting the burden to hire nurses to the facility, deprive residents in Enhanced ALRs of access to the Medicaid program as a potential source of funding when their money runs out.

To be sure, other alternatives are possible. Nationally, many states are experimenting with other ways to use Medicaid funds to pay for assisted living care under waivers to the Medicaid rules. Many have enacted Medicaid Home and Community Based Services Waivers to cover services in assisted living facilities.[22] In New York, one promising alternative is the "Assisted Living Program," or "ALP."

Confusingly similar in name, the ALP is significantly different from the ALR in concept. The ALP is an alternative to nursing home care that enables individuals who are eligible for a nursing home to receive Medicaid-funded home care services in the less intensive and lower-cost setting of an adult home or enriched housing program. The ALP provides room, board, housekeeping and necessary services, including personal care, supervision, home health services, nursing, physical and other therapies.[23] Typically, the operator will contract with a

licensed home care services agency, a long-term home health care program or a certified home health agency to provide the necessary services. According to the Department of Health, approximately 85% of ALP residents are Medicaid recipients.[24]

ALPs serve a vitally important function. Unfortunately, the small size of the program—merely 4,200 beds statewide—limits its reach and effectiveness. As of April 1, 2007, the Legislature authorized the addition of 1,500 ALP beds to the total number available.[25] This is promising, but much more is needed to serve our aging population. Continued expansion of the ALP system, coupled with clear and consistent retention and transfer criteria across the continuum of care, would go far to address the need for aging in place services in New York.

Conclusion

With increasing longevity and escalating heath care costs, more and more elders will run out of money before they run out of years. The ALR Act was intended to address this issue, by allowing individuals to age in place in the more cost-effective and less restrictive setting of an Enhanced ALR. Under the proposed regulations, however, the statute is unlikely to achieve these salutary goals.

Paradoxically, by placing the obligation to hire nurses on the residence, rather than the residents requiring such care, the proposed ALR regulations effectively transfer the cost of nursing care to the individuals living in the Enhanced ALR. This is because they increase the cost of living in the residence on a facility-wide basis. The result is to accelerate the spend-down process, while simultaneously depriving ALR residents of access to the Medicaid program as a potential source of funding when their private funds are depleted.

In enacting the ALR Act, the New York Legislature directed the creation of a task force on assisted living and charged it with making recommendations on ways to develop affordable assisted living. For the benefit of our health care system across the continuum of care, New York should consider and resolve the crucial issue of affordability before putting the ALR program into place.

Endnotes

1. N.Y Pub. Health Law Art. 46-B, §§ 4650-4663.
2. N.Y. St. Reg., vol. XXIX, Issue 13, at 14-18 (Mar. 28, 2007) (*available at* www.dos.state.ny.us/info/register/2007/mar28/pdfs/rules.pdf).
3. L 2004, chap. 2, § 5 (effective Feb. 23, 2005).
4. N.Y. Soc. Serv. Law § 2(21).
5. *Id.*; 18 N.Y.C.R.R. § 485.2.
6. N.Y. Soc. Serv. Law § 2(24), (25); 18 N.Y.C.R.R. § 485.2(b), (c).
7. N.Y. Pub. Health Law § 2801(2).
8. N.Y. Pub. Health Law § 4653.
9. N.Y. Soc. Serv. Law § 2(25).
10. N.Y. Soc. Serv. Law § 2(24).
11. 18 N.Y.C.R.R. §§ 487.4 (adult homes), 488.4 (enriched housing residences).
12. 18 N.Y.C.R.R. § 487.5(f)(7), (14)(i); 18 N.Y.C.R.R. § 488.5(e)(3), (e)(9).
13. N.Y. Pub. Health Law Art. 46-B, § 4651(1).
14. N.Y. Pub. Health Law Art. 46-B, § 4655(4).
15. Proposed 10 N.Y.C.R.R. § 1001.10.
16. *Boreali v. Axelrod*, 71 N.Y.2d 1, 6 (1987).
17. *See* N.Y. Const. Art. III, § 1.
18. N.Y. Pub. Health Law Art. 46-B, § 4655(1)(d).
19. *See* MetLife Market Survey of Assisted Living Costs, October 2005 (*available at* www.metlife.com/WPSAssets/849893261011307709 86V1F2005%20Assisted%20Living%20Survey.pdf).
20. *See* National Center for Assisted Living, Assisted Living State Regulatory Review 2007 (March 2007).
21. N.Y. Soc. Serv. Law § 365-a(2)(a).
22. *See* National Center for Assisted Living, Assisted Living State Regulatory Review 2007 (March 2007).
23. N.Y. Soc. Serv. Law § 367-h; N.Y. Pub. Health Law § 3614.
24. *See* New York State Department of Health, www.health.state.ny.us/health_care/medicaid/program/longterm/alps.htm
25. N.Y. Soc. Serv. Law § 461-*l*(h).

Jane Bello Burke is a Member of the firm of O'Connell & Aronowitz in Albany, New York.

Privacy and Security Solutions for Interoperable Health Information Exchange

Excerpts from the Final Assessment of Variation and Analysis of Solutions Report by the NYS Health Information Security and Privacy Collaborative

Appendix H: New York State Legal Analysis by Scenario, New York State Department of Health/Manatt, Phelps & Phillips

Editor's Note: The New York Health Information Security and Privacy Collaborative (NYHISPC) was convened to analyze and conduct a statewide dialogue about how to protect privacy and strengthen security of patients' health information in an electronic and interconnected health care delivery system. In April 2007, NYHISPC issued two final reports:

- *Final Assessment of Variation and Analysis of Solutions Report—Privacy and Security Solutions for Interoperable Health Information Exchange; and*
- *Final Implementation Plan Report—Privacy and Security Solutions for Interoperable Health Information Exchange*

The full reports, and more information about NYHISPC, are available at http://www.health.state.ny.us/technology/nyhispc/.

The "Final Assessment" Report included, as Appendix H, a legal analysis of several scenarios in which New York health care providers are asked to disclose health information. The report cautions readers that the legal analysis does not reflect the official position of the NYS Department of Health. Nonetheless it provides a straightforward, useful guide to analyzing common health information disclosure issues, with reference to both HIPAA and NYS requirements.

Due to space limitations, only four scenarios are set forth below. Readers interested in viewing the other eight scenarios (e.g., research data access, access by law enforcement, healthcare operations and marketing disclosures, etc.) should view Appendix H in its entirety. Moreover, readers interested in emerging policies on electronic health information exchange should review the full reports.

Finally, due to space limitations, this reprint of Appendix H eliminates repetitive analyses, and instead refers to the first location where that analysis appears.

New York State Legal Analysis by Scenario

The following is an analysis of the New York State laws as they pertain to the RTI scenarios of the Health Information Security and Privacy Collaboration project. The document discusses provisions under New York law that have been identified by the legal committee as relevant to the scenarios and domains described. Domains have been omitted where no relevant provision of state law was identified under the scenario presented. This document is not legal advice, nor is it intended to be legal advice, nor does it represent the official position of the Department of Health with respect to application and enforcement of state law and regulation on actual, non-hypothetical situations.

1. Patient Care Scenario A

> *Patient X presents to emergency room of General Hospital in State A. She has been in a serious car accident. The patient is an 89-year-old widow who appears very confused. Law enforcement personnel in the emergency room investigating the accident indicate that the patient was driving. There are questions concerning her possible impairment due to medications. Her adult daughter informed the ER staff that her mother has recently undergone treatment at a hospital in a neighboring state and has a prescription for an antipsychotic drug. The emergency room physician determines there is a need to obtain information about Patient X's prior diagnosis and treatment during the previous inpatient stay.*

Note: We assume for purposes of this analysis that New York is the neighboring state. We are also assuming for purposes of this analysis that the hospital in the neighboring state is a mental health facility licensed under Article 31 of the New York Mental Hygiene Law.

Domain 1—User and entity authentication is used to verify that a person or entity seeking access to electronic protected health information is who they claim to be.

Applicable New York Law—Hospitals are required to employ safeguards to ensure the security and confidentiality of their medical records. The safeguards must include: (1) the assignment of a unique identifier that is assigned in a confidential manner; and (2) certification in writing by the hospital and the user that the unique identifier is confidential and available only to the authorized user. 10 N.Y.C.R.R. § 405.10(c)(4)(i) and (ii).

Discussion—The requirement under New York law that hospitals assign each system user a unique identifier is consistent with HIPAA. See 45 C.F.R. § 164.312(a)(2)(i).

The assignment by the hospital of a unique user identifier to each doctor at the General Hospital in State A would appear to satisfy New York law.

Key Legal Barriers—New York law does not create any legal barriers relevant to this domain beyond requirements under HIPAA.

Domain 2—Information authorization and access controls to allow access only to people or software programs that have been granted access rights to electronic personal health information.

Applicable New York Law—Hospitals are required to employ safeguards to ensure the security and confidentiality of their medical records. The safeguards must include policies and procedures that restrict access to information to those individuals who have the need, a reason and permission for such access. 10 N.Y.C.R.R. § 405.10(c)(4)(iv). Hospitals must have procedures in place to modify or terminate use of an assigned identifier due to misuse or changes in the user's employment or affiliation with the hospital. 10 N.Y.C.R.R. § 405.10(c)(7).

Discussion—The requirement under New York law that hospitals have policies and procedures to restrict access to appropriately authorized individuals is consistent with HIPAA. See 45 C.F.R. §§ 164.308(a)(3)(i)(C), (4)(ii)(B) and (C). The requirement under New York law that hospitals adopt procedures to modify or terminate a system user's access rights based on the termination or modification of the user's relationship with the hospital is also consistent with HIPAA. See 45 C.F.R. § 164.308(a)(3)(ii)(C).

The hospital would appear to satisfy New York law if it adopts written policies and procedures identifying the health care organizations that have access to the hospital's medical records and the nature of their access and terminating the organizations' access rights under appropriate circumstances.

Key Legal Barriers—New York law does not create any legal barriers relevant to this domain beyond requirements under HIPAA.

Domain 3—Patient and provider identification to match identities across multiple information systems and locate electronic personal health information across enterprises.

Applicable New York Law—Hospitals are required to ensure the confidentiality of medical records. Information contained in such records may be released only to hospital staff involved in treating the patient "and individuals as permitted by Federal and State laws." 10 N.Y.C.R.R. § 405.10(a)(6).

Discussion—The general duty of hospitals to keep records confidential prohibits hospitals from releasing patient information to out of state entities unless the patient and provider status can be verified. This is consistent with HIPAA which requires covered entities to verify the identity of a person requesting protected health information and the authority of any such person to have access to protected health information, if the identity or any such authority of such person is not known to the covered entity. 45 C.F.R. § 514(h).

Key Legal Barriers—New York law does not create any legal barriers relevant to this domain beyond requirements under HIPAA.

Domain 4—Information transmission security or exchange protocols (i.e., encryption, etc.) for information that is being exchanged over an electronic communications network.

Applicable New York Law—Hospitals are required to employ "safeguards to ensure safety and confidentiality." 10 N.Y.C.R.R. § 405.10(c). *Discussion*—This requirement under New York law is general in nature and does not exceed HIPAA requirements. *Key Legal Barriers*—New York law does not create any legal barriers relevant to this domain beyond requirements under HIPAA.

Domain 5—Information protections so that electronic personal health information cannot be improperly modified. *Applicable New York Law*—Hospitals are required to employ "safeguards to ensure safety and confidentiality." 10 N.Y.C.R.R. § 405.10(c).

Discussion—This requirement under New York law is general in nature and does not exceed HIPAA requirements.

Key Legal Barriers—New York law does not create any legal barriers relevant to this domain beyond requirements under HIPAA.

Domain 6—Information audits that record and monitor the activity of health information systems.

Applicable New York Law—Hospitals are required to conduct audits to track access by system users. 10 N.Y.C.R.R. § 405.10(c)(4)(v). Public Health Law § 18(6) also requires the tracking and documentation by licensed professionals and facilities of certain disclosures to third parties (including initial disclosures to government and private payers). Either a copy of the subject's written authorization or the name of and address of such third party and a notation of the purpose of the disclosure must be indicated in the patient's file. Exceptions exist for facility staff and contractors, and government agencies for the purposes of facility inspections or professional conduct investigations.

Discussion—The requirement under 10 N.Y.C.R.R. § 405.10(c)(4)(v) that hospitals conduct audits to track access by system users does not impose any specific obligations regarding the timing or nature of the mandated audits and is consistent with HIPAA. See 45 C.F.R. § 164.312(b). Periodic audits of the access to the hospital's

records by other health care organizations would appear to satisfy New York law.

However, Public Health Law § 18(6) law requires additional tracking of disclosures by licensed professionals and facilities than is required under HIPAA. This provision requires tracking of disclosures made to external parties (including providers) not under contract with the disclosing provider, for initial payment disclosures to payers and for other disclosures not explicitly exempted in the law.

Key Legal Barriers—New York law requires additional administrative logging for disclosures by licensed providers beyond HIPAA mandates.

Domain 7—Administrative or physical security safeguards required to implement a comprehensive security platform for health IT.

Applicable New York Law—Hospitals must employ safeguards to ensure the security and confidentiality of their medical records. 10 N.Y.C.R.R. § 405.10(c)(4). Hospitals must adopt policies and procedures to ensure the security of electronic or computer equipment from unwarranted access. 10 N.Y.C.R.R. § 405.10(c)(4)(iii).

Discussion—The requirement under New York law that hospitals employ safeguards to ensure the confidentiality and security of their medical records is general in nature and does not add any specific obligations beyond what is required under the HIPAA privacy and security regulations. The requirement under New York law that hospitals adopt policies and procedures to prevent unwarranted access to computer equipment is consistent with HIPAA. See 45 C.F.R. §§ 164.308, 164.310.

The implementation of HIPAA-compliant safeguards, policies and procedures would appear to satisfy New York law.

Key Legal Barriers—New York law does not create any legal barriers relevant to this domain beyond the requirements of HIPAA.

Domain 8—State law restrictions about information types and classes, and the solutions by which electronic personal health information can be viewed and exchanged.

Applicable New York Law—Hospitals are required to ensure the confidentiality of medical records. Information contained in such records may be released only to hospital staff involved in treating the patient "and individuals as permitted by Federal and State laws." 10 N.Y.C.R.R. § 405.10(a)(6). This regulation requires hospitals to obtain consent from the patient prior to disclosing medical records to an outside entity, even for treatment or reimbursement purposes. See also *Williams v. Roosevelt Hospital*, 66 N.Y.2d 391(1985). Physicians also are prohibited from disclosing identifiable information without consent, except if authorized or required by law. Education Law § 6530(23) and 8 N.Y.C.R.R. § 29. Such state required consent may be a general consent permitting certain types of disclosures, and the consent does not have to be as specific as a HIPAA authorization or contain all of the HIPAA-mandated elements. If consent is oral or implied, it should be documented in the chart to enable enforcement and minimize litigation risk.

New York law permits medical services to be rendered without consent when in the physician's judgment an emergency exists and the person is in immediate need of medical attention and an attempt to secure consent would result in delay of treatment which would increase the risk to the person's life or health. N.Y.P.H.L § 2504(4). This provision has been interpreted to allow release of medical information under such circumstances, as well.

Hospitals operating mental health facilities licensed under Article 31 of the New York Mental Hygiene Law may disclose clinical records of such facilities without the patient's consent only for certain specifically defined purposes. Although the law does not expressly address the issue, the New York State Office of Mental Health ("OMH") is likely to take the position that mental health facilities may not rely on a general consent for the release of such records. OMH has developed a standard consent form for mental health facilities. With the consent of the patient or someone authorized to act on the patient's behalf, clinical records can be released to "persons and entities who have a demonstrable need for such information . . . provided that disclosure will not reasonably be expected to be detrimental to the patient."

N.Y. Mental Hygiene Law § 33.13(c)(7). New York law also provides that clinical records may be released to "appropriate persons and entities when necessary to prevent imminent serious harm to the patient or client or another person." N.Y. Mental Hygiene Law § 33.13(c)(9)(v). NOTE: Psychiatric care and medication is very often provided to patients on general in-patient units in non-OMH licensed hospitals. Such information is governed by the Department of Health (DOH) statutes and regulations applying to general medical information (i.e., 10 N.Y.C.R.R. § 405.10).

Discussion—The New York law requirement that hospitals obtain a general consent prior to releasing medical records is not relevant in this scenario because the hospital in question is a mental health facility licensed under Article 31 of the New York Mental Hygiene Law. Mental health facilities or units in general hospitals which are licensed by Office of Mental Hygiene (OMH) must obtain a standard consent that has been developed in conjunction with OMH unless the disclosure falls under a limited group of exceptions.

In this scenario, New York law is more stringent than HIPAA because the requested disclosure would require a

specific mental health consent. Such disclosures are permitted under HIPAA without patient consent or authorization. See 45 C.F.R. § 164.506(c)(2).

New York law does provide an exception for a mental health facility licensed by OMH to disclose information to another mental health facility licensed by OMH for treatment purposes. However, since the requested disclosure here is to the emergency room physician of a general hospital in a different state, the exception does not apply.

Another exception that could apply in this scenario is the "imminent serious harm" exception mentioned above. If the mental health facility concludes that disclosure is necessary to prevent imminent serious harm to the patient or another person, then it could disclose the prior diagnosis and treatment information without the patient's consent. However, it is unclear how this exception is interpreted and a narrow interpretation is unlikely to support disclosure in this scenario.

It is unlikely that the mental health facility already has a consent that would allow disclosure of the patient's diagnosis and treatment. Thus the facility would not be able to agree to the information request from the neighboring state without obtaining a consent unless it believed that such information was necessary to prevent imminent serious harm.

Key Legal Barriers—The mental health facility would not be able to disclose the patient's prior diagnosis and treatment without either (i) obtaining from the patient the standard consent for mental health facilities or (ii) concluding that the disclosure is necessary to prevent imminent serious harm.

4. Patient Care Scenario D

> *Patient X is HIV positive and is having a complete physical and an outpatient mammogram done in the Women's Imaging Center of General Hospital in State A. She had her last physical and mammogram in an outpatient clinic in a neighboring state. Her physician in State A is requesting a copy of her complete records and the radiologist at General Hospital would like to review the digital images of the mammogram performed at the outpatient clinic in State B for comparison purposes. She also is having a test for the BrCa gene and is requesting the genetic test results of her deceased aunt who had a history of breast cancer.*

Note: We assume for purposes of this analysis that New York is State B and that the New York outpatient clinic is run by a hospital licensed under Article 28 of the New York Public Health Law. We also assume that the genetic test results of the patient's deceased aunt are in the custody of the hospital in New York.

Domain 1—User and entity authentication is used to verify that a person or entity seeking access to electronic protected health information is who they claim to be: Same analysis as in Patient Care Scenario A.:

Domain 2—Information authorization and access controls to allow access only to people or software programs that have been granted access rights to electronic personal health information: Same analysis as in Patient Care Scenario A.

Domain 3—Patient and provider identification to match identities across multiple information systems and locate electronic personal health information across enterprises: Same analysis as in Patient Care Scenario A.

Domain 4—Information transmission security or exchange protocols (i.e., encryption, etc.) for information that is being exchanged over an electronic communications network.: Same analysis as in Patient Care Scenario A.

Domain 5—Information protections so that electronic personal health information cannot be improperly modified: Same analysis as in Patient Care Scenario A.

Domain 6—Information audits that record and monitor the activity of health information systems: Same analysis as in Patient Care Scenario A.

Domain 7—Administrative or physical security safeguards required to implement a comprehensive security platform for health IT.

Applicable New York Law—Hospitals must employ safeguards to ensure the security and confidentiality of their medical records. 10 N.Y.C.R.R. § 405.10(c)(4). Hospitals must adopt policies and procedures to ensure the security of electronic or computer equipment from unwarranted access. 10 N.Y.C.R.R. § 405.10(c)(4)(iii).

Health care providers and health care facilities must adopt protocols for ensuring that records (including electronic records) containing HIV-related information are maintained securely and used for appropriate purposes. 10 N.Y.C.R.R. § 63.9(d).

Discussion—The requirement under New York that hospitals employ safeguards to ensure the confidentiality and security of their medical records is general in nature and does not add any specific obligations beyond what is required under the HIPAA privacy and security regulations. The same is true of the requirement under New York law that protocols be adopted to ensure records containing HIV-related information are securely maintained and appropriately used. The requirement under New York law that hospitals adopt policies and procedures to prevent unwarranted access to computer equipment is consistent with HIPAA. See 45 C.F.R. § 164.310. The implementation of HIPAA-compliant safeguards, policies and procedures would appear to satisfy New York law.

Key Legal Barriers—New York law does not create any legal barriers relevant to this domain beyond HIPAA requirements.

Domain 8—State law restrictions about information types and classes, and the solutions by which electronic personal health information can be viewed and exchanged.

Applicable New York Law—Hospitals are required to ensure the confidentiality of medical records. Information contained in such records may be released only to hospital staff involved in treating the patient "and individuals as permitted by Federal and State laws." 10 N.Y.C.R.R. § 405.10(a)(6). This regulation requires hospitals to obtain consent from the patient prior to disclosing medical records to an outside entity, even for treatment or reimbursement purposes. See also *Williams v. Roosevelt Hospital*, 66 N.Y.2d 391(1985). Physicians also are prohibited from disclosing identifiable information without consent, except if authorized or required by law. Education Law § 6530(23) and 8 N.Y.C.R.R. § 29. Such state required consent may be a general consent permitting certain types of disclosures, and the consent does not have to be as specific as a HIPAA authorization or contain all of the HIPAA-mandated elements. If consent is oral or implied, it should be documented in the chart to enable enforcement and minimize litigation risk.

New York law permits medical services to be rendered without consent when in the physician's judgment an emergency exists and the person is in immediate need of medical attention and an attempt to secure consent would result in delay of treatment which would increase the risk to the person's life or health. N.Y.P.H.L § 2504(4). This provision has been interpreted to allow release of medical information under such circumstances, as well.

Health care providers may not disclose confidential HIV-related information without the patient's authorization except for certain specifically defined purposes. N.Y. Public Health Law Article 27-F. Confidential HIV-related information is defined as information in a health care provider's possession or obtained through a release of such information concerning whether a person has been subject to an HIV test, has an HIV infection, is being treated for an HIV-related illness, or any information that identifies or reasonably could identify the person as having one or more such conditions. N.Y. Public Health Law § 2780(7).

If the patient authorizes a release, the health care provider may release the information to whomever the patient directs. N.Y. Public Health Law § 2782(1)(b). However, the provider may not rely on a general consent from the patient but must obtain a special HIV release that expressly references the nature of the information being disclosed and contains certain mandated elements. N.Y. Public Health Law § 2780(9). The specific release form must be developed by DOH or approved by DOH. 10 N.Y.C.R.R. § 63.5(a).

There are exceptions to the general non-disclosure rule that go beyond cases where the patient has given consent to specifically release HIV information. A special HIV consent to disclosure form is not required for disclosure to a "health care provider" or "health facility" when knowledge of the HIV information is necessary to provide appropriate care or treatment to the person whose record contains HIV-related information. N.Y. Public Health Law § 2782(1)(d); 10 N.Y.C.R.R. § 63.6(a)(4). In such cases, a general consent is sufficient. "Health care provider" is defined broadly to include any physician or any other person involved in providing medical, nursing, counseling or other health care services. N.Y. Public Health Law § 2780(13). "Health facility" is defined to include any hospital as such term is defined elsewhere in the Public Health Law as "a facility or institution engaged principally in providing services by or under the supervision of a physician." N.Y. Public Health Law § 2780(12); N.Y. Public Health Law § 2801(1).

New York law requires that genetic test results are treated confidentially and not disclosed without the written informed consent of the person tested except in limited circumstances involving court orders and the testing of infants for certain diseases. N.Y. Civil Rights Law § 79-1(3), (4)(c). Once a person is deceased, the right of the deceased person to access his or her own medical records may be exercised by a personal representative (a technical term under New York's estates, powers and trusts law) or by a distributee of any deceased person for whom no personal representative has been appointed. N.Y. Public Health Law § 18(1)(g).

A treating provider must release the medical records, including original mammograms of a patient to another provider "upon the written request" of the patient. N.Y. Public Health Law § 17.

Discussion—New York law is more stringent than HIPAA because it requires patient consent for the disclosure of protected health information by hospitals to health plans for reimbursement or other payment-related purposes. Such disclosures are permitted under HIPAA without patient consent or authorization. See 45 C.F.R. § 164.506(c).

New York law would require the hospital to obtain a general consent from the patient prior to releasing her complete records to the doctor and the digital images of her mammogram to the radiologist at the hospital in State A. Most New York hospitals obtain a general consent from each patient as part of the admission or registration process so it is possible the hospital already has what it needs, but the language in the consent form may be narrowly tailored to permit the hospital to submit bills to the patient's insurer. Thus, the hospital could carefully review its consent form to determine whether the language is sufficiently broad to permit the disclosure requested here or require a new written request for the disclosure. See N.Y. Public Health Law § 17.

In addition, since the patient here is HIV positive, it is highly likely that her complete medical records contain confidential HIV-related information so that the outpatient clinic could not release her medical records to the hospital in State A without a specific HIV release from the patient, unless the outpatient clinic determined that release of her records to the hospital was necessary to provide her with appropriate care or treatment, in which case, a general release would suffice. The radiologist's request for the digital images of her last mammography are unlikely to fall under the HIV provisions because those images are unlikely to fall under the definition of confidential HIV-related information.

As to genetic tests, New York law is no more restrictive than HIPAA, which requires compliance with respect to protected health information for deceased individuals and states that if, under applicable law, an executor, administrator or other person has authority to act on behalf of a deceased individual (or the estate thereof), that person is a personal representative with respect to protected health information relevant to the personal representation. See 45 C.F.R. 164.502(f), (g)(4). Unless the patient is the personal representative of her deceased aunt, she cannot gain access to the genetic tests of the deceased aunt.

Key Legal Barriers—The hospital might have to revise its standard consent form to cover the provision of access to the EHR to the hospital in State A. In addition, for the complete medical records request, the hospital would have to obtain a special consent from the patient authorizing the release of HIV-related information in her records unless the hospital makes a determination that the release is necessary for the patient's care.

5. Payment Scenario

X Health Payer (third party, disability insurance, employee assistance programs) provides health insurance coverage to many subscribers in the region the health care provider serves. As part of the insurance coverage, it is necessary for the health plan case managers to approve/authorize all inpatient encounters. This requires access to the patient health information (e.g., emergency department records, clinic notes, etc.). The health care provider has recently implemented an electronic health record (EHR) system. All patient information is now maintained in the EHR and is accessible to users who have been granted access through an approval process. Access to the EHR has been restricted to the health care provider's workforce members and medical staff members and their office staff. X Health Payer is requesting access to the EHR for their accredited case management staff to approve/authorize inpatient encounters.

Note: We assume for purposes of this analysis that the health care provider is a hospital licensed under Article 28 of the New York Public Health Law.

Domain 1—User and entity authentication is used to verify that a person or entity seeking access to electronic protected health information is who they claim to be: Same analysis as in Patient Care Scenario A.

Domain 2—Information authorization and access controls to allow access only to people or software programs that have been granted access rights to electronic personal health information.

Applicable New York Law—Hospitals are required to employ safeguards to ensure the security and confidentiality of their medical records. The safeguards must include policies and procedures that restrict access to information to those individuals who have the need, a reason and permission for such access. 10 N.Y.C.R.R. § 405.10(c)(4)(iv). Hospitals must have procedures in place to modify or terminate use of an assigned identifier due to misuse or changes in the user's employment or affiliation with the hospital. 10 N.Y.C.R.R. § 405.10(c)(7).

Discussion—The requirement under New York law that hospitals have policies and procedures to restrict access to appropriately authorized individuals is consistent with HIPAA. See 45 C.F.R. §§ 164.308(a)(3)(i)(C), (4)(ii)(B) and (C). The requirement under New York law that hospitals adopt procedures to modify or terminate a system user's access rights based on the termination or modification of the user's relationship with the hospital is also consistent with HIPAA. See 45 C.F.R. § 164.308(a)(3)(ii)(C).

Assuming the patient has consented to grant the payer access to all his/her records for pre-authorization purposes, the hospital would appear to satisfy New York law if it adopts written policies and procedures (i) identifying and authenticating X Health Payer case management personnel who will have access to the EHR, (ii) requiring X Health Payer to monitor the scope of such access and promptly notify the hospital of abuse/misuse or the termination or reassignment of one of its case managers and (iii) obligating the hospital to terminate a case manager's access rights to the EHR upon notice from X Health Payer.

Note: Hospitals currently do not afford open access rights to persons who are not their employees or who are not professionally affiliated (e.g., attending physicians, etc.) with the hospital. Rather, hospital staff provide the information to the case manager, rather than have the case manager be able to access any patient's record in the hospital, or even all (and not just the relevant parts) the records for their enrollees. Unless software was in place to restrict case managers only to their own enrollees and only to parts of the record for which reimbursement is pending or with respect to which some audit issue exists,

it is unlikely that this arrangement would be determined to satisfy the security provisions of § 405.10.

Key Legal Barriers—New York law does not create any legal barriers relevant to this domain beyond the requirements of HIPAA.

Domain 3—Patient and provider identification to match identities across multiple information systems and locate electronic personal health information across enterprises: Same analysis as in Patient Care Scenario A.

Domain 4—Information transmission security or exchange protocols (i.e., encryption, etc.) for information that is being exchanged over an electronic communications network: Same analysis as in Patient Care Scenario A.

Domain 5—Information protections so that electronic personal health information cannot be improperly modified: Same analysis as in Patient Care Scenario A.

Domain 6—Information audits that record and monitor the activity of health information systems: Same analysis as in Patient Care Scenario A.

Domain 7—Administrative or physical security safeguards required to implement a comprehensive security platform for health IT.

Applicable New York Law—Hospitals must employ safeguards to ensure the security and confidentiality of their medical records. 10 N.Y.C.R.R. § 405.10(c)(4). Hospitals must adopt policies and procedures to ensure the security of electronic or computer equipment from unwarranted access. 10 N.Y.C.R.R. § 405.10(c)(4)(iii).

Health care providers and health care facilities must adopt protocols for ensuring that records (including electronic records) containing HIV-related information are maintained securely and used for appropriate purposes. 10 N.Y.C.R.R. § 63.9(d).

Discussion—The requirement under New York that hospitals employ safeguards to ensure the confidentiality and security of their medical records is general in nature and does not add any specific obligations beyond what is required under the HIPAA privacy and security regulations. The same is true of the requirement under New York law that protocols be adopted to ensure records containing HIV-related information are securely maintained and appropriately used. The requirement under New York law that hospitals adopt policies and procedures to prevent unwarranted access to computer equipment is consistent with HIPAA. See 45 C.F.R. § 164.310.

The implementation of HIPAA-compliant safeguards, policies and procedures would appear to satisfy New York law.

Key Legal Barriers—New York law does not create any legal barriers relevant to this domain beyond requirements under HIPAA.

Domain 8—State law restrictions about information types and classes, and the solutions by which electronic personal health information can be viewed and exchanged.

Applicable New York Law—Hospitals are required to ensure the confidentiality of medical records. Information contained in such records may be released only to hospital staff involved in treating the patient "and individuals as permitted by Federal and State laws." 10 N.Y.C.R.R. § 405.10(a)(6). This regulation requires hospitals to obtain consent from the patient prior to disclosing medical records to an outside entity, even for treatment or reimbursement purposes. See also *Williams v. Roosevelt Hospital*, 66 N.Y.2d 391(1985). Physicians also are prohibited from disclosing identifiable information without consent, except if authorized or required by law. Education Law § 6530(23) and 8 N.Y.C.R.R. § 29. Such state required consent may be a general consent permitting certain types of disclosures, and the consent does not have to be as specific as a HIPAA authorization or contain all of the HIPAA-mandated elements. If consent is oral or implied, it should be documented in the chart to enable enforcement and minimize litigation risk.

New York law contains a general requirement that disclosures by providers to third persons "shall be limited to that information necessary in light of the reason for disclosure." New York Public Health Law § 18(6). New York law also specifically addresses the scope of disclosures in limited circumstances, including disclosures related to HIV/AIDS, New York Public Health Law § 2782, and mental health, New York Mental Hygiene Law § 33.13.

New York law permits medical services to be rendered without consent when in the physician's judgment an emergency exists and the person is in immediate need of medical attention and an attempt to secure consent would result in delay of treatment which would increase the risk to the person's life or health. N.Y.P.H.L. § 2504(4). This provision has been interpreted to allow release of medical information under such circumstances, as well.

Health care providers may not disclose HIV-related information without the patient's authorization except for certain specifically defined purposes. N.Y. Public Health Law Article 27-F. In cases where the patient's authorization is required, the provider may not rely on a general consent; it must obtain a special HIV release that expressly references the nature of the information being disclosed and contains certain mandated elements. N.Y. Public Health Law § 2780(9). The permitted purposes include disclosure to third party payers as necessary to obtain reimbursement for health care services, provided that, to the extent necessary under other laws, the provider or facility has obtained a general consent from the patient for the disclosure. N.Y. Public Health Law § 2782(1)(i); 10 N.Y.C.R.R. § 63.6(a)(9). Disclosures to insurance institutions for reasons other than reimbursement are permitted only if the insurance institution obtains a written

authorization stating the nature of the information being disclosed and the purpose of the disclosure. N.Y. Public Health Law § 2782(1)(j); 10 N.Y.C.R.R. § 63.6(a)(10).

Hospitals operating mental health facilities licensed under Article 31 of the New York Mental Hygiene Law may disclose clinical records of such facilities without the patient's consent only for certain specifically defined purposes. Although the law does not expressly address the issue, the New York State Office of Mental Health ("OMH") is likely to take the position that mental health facilities may not rely on a general consent for the release of such records. OMH has developed a standard consent form for mental health facilities. The permitted purposes include disclosures to government agencies, licensed insurance companies and other third parties as necessary to obtain reimbursement for mental health services. N.Y. Mental Hygiene Law § 33.13(c)(9)(i).

Discussion—New York law is more stringent than HIPAA because it requires patient consent for the disclosure of protected health information by hospitals to health plans for reimbursement or other payment-related purposes. Such disclosures are permitted under HIPAA without patient consent or authorization. See 45 C.F.R. § 164.506(c).

At a minimum, New York law would require the hospital to obtain a general consent from each patient prior to permitting X Health Plan to have access to the patient's records. Most New York hospitals obtain a general consent from each patient as part of the admission or registration process. However, the language in the consent form may be narrowly tailored to permit the hospital to submit bills to the patient's insurer. A hospital would have to carefully review its consent form to determine whether the language is sufficiently broad to permit X Health Plan's access to the patient's entire EHR for pre-authorization purposes.

In addition, to the extent an EHR contains HIV-related information, it is unclear whether DOH would take the position that X Health Plan's access to the EHR for pre-authorization purposes falls within the reimbursement exception to New York's HIV confidentiality law. There appears to be a strong argument that it does because pre-authorization is a condition of payment. However, if the law were interpreted more restrictively, the hospital or payer would have to obtain a more specific authorization from any patient whose EHR contained HIV-related information.

Likewise, to the extent an EHR is maintained by a hospital facility licensed under Article 31 of the Mental Hygiene Law, it is unclear whether OMH would take the position that X Health Plan's access to the EHR for pre-authorization purposes falls within the reimbursement exception to New York's mental health confidentiality law. There appears to be a strong argument that it does because pre-authorization is a condition of payment. However, if the law were interpreted more restrictively, the hospital would have to obtain a more specific patient consent prior to providing access to its mental health facility records.

New York law's general requirement that all disclosures by providers to third persons are limited to that information necessary in light of the reason for disclosure exceed the HIPAA concept of "minimum necessary," which does not apply to release of information for treatment purposes. However, here, where the disclosure is for payment purposes, New York law would not exceed HIPAA requirements.

Key Legal Barriers—The hospital or payer might have to revise its standard consent form to cover the provision of access to the EHR to X Health Plan. In addition, depending on how New York's HIV and mental health confidentiality laws are interpreted by DOH and OMH, respectively, the hospital or payer might be required to obtain a more specific patient authorization covering HIV and mental health records, which would effectively preclude X Health Plan from gaining access to this information.

6. RHIO Scenario

The RHIO in your region wants to access patient identifiable data from all participating organizations (and their patients) to monitor the incidence and management of diabetic patients. The RHIO also intends to monitor participating providers to rank them for the provision of preventive services to their diabetic patients.

Note: We assume for purposes of this analysis that the RHIO consists of hospitals, private physician practices, pharmacies and clinical laboratories. We also assume that the data regarding diabetic patients does not include HIV-related or mental health information.

Domain 1—User and entity authentication is used to verify that a person or entity seeking access to electronic protected health information is who they claim to be: Same analysis as in Patient Care Scenario A.

Domain 2—Information authorization and access controls to allow access only to people or software programs that have been granted access rights to electronic personal health information.

Applicable New York Law—Hospitals are required to employ safeguards to ensure the security and confidentiality of their medical records. The safeguards must include policies and procedures that restrict access to information to those individuals who have the need, a reason and permission for such access. 10 N.Y.C.R.R. § 405.10(c)(4)(iv). Hospitals must have procedures in place to modify or terminate use of an assigned identifier due to misuse or changes in the user's employment or affiliation with the hospital. 10 N.Y.C.R.R. § 405.10(c)(7).

Only pharmacists and pharmacy interns may "access the data" in a computerized prescription management system maintained by a pharmacy, except that unlicensed persons may be granted such access to assist with specified administrative functions. 8 N.Y.C.R.R. §§ 29.7(a)(8)(vii) and (a)(21). The phrase "access the data" is not defined in the regulations.

Discussion—The requirement under New York law that hospitals have policies and procedures to restrict access to appropriately authorized individuals is consistent with HIPAA. See 45 C.F.R. §§ 164.308(a)(3)(i)(C), (4)(ii)(B) and (C). The requirement under New York law that hospitals adopt procedures to modify or terminate a system user's access rights based on the termination or modification of the user's relationship with the hospital is also consistent with HIPAA. See 45 C.F.R. § 164.308(a)(3)(ii)(C). The hospitals would appear to satisfy New York law if they adopt written policies and procedures (i) identifying RHIO personnel who will have access to their records, (ii) requiring the RHIO to monitor such access and to promptly notify the hospital of the termination or reassignment of one of these employees and (iii) obligating the hospital to terminate a RHIO employee's access rights to the system upon notice from the RHIO.

Although New York regulations state that pharmacies must restrict access to licensed professionals or other pharmacy personnel performing administrative functions, it is not clear how "access the data" is defined in this context. If "access the data" does not include accessing patient identifiable data that is extracted from the original prescription record in the electronic data processing system, the pharmacies could provide access to the RHIO without violating the above-cited regulation. However, if "access the data" means the capacity to receive the patient information in the data, the above-cited regulation might be construed as prohibiting the RHIO from accessing the information in the pharmacies' electronic prescription management system. Such an interpretation would make New York law more stringent than HIPAA, which permits the pharmacies to share data with the RHIO for quality improvement purposes if the RHIO is functioning as the pharmacies' business associate. 45 C.F.R. §§ 164.502(e), 504(e) and 164.506(c).

Key Legal Barriers—If New York law is interpreted as prohibiting pharmacies from permitting individuals other than pharmacists, pharmacy interns or their administrative personnel from viewing data in a pharmacy's prescription data management system, this would prohibit the RHIO from directly accessing data in pharmacies' information systems.

Domain 3—Patient and provider identification to match identities across multiple information systems and locate electronic personal health information across enterprises: Same analysis as in Patient Care Scenario A.

Domain 4—Information transmission security or exchange protocols (i.e., encryption, etc.) for information that is being exchanged over an electronic communications network: Same analysis as in Patient Care Scenario A.

Domain 5—Information protections so that electronic personal health information cannot be improperly modified.

Applicable New York Law—Hospitals are required to employ "safeguards to ensure safety and confidentiality." 10 N.Y.C.R.R. § 405.10(c). Pharmacies utilizing a computerized prescription management system "shall provide adequate safeguards against improper manipulation or alteration of stored records." 8 N.Y.C.R.R. § 29.7(a)(8)(i).

Discussion—The requirement that hospitals employ safeguards to ensure safety and confidentiality under New York law is general in nature and does not exceed HIPAA requirements.

The requirement that pharmacies adopt safeguards against improper manipulation or alteration of stored records parallels the obligation of covered entities under HIPAA to implement integrity controls. 45 C.F.R. § 164.312(c). Compliance with this HIPAA mandate would appear to satisfy New York law.

Key Legal Barriers—New York law does not create any legal barriers relevant to this domain beyond requirements under HIPAA.

Domain 6—Information audits that record and monitor the activity of health information systems: Same analysis as in Patient Care Scenario A.

Domain 7—Administrative or physical security safeguards required to implement a comprehensive security platform for health IT: Same analysis as in Patient Care Scenario A.

Domain 8—State law restrictions about information types and classes, and the solutions by which electronic personal health information can be viewed and exchanged.

Applicable New York Law—Hospitals are required to ensure the confidentiality of medical records. Information contained in such records may be released only to hospital staff involved in treating the patient "and individuals as permitted by Federal and State laws." 10 N.Y.C.R.R. § 405.10(a)(6). This regulation requires hospitals to obtain consent from the patient prior to disclosing medical records to an outside entity, even for treatment or reimbursement purposes. See also *Williams v. Roosevelt Hospital*, 66 N.Y.2d 391(1985). Physicians also are prohibited from disclosing identifiable information without consent, except if authorized or required by law. Education Law § 6530(23) and 8 N.Y.C.R.R. § 29. Such state required consent may be a general consent permitting certain types

of disclosures, and the consent does not have to be as specific as a HIPAA authorization or contain all of the HIPAA-mandated elements. If consent is oral or implied, it should be documented in the chart to enable enforcement and minimize litigation risk.

New York law permits medical services to be rendered without consent when in the physician's judgment an emergency exists and the person is in immediate need of medical attention and an attempt to secure consent would result in delay of treatment which would increase the risk to the person's life or health. N.Y.P.H.L § 2504(4). This provision has been interpreted to allow release of medical information under such circumstances, as well.

It is professional misconduct for pharmacists and physicians to reveal "personally identifiable facts, data or information obtained in a professional capacity without the prior consent of the patient or client, except as authorized or required by law." N.Y. Education Law § 6530(23); 8 N.Y.C.R.R. § 29.1(b)(8). DOH has interpreted this regulation in a manner similar to its interpretation of the above-cited hospital regulation, i.e., pharmacists and physicians are required to obtain patient consent for the disclosure of records to outside entities, even for treatment, quality improvement or other purposes permitted by HIPAA without patient authorization.

Clinical laboratories may report test results only to "a physician, his agent, or other person authorized by law to employ the results thereof in the conduct of his practice or in the fulfillment of his official duties." 10 N.Y.C.R.R. § 58-1.8. It is unclear how the term "agent" is defined under this regulation and whether the RHIO could serve as the physician's agent if the physician authorized the RHIO, in a written agreement or otherwise, to receive test results on his or her behalf.

Discussion—New York law is more stringent than HIPAA because it requires patient consent for the disclosure of protected health information by hospitals, physicians and pharmacists to an outside entity such as the RHIO for quality improvement purposes. Such disclosures are permitted under HIPAA without patient consent or authorization. See 45 C.F.R. § 164.506(c)(4). Data aggregation also is permitted by business associates under HIPAA. 45 C.F.R. §§ 164.501, 164.504(e)(2)(i)(B).

New York law would require the hospitals, pharmacies and physicians participating in the RHIO to obtain a general consent from each patient prior to permitting the RHIO to have access to the patient's records. Most New York hospitals and some physicians obtain a general consent from each patient as part of the admission or registration process. However, the language in the consent form may be narrowly tailored to permit the hospital or physician to provide treatment or submit bills to the patient's insurer. Hospitals and physicians would have to carefully review their consent forms to determine whether the language is sufficiently broad to permit the RHIO to obtain access to their patients' records. In addition, pharmacies typically do not obtain patient consents as part of their standard business practices.

Clinical laboratories would not be permitted to send test results to the RHIO under New York law unless the RHIO were deemed the physician's "agent" under the clinical laboratory regulation cited above. Clarification would be required from DOH to determine how the term "agent" is defined in this context. If test results could not be transmitted by the clinical laboratories, it might be possible for the RHIO to obtain the results from the ordering physician if the physician obtained patient consent as described above.

Key Legal Barriers—The hospitals and physicians might have to revise their standard consent forms to cover the disclosure of information to the RHIO.

The pharmacies would not be permitted to share information with the RHIO unless they obtained patient consents, which would constitute a new business practice that is unlikely to be adopted by most pharmacies.

The clinical laboratories would be permitted to share information with the RHIO only if they could be deemed the ordering physician's agent under applicable regulations.

Editor's Selected Court Decision

***McKinney v. Commr. of DOH*, 15 Misc. 3d 743 (2007), 2007 N.Y. Slip. Op. 27097, *aff'd*, 41 A.D.3d 252, 1st Dep't 2007)** (see page 55 for 1st Dep't's decision)

Supreme Court of the State of New York, Bronx County, March 8, 2007

Opinion of the Court

Maryann Brigantti-Hughes, J.

Plaintiffs, Mary McKinney and Mechler Hall Community Services, Inc . moved by order to show cause for a temporary restraining order (TRO) enjoining the defendants, the Commissioner of the New York State Department of Health, the New York State Department of Health (NYSDH) and the State of New York from implementing the recommendations of the Commission on Health Care Facilities in the 21st Century to close the Westchester Square Medical Center (WSMC), located at 2475 St. Raymond Avenue, in Bronx County, and other similarly situated medical facilities. Defendants cross-moved for an order pursuant to CPLR 3211 (a) for summary judgment dismissing plaintiffs' complaint for failure to state a cause of action, lack of standing and failure to join a necessary party.

On January 3, 2007, this court heard oral argument on the TRO proposed by the plaintiffs. After hearing the arguments, the court granted the TRO only as it applied to WSMC and did not rule on the various underlying issues raised. The court afforded all of the parties an opportunity to submit answering and/or reply papers and memorandum of law no later than January 29, 2007.

The Commission, also known as the Berger Commission, was specially created by the New York State Legislature as the result of its recognition that the possible existence of excess hospital capacity would threaten both the stability and efficiency of New York State's health care system. The Commission was empowered by the Legislature to conduct "a rational, independent review of health care capacity and resources in the state . . . [and was] . . . charged with examining the supply of general hospital and nursing home facilities, and recommending changes that will result in a more coherent, streamlined health care system in the state of New York." (*See* L 2005, ch 63, part E, § 31, adding part K [Enabling Legislation], § 1 [establishing a Commission on Health Care Facilities in the 21st Century].)

The Enabling Legislation provides that the Commission shall consist of 18 statewide members and up to 36 regional members who are appointed by the Governor and the Legislature. (*See* Enabling Legislation §§ 2, 7.)

The regional members are selected from six regions: New York City, Long Island, Hudson Valley, and Northern, Central and Western New York, thus creating six "Regional Advisory Committees" (RACs). Regional members were authorized to vote only on those recommendations related to their respective regions. (*See* Enabling Legislation § 7.)

Additionally, RACs were required to "develop recommendations for reconfiguring its region's general hospital and nursing home supply to align bed supply with regional and local needs." (Enabling Legislation § 7 [d].) Each RAC was required to transmit its individual report to the Commission on November 15, 2006. (See Enabling Legislation § 7 [c], [d].)

Thereafter, the 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 [and to] . . . make recommendations relating to facilities to be closed and facilities to be resized, consolidated, converted or restructured" in each of the six regions of the state. (Enabling Legislation § 8 [a], [b].) In carrying out its functions, the Commission was required to collaborate with the RACs to foster discussion and obtain community input and to take into consideration the recommendations of the RACs. In addition, the Commission was required to transmit its final report to the Governor on or before December 1, 2006. (*See* Enabling Legislation § 8.)

Section 9 of the Enabling Legislation states that, unless the Governor failed to transmit the final report by December 5, 2006 or a majority of the members of each house of the New York State Legislature voted to adopt a concurrent resolution rejecting the Commission's recommendations in its entirety by December 31, 2006, the Commissioner of Health "shall take all actions necessary to implement, in a reasonable, cost-efficient manner, the recommendations of the commission." (Enabling Legislation § 9 [a], [b].)

The Enabling Legislation established the following nine factors to be considered as part of the analytic methodology: the need for capacity in each of the hospital and nursing homes systems; current capacity in each system; the economic impact of right sizing actions; the amount of capital debt; the availability of alternative sources of funding; the existence of other health care services; the potential conversion of facilities for alternate uses; the extent to which a facility serves the need of the region and vulnerable populations; and the potential for improved quality of care. (*See* Enabling Legislation § 5.)

The Commission consolidated the factors into the following six key criteria: service to vulnerable populations, availability of services, quality of care, utilization, viability, and economic impact. Nineteen public hearings were conducted by the Commission, or its RACs to gather information and community input throughout the state. Five such hearings were held in New York City, one in each borough. (*See* Final Report of Common Health Care Facilities in 21st Century, *A Plan to Stabilize and Strengthen New York's Health Care System* [Final Report] at 68-70, <http://www.nyhealthcarecommission.org/docs/final/commissionfinalreport.pdf> [Dec. 2006], cached at <http://www.courts.state.ny.us/reporter/webdocs/commissionfinalreport.pdf>.)

The Commission's Final Report, entitled "A Plan to Stabilize and Strengthen New York's Health Care System" contained recommendations for the closing, downsizing or reconfiguration of a total of 57 acute health care facilities throughout New York State. Its effects reach approximately one quarter of all the hospital space in this state. With respect to WSMC, the Commission made the following observations: WSMC only provides general adult medical/surgical care and no specialty medical care. WSMC provides no maternity care, psychiatric service or substance abuse care. WSMC operates at a near-break-even operating margin. Despite its location in a federally designated medically underserved area, WSMC's payor mix includes few Medicaid-covered and uninsured patients. In 2004, 12% of the hospital patients were either Medicaid or uninsured clients. In 2004, WSMC records indicate that its bed occupancy rate was a mere 51%. WSMC functions largely as a feeder to tertiary hospitals in the New York Presbyterian Health System (NYPHS). A review of the medical facilities available to patients in the same area shows that WSMC patients could be absorbed by surrounding medical facilities such as St. Barnabas Hospital, Montefiore/Weiler Campus and Moses Campus, Jacobi Hospital, Our Lady of Mercy Hospital, and other medical facilities belonging to the NYPHS. (*See* Final Report at 159-160.)

As a consequence, the Final Report of the Commission indicated that WSMC represented excess capacity in the health care system and recommended that it be closed. (*See* Final Report at 159.) The Final Report also stated, "Unless otherwise specified, the Commissioner of Health shall implement each recommendation as expeditiously as possible, but in no event later than June 30, 2008." (*See* Final Report at 90.)

The Final Report was transmitted in a timely fashion to the Governor and the Legislature on November 28, 2006. (*See* Enabling Legislation § 8; Final Report.) The Governor subsequently transmitted the Final Report, with his approval thereof, to the Legislature on November 30, 2006. The Legislature did not pass a concurrent resolution rejecting the Final Report prior to the end of 2006. As such, the Commissioner of Health is mandated by the Enabling Legislation to implement the Commission's recommendations. (*See* Enabling Legislation § 9.)

Joinder

WSMC, the subject medical facility, was not joined in this action and has specifically declined being a party to this action.[1] Defendants argue that this action must be dismissed because WSMC may suffer prejudice if it is bound by this court's determination. In support of its argument, defendants cite CPLR 1001 (a) and its purposes: it "prevents multiple, inconsistent judgments" and "protects the otherwise absent parties who . . . have had no opportunity to be heard." (*Saratoga County Chamber of Commerce v. Pataki*, 100 NY2d 801, 820 [2003] [internal quotation marks omitted].)

Plaintiffs argue that WSMC is not a necessary party to the action because WSMC chose not to intervene (*see id.*); WSMC would raise distinct issues; WSMC is not a necessary party to reach the constitutionality issue and it has not been shown how WSMC would be prejudiced. (*International Assn. of Machinists & Aerospace Workers v. Allegis Corp.*, 144 Misc. 2d 983 [Sup. Ct., N.Y. County 1989]; *Phillips v. Town of Stony Point*, 104 AD2d 1033 [2d Dep't 1984].)

The courts are afforded wide latitude in determining whether there is a nonjoinder pursuant to CPLR 1001 (a), which should be liberally construed. (*Micucci v. Franklin Gen. Hosp.*, 136 AD2d 528 [2d Dep't 1988]; *Gross v. BFH Co.*, 151 AD2d 452 [2d Dep't 1989].) To the extent WSMC may claim that the Enabling Legislation is unconstitutional, WSMC's and plaintiffs interests are intertwined and coincide. (*Matter of 27th St. Block Assn. v. Dormitory Auth. of State of N.Y.*, 302 AD2d 155 [1st Dep't 2002]; *Matter of Long Is. Contractors' Assn. v. Town of Riverhead*, 17 AD3d 590 [2d Dep't 2005].) In addition, WSMC, "obviously aware of the proceeding, could have avoided any prejudice by seeking intervention." (*27th St. Block Assn.* at 163.) Furthermore, as plaintiffs' only cause of action involves an issue of law, to wit, the constitutionality of the Enabling Legislation, it is the opinion of this court that WSMC is not a necessary party to the instant action. (*Kronish Lieb Weiner & Hellman LLP v. Tahari, Ltd.*, 35 AD3d 317 [1st Dep't 2006].)

Standing

As it is alleged that it will take billions of dollars to effectuate the Commission's report, plaintiffs assert their standing to bring the petition and present motion based on the right of a taxpayer to maintain an action for relief for an allegedly unconstitutional disbursement of state funds (*see* State Finance Law, art 7-A, § 123-b *et seq.*; *Stanton v. Board of Supervisors of County of Essex*, 191 N.Y. 428 [1908]), as well as from the common law. (*See Doe v. Axelrod*, 136 AD2d 410 [1st Dep't 1988], *mod on other grounds*

73 NY2d 748 [1988]; *Community Serv. Socy. v. Cuomo*, 167 AD2d 168 [1st Dep't 1990] [where the courts have found that the proposed regulations affected the rights of plaintiff in the action].)

Plaintiff McKinney bases her common-law standing on her long-time relationship with WSMC. She argues that the closure of WSMC will significantly disrupt her health care. For example, McKinney faces the possible loss of her relationship with her physicians who are affiliated with WSMC and may have to relocate due to its closing. In addition, McKinney alleges that the increased travel time to another hospital for an emergency room visit will impose significant burdens on her access to necessary health care. In support of this contention, she presents her own affidavit, affidavits from a doctor and several of the nursing staff of WSMC stating their concerns for the health of their patients and the good of the community, and affidavits provided by administrators from several local centers and senior facilities indicating that many of their clients prefer to stay in the community atmosphere of WSMC.

Plaintiff Mechler Hall is a not-for-profit corporation that services the senior citizens in the Parkchester area of the Bronx. Like McKinney, many of the 65 to 80 members of Mechler rely on WSMC for their health care. Mechler has also provided an affidavit, from its executive director, which introduced two of its members who would be negatively affected by WSMC's closing.

In opposition, defendants argue that plaintiffs lack common-law standing because plaintiffs do not have an actual legal stake in operating certificates, do not have a legal right to medical care at WSMC, and do not have an in-fact injury within the zone of interests. (*Society of Plastics Indus, v. County of Suffolk*, 77 NY2d 761 [1991].) Defendants further allege that plaintiffs' allegation that the state funds will not be spent wisely does not have a sufficient nexus to fiscal activities of the State and is insufficient to confer standing. (*Rudder v. Pataki*, 93 NY2d 273 [1999]; *Saratoga County Chamber of Commerce* at 813-814 ["a claim that state funds are not being spent wisely is patently insufficient to satisfy the minimum threshold for standing, but a claim that it is illegal to spend money *at all* for the questioned activity likely would provide the plaintiff with standing"].)

Taxpayer Standing

Plaintiffs do not have taxpayer standing as its cause of action is a constitutional challenge of the Enabling Legislation. Although state funds are going to be expended in implementing the Final Report, the purpose of the Enabling Legislation is not the expenditure of state funds. Thus, plaintiffs attempt to obtain judicial scrutiny over the State's nonfiscal activity. (*See Rudder* at 281.) In *Rudder*, the Court of Appeals stated:

> Since most activities can be viewed as having some relationship to expenditures, . . . too broad a reading of section 123-b would create standing for any citizen who had the desire to challenge virtually all governmental acts. The claims here regarding [defendant's] nonfiscal rule-making review function do not demonstrate a sufficient nexus to fiscal activities of the State to allow for section 123-b standing. (*Id.*)

Thus, it is the opinion of this court that plaintiffs do not have taxpayer standing to challenge the Enabling Legislation.

Common-Law Standing

It is well settled that a party does not have standing to contest an administrative determination unless the party has an injury-in-fact or actual stake in the matter, the injury falls within the zone of interests sought to be protected by the statute, and the injury is different from that suffered by the public at large. (*See Society of Plastics* at 773-774.) These same principles of standing apply whether the party seeking relief is one person or an association of persons. (*Id.* at 775.) In addition to the above principles, in order to establish organizational standing, a plaintiff must demonstrate that at least one of its members would have standing to sue; that the interests it asserts are germane to its purposes so as to satisfy the court that it is an appropriate representative of those interests; and that the case would not require the participation of its individual members. (*Id.*) The requirement that a petitioner's injury fall within the concerns the Legislature sought to advance or protect by the statute assures that groups whose interests are only marginally related to, or even inconsistent with, the purposes of the statute cannot use the courts to further their own purposes at the expense of the statutory purpose. (*Id.* at 774.)

In the instant case, plaintiffs do not have a legal stake or right to the operating licenses. in addition, the injury suffered by plaintiffs, i.e., that access to health care *might* be disrupted, is speculative and no different from the injury that the public *might* experience. (*Matter of Rent Stabilization Assn. of N.Y.C., Inc. v. Miller*, 15 AD3d 194 [1st Dep't 2005]; *Urban Justice Ctr. v. Pataki*, 38 AD3d 20 [1st Dep't 2006].) Furthermore, the purpose of the Enabling Legislation to "streamline"[2] the health care system and make it more efficient by closing or downsizing hospitals and nursing homes reflects the policy decision of the Legislature. As such, plaintiffs' injury does not fall within the zone of interests sought to be protected by the Enabling Legislation.

However, it is significant to note that the Court of Appeals and Appellate Division, Third Department, have

given a more liberal construction to standing. "[T]he increasing pervasiveness of administrative influence on daily life . . . necessitates a concomitant broadening of the category of persons entitled to a judicial determination of administrative actions." (*Matter of New York State Socy. of Surgeons v. Axelrod*, 157 AD2d 54, 56 [3d Dep't 1990] [internal quotation marks omitted], quoting *Matter of Dairylea Coop, v. Walkley*, 38 NY2d 6, 10 [1975].)

A fundamental tenet of our judicial system is when a government agency seeks to act in a manner adversely affecting a party, judicial review of that action may be had. (*Matter of Dairylea Coop*, at 10.) As opposed to the zone of interest test applied in *Society of Plastics* (*supra*), the right to challenge administrative action has been enlarged by the courts. (*Id.*) As such, a broader interpretation of the principle of legal standing requires that standing be conferred to a party adversely affected by a decision or regulation of an administrative agency.

Therefore, it is the opinion of this court that the constitutional issue presented herein necessitates a ruling on the merits.

Plaintiffs' Cause of Action

The plaintiffs challenge the constitutionality of the Enabling Legislation which delegates to a nonelected public commission the power to redirect the critical health care resources of the State of New York. in their verified complaint, plaintiffs seek (1) a declaration that the Enabling Legislation was an unconstitutional delegation of legislative power and violated the Constitution's separation of powers doctrine; and (2) an injunction enjoining the Commissioner of Health from implementing the Commission's recommendations. In their order to show cause, plaintiffs essentially present three arguments to support their claim that the legislation is unconstitutional. First, the legislation is unconstitutional because it authorizes the Commission the ability to make policy decisions that are the constitutional responsibility of the Legislature. Second, the legislation fails to provide meaningful standards to govern the Commission's authority. Third, the legislation impermissibly grants the Commission the ability to nullify existing laws. As such, plaintiffs argue that the Enabling Legislation is in violation of article III, section 1 of the New York State Constitution, which mandates that the legislative power of the State shall be vested in the Senate and the Assembly. Implicit in the Constitution is the nondelegation principle. Thus, plaintiffs argue that the Enabling Legislation violates the nondelegation principle.

In support of its position, plaintiffs provide affidavits from WSMC's district State Senator and Assemblyman averring that the Legislature had no opportunity to accept or reject the recommendations of the Final Report. Also, plaintiffs cite various decisions of the Court of Appeals, and other appellate courts, interpreting this constitutional mandate. (*See Boreali v. Axelrod*, 71 NY2d 1 [1987]; *Matter of Medical Socy. of State of N.Y. v. Serio*, 100 NY2d 854 [2003].)

In opposition, it is significant to note that the defendants cite to many of the same appellate decisions relied upon by plaintiffs to support their position that the Enabling Legislation suffers from no defect or infirmity of constitutional law. (*E.g., Boreali*; *Medical Socy.*) Defendants argue that the Enabling Legislation's nine enumerated factors provided the Commission with detailed guidance and clear vision as to the policy considerations to be observed by the Commission. Defendants also note the efforts built into the legislation to guarantee that all regions of the state were fairly represented and their interests protected. Thus, defendants argue that the Enabling Legislation does not violate either this State's Constitution or its separation of powers doctrine. (*See also, Clark v. Cuomo*, 66 NY2d 185 [1985]; *Saratoga County Chamber of Commerce, supra; Boreali, supra.*)

Delegation of Policy Decisions

The constitutional principle of separation of powers requires that the legislative branch make the critical policy decisions, while the executive branch implements those policies. (*Matter of New York State Health Facilities Assn. v. Axelrod*, 77 NY2d 340 [1991].) That the Legislature cannot delegate all of its lawmaking power to an administrative agency is a principle firmly rooted in the system of government (*Matter of Nicholas v. Kahn*, 47 NY2d 24 [1979]), but it is applied with the "utmost reluctance." (*Boreali* at 9.) In addition, the separation of powers doctrine does not divide the branches into watertight compartments, and the lines of demarcation for the legislative and executive branches cannot be easily drawn. (*Bourquin v. Cuomo*, 85 NY2d 781, 784 [1995].) The courts have recognized the necessity of some overlap among the branches of government as well as the great flexibility to be accorded the administrative official in determining the methods for achieving the legislative mandates. (*Id.* at 785.) The administrative official is accorded flexibility in determining the proper methods to achieve the legislative mandates and the degree of flexibility varies according to the nature of the problem sought to be remedied by the Legislature. (*Matter of Broidrick v. Lindsay*, 39 NY2d 641 [1976].) "Where it is impracticable for the legislative body to fix specific standards . . . broad flexibility in determining the proper methods" will be sustained. (*Id.* at 646.)

In addition, the courts have acknowledged that there need not be a specific and detailed legislative expression authorizing a particular administrative act as long as the basic policy decision has been made and articulated by the Legislature. (*Bourquin* at 785.) Indeed, the difficulty and complexity of most of the policy determinations mandate that the legislative body be permitted to provide for the implementation of basic policy through the use

of specialized agencies concentrating upon one particular problem at a time. (*Matter of Citizens For An Orderly Energy Policy v. Cuomo*, 78 NY2d 398, 411 [1991]; *Nicholas* at 31.) Thus, it is not necessary that the Legislature supply administrative officials with rigid formulas in areas where there are infinitely variable conditions thereby necessitating flexibility. (*Id.*) Rather, the standards prescribed by the Legislature are to be read in light of the conditions in which they are to be applied. (*Id.*)

As such, delegation to an administrative agency, panel or committee of the power to make regulations or fill in the details regarding the Legislature's policy does not violate the separation of powers doctrine. The Court of Appeals in *Dorst v. Pataki* (90 NY2d 696 [1997]) stated:

> We previously have recognized that executive or administrative rulemaking may entail some policy selectivity without offending separation of powers doctrine, so long as the basic policy choices have been made and articulated by the Legislature (*see, Bourquin v. Cuomo*, 85 NY2d 781, 785). The Legislature is free to announce its policy in general terms and authorize administrators 'to fill in details and interstices and to make subsidiary policy choices consistent with the enabling legislation' (*Matter of Citizens For An Orderly Energy Policy v. Cuomo*, 78 NY2d 398, 410, *rearg denied* 79 NY2d 851). (*Dorst* at 699.)

"The cornerstone of administrative law is derived from the principle that the Legislature may declare its will, and after fixing a primary standard, endow administrative agencies with the power to fill in the interstices in the legislative product by prescribing rules and regulations consistent with the enabling legislation." (*Nicholas* at 31.)

More and more must the laws become general in form, leaving to commissions, boards or other administrative bodies the establishment of rules and regulations and the determination of the facts to which the general law will apply. (*Darweger v. Stoats*, 267 NY 290 [1935].)

The parties are in agreement that the Legislature has authority to delegate some of its policy-making powers to the administrative official. To the extent that plaintiffs argue that the Legislature could not delegate to the Commission the decision concerning which hospitals and nursing homes to be closed or downsized, this court finds no merit to that argument. The Legislature has enacted broad statutes in many instances, leaving to the administrative official the duty to arrange the details. (*Matter of Levine v. Whalen*, 39 NY2d 510 [1976].) It is not always necessary that legislation prescribe a specific action, and, where it is difficult or impractical for the Legislature to lay down a definite and comprehensive rule, a reasonable amount of discretion may be delegated to the administrative official. (*Levine* at 516.) Because of the complexity and difficulty of the issues involved with streamlining a health care system, the court finds no constitutional violation of the Legislature's deference to a commission with specialized knowledge (*Citizens For An Orderly Energy Policy* at 411; *Rent Stabilization Assn. of N.Y. City v. Higgins*, 83 NY2d 156 [1993]), so long as the requisite guidelines are established.

Sufficiency of Guidelines

The Legislature may constitutionally confer discretion upon an administrative agency only if it limits the field in which that discretion is to operate and provides standards to govern its exercise. (*Levine* at 515.) This does not mean that a precise or specific formula must be furnished. (*Id.*) The standards or guidelines need only be prescribed in so detailed a fashion as is reasonably practicable in light of the complexities of the particular area to be regulated. (*Id.*)

An administrative agency cannot effect its own policy choices but may only adopt rules and regulations that are consistent with the statutory purpose. (*New York State Health Facilities Assn.* at 346.) The Court of Appeals stated in *New York State Health Facilities Assn.:*

> Agencies, as creatures of the Legislature, act pursuant to specific grants of authority conferred by their creator. In discharging responsibilities, an agency is 'clothed with those powers expressly conferred by its authorizing statute, as well as those required by necessary implication. . . . Where an agency has been endowed with broad power to regulate in the public interest, we have not hesitated to uphold reasonable acts on its part designed to further the regulatory scheme'. . . . It is correspondingly axiomatic, however, that an administrative officer [has] no power to declare through administrative fiat that which was never contemplated or delegated by the Legislature. An agency cannot by its regulations effect its vision of societal policy choices . . . and may adopt only rules and regulations which are in harmony with the statutory responsibilities it has been given to administer. (*Id.*, quoting *Matter of Campagna v. Shaffer*, 73 NY2d 237, 242-243 [1989].)

Thus, it is only when the administrative acts are inconsistent with the Legislature or usurp legislative prerogatives that the doctrine of separation of powers is violated. (*Bourquin* at 785.)

The Court of Appeals case, *Boreali*, is instructive. There, the Court indicated that there were several "coalescing circumstances," any of which, standing alone, is insufficient to warrant the conclusion that the separation of powers doctrine was violated, but, when viewed together, paint a portrait of an agency that improperly assumed for itself open-ended discretion to choose its ends. (*Boreali* at 11.) The factors include whether the agency had to balance competing concerns of public health and economic costs, whether the Legislature provided guidelines, whether there was special expertise or technical competence utilized, and whether there was legislative inaction. (*Id.* at 13.)

Applying these circumstances to the case at bar, it is evident that guidelines and specialized expertise were utilized. Although plaintiffs argue that the guidelines were insufficient, the court finds the guidelines sufficient, and in any event finds that general guidelines were necessary due to the complexity of the matter and the Commission should have been afforded great flexibility.

The courts are hesitant to apply persuasive significance to legislative inaction. (*Boreali* at 14; *Bourquin* at 787-788 ["Legislative inaction . . . 'affords the most dubious foundation for drawing positive inferences'"]; *Clark* at 190-191; *see also New York State Health Facilities Assn.* at 348 ["we ascribe no particular significance to the legislative inaction in this case"].)

Thus, the failure of the Legislature to reach an agreement is not an indication or "indirect proof that the Legislature disapproved of such legislation but evinces a legislative preference to yield to administrative expertise. (*Medical Socy.* at 866.)

When considered in light of the purpose of the Enabling Legislation and the guidelines provided thereto, the balancing of competing social and economic interests by the Commission, in and of itself, is not a violation of the doctrine of the separation of powers. As a matter of fact, "many regulatory decisions involve weighing economic and social concerns against the specific values that the regulatory agency is mandated to promote." (*Boreali* at 12.) Unlike *Boreali*, where the Commissioner was not mandated to utilize a cost-benefit approach, the Legislature, in the case at bar, did authorize the Commission to utilize an economic/cost-benefit analysis. Contrary to plaintiffs' argument, *Boreali* does not require that the Legislature promulgate specific guidelines as to how competing interests and costs are to be weighed; it merely finds that a commission must be authorized by the Legislature to utilize a cost-benefit analysis before it can do so.

Furthermore, the cases cited by plaintiff are inapplicable as they were situations where the regulation was not contemplated or delegated by the Legislature, was arbitrary, unreasonable, or inconsistent with legislative policy, or usurped legislative prerogative.

In addition, plaintiffs have not claimed that the proposed regulations in the Final Report are unreasonable, arbitrary or capricious. Nor have they claimed that the Final Report is inconsistent with the Legislature's policy. (*Dorst* at 699.) An administrative regulation, legislative in character, will be upheld as valid if it has a rational basis, that is, if it is not unreasonable, arbitrary or capricious. (*Levine* at 518.)

Finally, that part of the Enabling Legislation that authorizes the Commission to look at additional factors implies that the factors must be consistent with the legislative policy. To the extent that the factors considered by the Commission were consistent with the legislative policy, there is no separation of powers violation.

In the instant case, the Legislature has articulated a social policy and purpose of streamlining the health care system and reducing excess capacity by downsizing or closing hospitals and nursing homes. The Enabling Legislation enumerated criteria that were to be used by the Commission in arriving at its recommendations. Given the complexity of the task involved, the Commission is accorded great flexibility in resolving the issues presented. Thus, the Legislature need not promulgate a specific law indicating which hospitals or nursing homes are to be affected. Furthermore, the Commission's recommendations are consistent with the intent of the Enabling Legislation. In the present matter, the court finds that the language of the Enabling Legislation plainly sets forth the Legislature's intent for its passage, creation of the Commission, and sufficiently clear guidelines for the Commission to follow. in *Medical Socy.*, the Court of Appeals stated (at 865): "the Superintendent did not promulgate regulations on a blank slate without any legislative guidance, nor did the revised regulations effectuate a profound change in social and economic policy." With such a fixed policy intent and structural form firmly in place, the court finds little merit to plaintiffs' position that said Enabling Legislation constituted a violation of the separation of powers doctrine.

Authority to Nullify Existing Laws

The court finds plaintiffs' argument that the Commissioner has the authority to nullify existing laws in implementing the Commission's recommendations unavailing. In phrasing the Enabling Legislation with the "notwithstanding" language, the Legislature essentially intended to affect, nullify, or amend some of the existing general laws only to the extent that they contradicted the findings and regulations stated in the enabling statutes and the Final Report. Since this lies within the purview of the Legislature, there is no constitutional infirmity with the mandates issued to the Commissioner. The affected entities had the opportunity to be heard and the powers

given to the Commission, such as the ability to determine whether operating licenses would be revoked, is no greater than the power already granted to the Commissioner of Health.

Conclusion

A "facially broad . . . legislative grant of authority must be construed, whenever possible, so that it is no broader than that which the separation of powers doctrine permits." (*Boreali* at 9, citing Tribe, *American Constitutional Law* § 5-17, at 288-289.) "That a legislative enactment will be presumed constitutional is an elementary but significant principal of law. . . . While this presumption is rebuttable, unconstitutionality must be demonstrated beyond a reasonable doubt." (*Medical Socy. of State of N.Y. v. Sobol*, 192 AD2d 78, 81 [3d Dep't 1993].) This is a heavy burden and only as a last resort will the courts strike down legislative enactments on the ground of constitutionality. *Martin v. State Liq. Auth.*, 43 Misc. 2d 682 [1964].) Since plaintiffs have failed to present authority or a case with the same fact pattern as the case at bar, that is, where the Enabling Legislation indicated the policy, enumerated standards, and appointed a commission within its area of competence to promulgate regulations, in which the courts found an unconstitutional delegation of authority, plaintiffs have failed to meet their burden. As such, plaintiffs have failed to establish beyond a reasonable doubt that the Enabling Legislation is unconstitutional.

Accordingly, the court finds no constitutional infirmity in the Enabling Legislation, in its creation of the Commission or in its delegation to said Commission of the power to examine, analyze and make recommendations concerning the future of New York State's health care resources and determine which hospitals and nursing homes are to be closed or downsized.

This court is cognizant of the difficulties patients such as Ms. McKinney may face by the closing of their trusted medical facility, but the legal issues raised herein necessitate the denial of the extraordinary relief requested by the plaintiffs and dismissal of plaintiffs' complaint.

For all of the foregoing reasons, the court denies the plaintiffs' motion for injunctive relief. Defendants' cross motion for dismissal of the complaint is granted.

Endnotes

1. The record establishes that WSMC has filed a petition in the United States Bankruptcy Court pursuant to chapter 11. In said petition, WSMC indicated that it was affiliated with NYPHS and that NYPHS had already proposed a willingness to continue health care services for those using the WSMC facility. (See defendants' exhibit B, copy of WSMC bankruptcy petition.) Apparently, WSMC was not joined in this action due to the automatic stay provisions of the Bankruptcy Code.
2. The definition of s*treamline* as provided in Webster's Dictionary is "to make shorter, simpler or more efficient."

McKinney v. Commissioner of N.Y. State Dept. of Health, 41 A.D.2d 252 (1st Dep't 2007)

Chadbourne & Parke LLP, New York
(Thomas E. Bezanson of counsel), for appellants.

Andrew M. Cuomo, Attorney General, New York
(Sasha Samberg-Champion of counsel), for respondents.

Order, Supreme Court, Bronx County (Mary Ann Brigantti-Hughes, J.), entered on or about March 9, 2007, which, in an action challenging the constitutionality of the legislation establishing the Commission on Health Care Facilities in the 21st Century (L 2005, ch 63, part E, § 31), granted defendants' motion pursuant to CPLR 3211 (a) to dismiss the complaint, unanimously affirmed, without costs.

We reject defendants' arguments that the individual plaintiff does not have taxpayer standing under State Finance Law § 123-b (1) (see *Saratoga County Chamber of Commerce v. Pataki*, 100 NY2d 801, 813-814 [2003], *cert denied* 540 US 1017 [2003] [claim that it is illegal to spend money at all for questioned activity likely provides taxpayer standing]), and that Westchester Square Medical Center (WSMC), on which the individual plaintiff allegedly depends for medical care but which chose not to participate in the action after being notified thereof, would be inequitably affected by a judgment or is otherwise a necessary party (CPLR 1001 [a]; *cf. Matter of Castaways Motel v. Schuyler*, 24 NY2d 120, 125 [1969], *adhered to on rearg* 25 NY2d 692 [1969]; *Kronish Lieb Weiner & Hellman LLP v. Tahari, Ltd.*, 35 AD3d 317 [2006]). In view of the foregoing, we need not address the issue of plaintiffs' standing under the common law. However, we also reject plaintiffs' argument that the subject legislation unconstitutionally delegated the Legislature's lawmaking power to the executive branch, and accordingly affirm dismissal of the action. Enabling statutes even broader than this one have been found constitutional (*see e.g. Matter of Medical Socy. of State of N.Y. v. Serio*, 100 NY2d 854, 864-865 [2003]; *Boreali v. Axelrod*, 71 NY2d 1, 9 [1987]). Having made the basic policy choice that some hospitals and nursing homes needed to be closed and others needed to be resized, consolidated, converted, or restructured, the legislation permissibly authorized the Commission "'to fill in details and interstices and to make subsidiary policy choices consistent with the enabling legislation'" (*Dorst v. Pataki*, 90 NY2d 696, 699 [1997], quoting [*2] *Matter of Citizens For An Orderly Energy Policy v. Cuomo*, 78 NY2d 398, 410 [1991]; *see also Medical Socy.*, 100 NY2d at 865). Concur—Friedman, J.P., Nardelli, Buckley, Sweeny and Malone, JJ. [See 15 Misc 3d 743 (2007).]

New Section Chair—Peter J. Millock

In June, Peter J. Millock became the eleventh Chair of the Health Law Section. Peter is a member of Nixon Peabody, LLP and its Health Services Practice Group, and his practice focuses on affiliations and mergers of physicians and hospitals, regulatory and enforcement matters before state agencies, and legislative lobbying for health care entities.

Prior to joining the firm, Peter served as General Counsel to the New York State Department of Health from 1980 to 1995. In that capacity, he was chief legal advisor to the Commissioner of Health and to state policy makers on all health-related matters.

Peter is a frequent speaker before health and legal groups statewide. He is an Associate Professor at the School of Public Health, State University of New York at Albany.

One of the founding members of the Health Law Section, Peter has long been active on its Executive Committee in various capacities.

Peter earned his undergraduate degree in economics from Harvard College, and his law degree from Harvard Law School.

The Chair's term is one year. In June 2008, the current Chair-Elect, Ross Lanzafame, will assume that office.

Past Chairs of the Health Law Section

Barry A. Gold	**1996-98**
Jerome Levy	**1998-99**
Robert N. Swidler	**1999-00**
Tracy E. Miller	**2000-01**
Robert Abrams	**2001-02**
James Lytle	**2002-03**
Salvatore Russo	**2003-04**
Philip Rosenberg	**2004-05**
Lynn Stansel	**2005-06**
Mark Barnes	**2006-07**

NEWS flash

What's Happening in the Section

Recent Events

The Health Law Section held its popular Introduction to Health Law Program in May in three locations: New York City, Melville and Albany. The Overall Planning Chair was Salvatore Russo of the N.Y.C. Health and Hospitals Corporation. The Local Chairs were Salvatore Russo (N.Y.C.); Robert A. Wild of Garfunkel, Wild & Travis (Melville); and Philip Rosenberg of Wilson, Elser, Moskowitz, Edelman, Dicker (Albany). The program generated an excellent course book, "Introduction to Health Law," which is available from the NYSBA publications department.

Upcoming Programs—Save These Dates

- **October 19, 2007—Primer on Human Subject Research**. The Section is sponsoring a program on Human Subject Research, which will be held at the Cornell Club in New York City. The Planning Chair is Salvatore Russo of N.Y.C. Health and Hospitals Corporation.
- **November 3, 2007—Fall Retreat in Cooperstown.** The Section will hold its next Fall Retreat and Conference at the picturesque Otesaga Hotel in Cooperstown, New York. The conference topic will be "Medicaid Fraud—New Era, New Faces, New and Old Problems." Marcia Smith of Iseman Cunningham in Albany is the Overall Planning Chair for the program. Among the prominent speakers scheduled to participate are Deborah Bachrach, Deputy Commissioner of the N.Y.S. Health Department Office of Health Insurance Programs (OHIP) and the State's Medicaid Director; and James Sheehan, the N.Y.S. Medical Inspector General.

The Retreat will include ample time for relaxing, socializing, enjoying the beautiful scenery around Lake Otsego, and of course a visit to the Baseball Hall of Fame.

Upcoming *Journal* Edition

The Fall '07 *Journal* will be a special edition on "Select Issues in Medical Malpractice Litigation."William Yoquinto of Carter Conboy in Albany will be Special Editor. Persons wishing to submit an article for the edition should contact Bill at wyoquinto@carterconboy.com.

Notable Committee Activities

The Public Health Committee is studying New York State's powers in the event of a public health emergency, both as they exist under current State law, and as set forth in the Model State Emergency Powers Act and the Model State Public Health Law.

Proposed legislation over the past several years to provide the State with certain emergency powers is based upon the Model State Emergency Powers Act, which some believe does not adequately protect the rights of individuals if the State wishes to take action.

The Committee is planning an educational session to promote discussion between the multiple parties involved in these issues, including the legal and medical professions, the judiciary, and the police.

The Public Health Committee is chaired by Margie Davino of Kaufman, Borgeest & Ryan in New York City.

Introducing

Supraspinatus

The Official Unofficial Blog of the Health Law Section

http://nysbar.com/blogs/healthlaw

Visit Supraspinatus (SOO-pra-spy-NATE-us) to:

- Catch the latest news and developments affecting New York health law practitioners.
- Find links to primary and secondary sources (as available).
- Search through back posts on topics of interest.
- Read comments from other visitors and submit your own!

Please join in the discussions, voice your considered opinion and impact trends in the making . . . and more! Or just visit and browse quietly.

http://nysbar.com/blogs/healthlaw

(updated on a regular basis!)

The supraspinatus muscle attaches the top of the humerus (upper arm bone) to the medial scapula (shoulder blade) and initiates the first 15 degrees of motion of the upper arm—such as when one raises a hand to ask a question or to volunteer.

Introducing Supraspinatus—The Health Law Section's Blog

Largely through the efforts of Paul Gillan, an attorney with Capital District Health Plan, in May the Section began a six month demonstration of a health law blog, named Supraspinatus. The blog can be found at http://nysbar.com/blogs/healthlaw/.

The purpose of Supraspinatus is to provide timely notice of significant events and developments affecting practitioners of health care law in New York. Blog posts may cover subjects ranging from new legislation to court decisions to agency interpretations. Topics are selected by contributing authors based on personal choice for the purpose of sharing knowledge about, exploring, and illustrating interrelated (and in some cases interdisciplinary) aspects of current news events and the latest thinking in policy, law and/or regulation.

Current contributing authors include, in addition to Paul Gillan: Tricia Asaro, Leonard Rosenberg, Joan Shipman, Marcia Smith, and Melissa Zambri. Others wishing to contribute should contact Paul at pgillan@cdphp.com.

The blog is named after an obscure muscle that attaches the top of the humerus (upper arm bone) to the medial scapula (shoulder blade). It is responsible for the first 15 degrees of motion of the upper arm—such as when one raises a hand to ask a question.

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.

Committee on Consumer/Patient Rights
Mark Scherzer
Law Offices of Mark Scherzer
7 Dey Street, Suite 600
New York, NY 10007-3105
mark.scherzer@verizon.net

Randye S. Retkin
New York Legal Assistance Group
450 West 33rd Street, 11th Floor
New York, NY 10001
rretkin@nylag.org

Committee on Ethical Issues in the Provision of Health Care
Kathleen M. Burke
New York Presbyterian Hospital
525 East 68th St.
Room W-109
New York, NY 10021-4873
kburke@nyp.org

Committee on Fraud, Abuse and Compliance
Steven Chananie
Garfunkel, Wild & Travis
111 Great Neck Road
Great Neck, NY 11021
schananie@gwtlaw.com

Marcia B. Smith
Iseman Cunningham Riester & Hyde, LLP
9 Thurlow Terrace
Albany, NY 12203
msmith@icrh.com

Committee on Health Care Providers
Francis J. Serbaroli
Cadwalader Wickersham & Taft LLP
1 World Financial Center, 31-138
New York, NY 10281
francis.serbaroli@cwt.com

Committee on Long Term Care
Raul A. Tabora, Jr.
Ruffo, Tabora, Mainello & McKay, P.C.
300 Great Oaks Boulevard, Suite 311
Albany, NY 12203
rtabora@ruffotabora.com

Committee on Managed Care
Robert P. Borsody
Phillips Nizer LLP
666 Fifth Avenue, 29th Floor
New York, NY 10103
rborsody@phillipsnizer.com

Harold N. Iselin
Greenberg Traurig LLP
54 State Street
Albany, NY 12207
iselinh@gtlaw.com

Committee on Membership
Hon. James F. Horan, ALJ
New York State Health Department
433 River Street
5th Floor, Suite 330
Troy, NY 12180-2299
jfh01@health.state.ny.us

Committee on Mental Health Issues
J. David Seay
National Alliance for the Mentally Ill
PO Box 245
North Chatham, NY 12132
jdavidseay@aol.com

Henry A. Dlugacz
Law Offices of Henry A. Dlugacz
488 Madison Avenue, 19th Floor
New York, NY 10022
HD@Dlugacz.com

Nominating Committee
James D. Horwitz
Glens Falls Hospital
100 Park Street
Glens Falls, NY 12801
jhorwitz@glensfallshosp.org

Committee on Professional Discipline
Carolyn Shearer
Bond, Schoeneck & King, PLLC
111 Washington Avenue
Albany, NY 12210-2211
cshearer@bsk.com

Kenneth R. Larywon
Martin Clearwater & Bell, LLP
44 Tulip Lane
New Rochelle, NY 10804-1915
larywk@mcblaw.com

Committee on Public Health
Margaret J. Davino
Kaufman Borgeest & Ryan
99 Park Avenue, 19th Floor
New York, NY 10016
mdavino@kbrlaw.com

Committee on Publications
Robert N. Swidler
General Counsel and Vice President for Legal Affairs
Northeast Health
2212 Burdett Avenue
Troy, NY 12180
swidlerr@nehealth.com

Executive Committee
Peter J. Millock
Nixon Peabody, LLP
30 S. Pearl Street, 9th Floor
Albany, NY 12207
pmillock@nixonpeabody.com

Special Committee on Bylaws
Patrick Formato
Abrams Fensterman Fensterman et al
1111 Marcus Avenue, Suite 107
Lake Success, NY 11042-1109
pformato@abramslaw.com

Special Committee on Insurance and Liability Issues
Esther Widowski
Widowski and Steinhart, LLP
425 Madison Avenue, Suite 700
New York, NY 10017-1126
ewidowski@aol.com

Special Committee on Legislative Issues
James W. Lytle
Manatt, Phelps & Phillips LLP
30 South Pearl Street, 12th Floor
Albany, NY 12207
jlytle@manatt.com

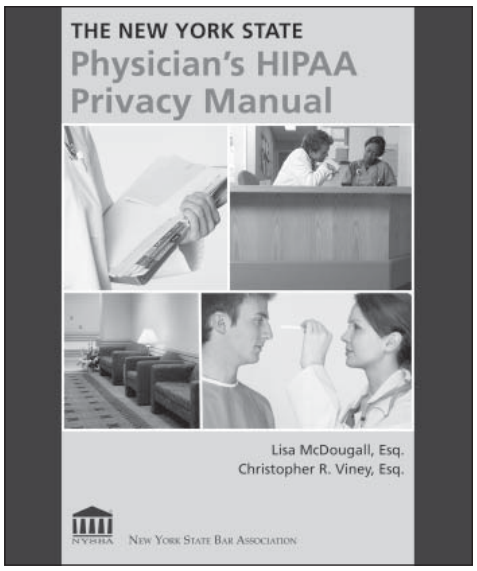
Special Committee on Mental Retardation/Developmental Disabilities Providers
Hermes Fernandez
Bond Schoeneck & King, PLLC
111 Washington Ave
Albany, NY 12210-2211
hfernandez@bsk.com

Website Coordinator
Ross P. Lanzafame
Harter Secrest & Emery LLP
1600 Bausch and Lomb Pl.
Rochester, NY 14604
rlanzafame@hselaw.com

From the NYSBA Bookstore

The New York State Physician's HIPAA Privacy Manual

New



Product Info and Prices
2007 • 288 pp., loose-leaf
• PN: 4167
NYSBA Members $75
Non-members $95

Prices include shipping and handling but not applicable sales tax.

"An excellent resource for all physicians and providers in New York, the HIPAA Manual incorporates both HIPAA and New York law, which is extremely useful because New York law can be more stringent than HIPAA. The forms are very helpful, and physicians' offices can easily adapt them for their own use."

— Margaret Davino, Kaufman Borgeest & Ryan, New York City

Authors

Lisa McDougall, Esq.
Philips, Lytle LLP
Buffalo, NY

Christopher R. Viney, Esq.
Deputy General Counsel
Roswell Park Cancer Institute
Buffalo, NY

This new title is designed to be a "hands on" tool for health care providers as well as their legal counsel. Consisting of 36 policies and procedures—as well as the forms necessary to implement them—the *Manual* provides the day-to-day guidance necessary to allow the physician's office to respond to routine, everyday inquiries about protected health information. It also provides the framework to enable the privacy officer and the health care provider's counsel to respond properly to even non-routine issues.

The *Manual* is organized in a way that parallels the various aspects of the HIPAA Privacy Rule, and incorporates pertinent New York State law considerations as well.

This invaluable book is a useful tool for both the health care and legal practitioner alike.

Co-sponsored by the New York State Bar Association's Health Law Section and the Committee on Continuing Legal Education

Get the Information Edge

NEW YORK STATE BAR ASSOCIATION

1.800.582.2452 www.nysba.org/pubs Mention Code: PUB0120

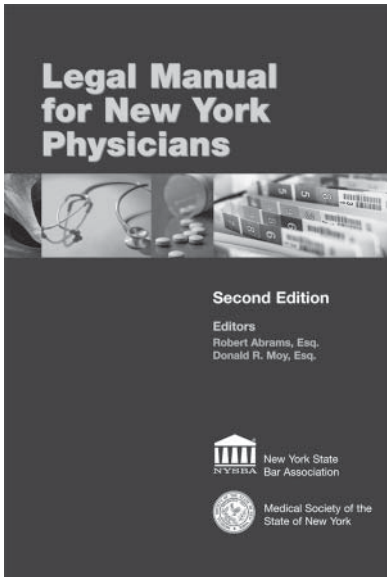
NYSBA

NYSBA**BOOKS**

Legal Manual for New York Physicians

Second Edition

Editors: Robert Abrams, Esq.
Donald R. Moy, Esq.



Written and edited by more than fifty experienced practitioners, *Legal Manual for New York Physicians*, Second Edition is a practical reference guide for attorneys representing physicians and anyone involved with the medical profession.

Includes major contributions by the Department of Health and other state agencies.

Over fifty topics including:

- Reimbursement and Billing Issues
- Employment and Office Management Issues
- OSHA
- Fraud and Abuse, Anti-Kickback and Self-Referral (Stark) Laws and Regulations
- Informed Consent
- Child and Adult Abuse Laws
- Physician Contracting with Hospitals, HMOs and Other Third Party Payors
- Health Department Disciplinary Programs
- Special Issues Involving Infectious Diseases
- Treatment of Minors
- Physician Advertising

2006 • 1,032 pp. • PN: 41325
List Price: $105*
Member Price: $90*

* Prices include shipping and handling, but not applicable sales tax.

To order call **1-800-582-2452** or visit us online at **www.nysba.org/pubs**
Mention code: PUB0121 when ordering.

Publication and Editorial Policy

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.

Publication Policy: All articles should be submitted to:

Robert N. Swidler
Northeast Health
2212 Burdett Avenue
Troy, NY 12180
(518) 271-5027
e-mail: swidlerr@nehealth.com

Submitted articles must include a cover letter giving permission for publication in this *Journal.* We will assume your submission is for the exclusive use of this *Journal* unless you advise to the contrary in your letter. Authors will be notified only if articles are rejected. Authors are encouraged to include a brief biography with their submissions.

Editorial Policy: The articles in this *Journal* represent the authors' viewpoints and research and not that of the *Journal* Editorial Staff or Section Officers. The accuracy of the sources used and the cases cited in submissions is the responsibility of the author.

Subscriptions

This *Journal* is a benefit of membership in the Health Law Section of the New York State Bar Association.

The *Journal* is available by subscription to non-attorneys, libraries and organizations. The subscription rate for 2007 is $75.00. Send your request and check to Newsletter Dept., New York State Bar Association, One Elk Street, Albany, NY 12207.

HEALTH LAW JOURNAL

Editor
Robert N. Swidler
Northeast Health
2212 Burdett Avenue
Troy, NY 12180
(518) 271-5027
swidlerr@nehealth.com

Section Officers

Chair
Peter J. Millock
Nixon Peabody, LLP
30 S. Pearl Street, 9th Floor
Albany, NY 12207
pmillock@nixonpeabody.com

Chair-Elect
Ross P. Lanzafame
Harter Secrest & Emery LLP
1600 Bausch and Lomb Pl.
Rochester, NY 14604
rlanzafame@hselaw.com

Vice-Chair
Edward S. Kornreich
Proskauer Rose LLP
1585 Broadway, 19th Floor
New York, NY 10036
ekornreich@proskauer.com

Secretary
Ari J. Markenson
Cypress Health Care Management
44 South Broadway, Suite 614
White Plains,NY 10601
amarkenson@cypresshealthcare.net

Treasurer
Francis J. Serbaroli
Cadwalader Wickersham & Taft LLP
1 World Financial Center, 31-138
New York, NY 10281
francis.serbaroli@cwt.com

Copyright 2007 by the New York State Bar Association.

ISSN 1530-3926 ISSN 1933-8406 (online)

NEW YORK STATE BAR ASSOCIATION
HEALTH LAW SECTION
One Elk Street, Albany, New York 12207-1002

ADDRESS SERVICE REQUESTED

NON PROFIT ORG.
U.S. POSTAGE
PAID
ALBANY, N.Y.
PERMIT NO. 155