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Health Law Journal

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

- NYS Medical Indemnity Fund
- Understanding Subpoenas
- Federalism and the Individual Health Insurance Mandate
- Choosing an Agent to Pay for Health Care
- Public Health Law § 2801-d
- NYS Physician Profile

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THE HEALTH LAW SECTION
NEW YORK STATE BAR ASSOCIATION

Table of Contents

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Queensboro Bridge, by Edward Hopper (1913)

A Message from the Section Chair

I am honored to have been chosen by you to serve as Chair of the Health Law Section for 2011-2012. I have been a member for more years than I care to admit, going back to the days when our Section was just a Committee, and we had perhaps 45 members. Our Section is now 1,207 strong, and I am confident that our ranks will continue to grow in the coming years.

I know I speak for our entire Section in expressing sincere appreciation to Ari Markenson for his energetic and creative leadership during the past year. Ari began important initiatives, and was tireless in protecting, representing and promoting our Section both within and outside of the Bar Association. We are a better Section for his efforts.

We have much planned for the coming year. Our Fall Program, which will take place at the Yale Club in New York City on October 22, will focus on the many legal, regulatory, and corporate aspects of forming an Accountable Care Organization in New York State. We have lined up a stellar faculty for this Program, and expect record attendance. We are planning more programs on current topics, and preparations for our Annual Meeting are under way.

With health care currently consuming 17% of GDP, and predicted to rise to 20% in coming years, there are many federal and state initiatives to rein in costs while also improving quality and access. Here in New York, the Cuomo Administration has embarked upon an extensive restructuring of New York's $52 billion Medicaid program. Our Section will have the opportunity to be heard on important legislative and regulatory proposals that come out of the Medicaid Reform Task force.

The *Health Law Journal*, under the able and dedicated editorship of Robert Swidler, continues to be the best publication of its kind of any state bar association. Having authored many articles for the *New York Law Journal* and other publications for many years, I know from personal experience that:

a) there is no shortage of topics to write about; and

b) writing articles takes time and effort.

I encourage you to consider contributing articles to our *Health Law Journal*, and to share your knowledge and expertise with your fellow Section members.

We will also be consolidating some of our committees and encouraging more active participation in committee work.

Lastly, we will continue our efforts to promote diversity in our Section. Health care touches everyone in our society at one time or another, and we as a Section simply must be more representative of society. Our Association's new president, Vincent Doyle, III, has made greater diversity a hallmark of his tenure, and I will do all I can to continue our Section's diversity efforts.

I encourage each of you to be active and involved in our Section. All Section officers are here from our members, but we need our members to be involved. Volunteer to organize a program. Participate in preparing Section position papers. Join a Section committee. Write an article for the *Journal*. There are so many ways to participate, and I am certain you will not only enjoy it, but also benefit other lawyers who practice or have an interest in health care law.

I look forward to a productive year ahead, and to meeting many of you. Have a great Summer!

Cordially,

Francis J. Serbaroli

In the New York State Courts

By Leonard M. Rosenberg

HIPAA Privacy Rule Prohibits Disclosure of Medical Records for Use in Kendra's Law Proceeding Without Patient's Consent or Noticet to Patient

Miguel M. v. Barron, 2011 WL 1752228 (Court of Appeals, 2011). Dr. Charles Barron, as designee of the New York City Department of Health and Mental Hygiene, applied for an order under Mental Hygiene Law ("MHL") § 9.60 (Kendra's Law) requiring assisted outpatient treatment ("AOT") for patient Miguel M. At the hearing on the AOT petition, The City offered into evidence Plaintiff's hospital records relating to three occasions on which Plaintiff was hospitalized. A witness testified that the hospitals had furnished such records without authorization by or notice to Plaintiff, and that no court order for their disclosure was sought or obtained. The records were received into evidence, over Plaintiff's objections, and the Supreme Court ordered Plaintiff to receive and accept AOT for six months. The Appellate Division affirmed. The Court of Appeals granted leave to appeal, and reversed.

Kendra's Law provides that, on a proper showing, a mentally ill person whose lack of compliance with treatment has, twice within the last 36 months, caused him or her to be hospitalized, may be the subject of AOT pursuant to a plan stated in a court order. Under the Mental Hygiene Law, public officials identified as "directors of community services" (or their designees) may file a petition to require AOT. MHL § 33.13(c)(12) permits disclosure of medical records to a director of community services who requests it in the exercise of his or her duties. Thus, state law permits disclosure of patient's medical records for purposes of an AOT, unless preempted by federal law.

The Court of Appeals found that the state law provisions which permit such disclosure are inconsistent with, and therefore, preempted by, HIPAA and the Privacy Rule promulgated thereunder. The Privacy Rule prohibits disclosure of an identifiable patient's health information without the patient's authorization, subject to certain exceptions, and preempts contrary state laws unless they offer more stringent privacy safeguards. Observing that New York law does not offer any more stringent protection relevant to the case, the Court of Appeals determined that the preemption issue turned on whether the disclosure of Defendant's medical records was permitted by an exception to the Privacy Rule.

The Court ruled that the two exceptions to the Privacy Rule relied upon by the City, *i.e.*, those permitting disclosure for purposes of "public health" and "treatment," did not permit the disclosure of a mentally ill person's hospital records for purposes of requiring that person to accept AOT. The Court rejected the contention that, because mentally ill people might kill or injure members of the public, such disclosures satisfy the intent of the statutory exception to protect the public health. The Court ruled that, to the contrary, the apparent purpose of the public health exception was to facilitate government activities that protect large numbers of people and that disclosure of private information about particular people to prevent them from harming themselves or others, effects a very substantial invasion of privacy without effecting the exception's intended generalized public benefit.

The Court of Appeals similarly rejected the City's reliance on the "treatment" exception to the Privacy Rule, holding that the exception was meant to facilitate information sharing among health care providers working together and did not appear to permit such sharing of information for treatment over the patient's objection.

Accordingly, the Court held that unauthorized disclosure without notice for purposes of requiring the mentally ill to accept AOT was inconsistent with HIPAA and the Privacy Rule, and that medical records obtained in violation of HIPAA or the Privacy Rule, and the information contained in those records, are not admissible in a proceeding to compel AOT.

While recognizing the strong public interest in ensuring that mentally ill people who might otherwise be dangerous receive necessary treatment, the Court ruled that in the interest of fairness, and considering that it is not burdensome on public agencies charged with enforcing Kendra's Law, patients must be given notice and a chance to object before their medical records are disclosed. The Court advised that this alternative was available under an exception to the Privacy Rule "in the course of any judicial or administrative proceeding" in response to either a court order or a subpoena. To use this exception, the party seeking information must provide "satisfactory assurance" to the entity making the disclosure that reasonable efforts have been made to provide the patient whose protected health information is the subject of inquiry with notice of the request, or that a protective order has been sought.

The Court also advised that it may often be possible to avoid all disclosure problems by getting the patient to authorize the disclosure in

advance, and that even if a patient objects to the disclosure of his medical records after being given notice, in many cases there will be no valid ground for withholding the medical records.

Appellate Division Dismisses Whistleblower Claims Under Labor Law §§ 740 and 741, and Awards Attorneys' Fees to Hospital Defendant

Tomo v. Episcopal Health Services, Inc., 2011 WL 2297852 (2d Dep't, 2011). Plaintiff, a hospital security and information officer, alleged that his employer, in violation of Labor Law §§ 740 and 741, retaliated against him for complaining about the planned installation of an electronic white board and the failure to keep patient records secure prior to shredding.

Reversing the motion court, the Appellate Division for the Second Department granted Defendants' motion to dismiss Plaintiff's alleged violations of Labor Law § 740 and § 741, and awarded to Defendants their attorneys' fees and costs incurred in defending against Plaintiff's Labor Law § 741 claim.

The court reasoned that because the whiteboard was never installed, there was no actual violation of any "law, rule or regulation," which is required to sustain an action under § 740, and an employee's good faith belief that such a violation occurred is not sufficient. Plaintiff's cause of action under § 740 also failed because Plaintiff's complaints concerned the privacy of confidential information. The court held that such allegations did not satisfy the element of a "threat to public health and safety" as required under § 740.

The court also dismissed Plaintiff's § 741 claim, because that statute (known as New York's Health Care Whistleblower Law) only protects persons who actually supply health care services, which Plaintiff did not. Due to Plaintiff's "recalcitrant refusal" to bow to binding precedent on that point, the court, pursuant to Labor Law § 740(6), awarded to Defendants their costs and attorneys' fees incurred in defending against the § 741 claim.

District Court Holds that the Federal Nursing Home Reform Amendments ("FNHRA") Confers a Private Right of Action Upon Nursing Home Residents Enforceable Under § 1983

Pantalone v. County of Fulton, 2011 WL 1457935 (N.D.N.Y., 2011). Plaintiff, a nursing home resident, brought an action pursuant to 42 U.S.C. § 1983 alleging that Defendants violated his rights under the Federal Nursing Home Reform Amendments ("FNHRA"), 42 U.S.C. § 1369r *et seq.* Defendants moved to dismiss the action arguing that FNHRA does not provide an enforceable federal right under § 1983.

In a matter of first impression, the District Court, Northern District of New York (Hurd, J.) held that the FNHRA confers individual rights enforceable through § 1983.

After Plaintiff fell and fractured his leg under the care of Defendants, a nursing home facility, Plaintiff filed a lawsuit asserting that Defendants violated 42 U.SC. § 1369r(b)(1)(A) and (b)(4)(A)(i). 42 U.SC. § 1369r(b)(1)(A) provides that a nursing facility must care for its residents in an environment that will promote maintenance or enhancement of the resident's quality of life. 42 U.S.C. § 1369r(b)(4)(A)(i) provides that a nursing facility must provide nursing and specialized rehabilitative services to attain the highest practicable physical and mental well-being of the resident.

The court noted that although the FNHRA does not provide a private cause of action to be brought under the statute directly, "a statute can create a right, enforceable through § 1983, by evidencing an 'unambiguous' intent to confer such a right upon a class of beneficiaries." The Defendants argued that Congress did not intend the FNHRA to provide nursing home residents with enforceable rights.

To establish a claim under § 1983, the plaintiff must allege (a) a violation of a right under the Constitution or federal law and (b) the alleged deprivation of that right was committed "under the color of state law." The court quickly determined that Plaintiff met the second prong of this test as Defendants include Fulton County and a county-run facility. To determine whether the Plaintiff met the first prong, the court set forth a three-point test established in *Blessing v. Freestone* to determine whether Congress intended to create a federal right. The *Blessing* factors include (a) Congressional intent that the provision in question benefit the plaintiff, (b) the asserted right was neither vague nor amorphous as to "strain judicial competence through enforcement," and (c) the statute must "unambiguously impose a binding obligation on the States."

The Court concluded that Plaintiff established all three of these elements, demonstrating that its "right is presumptively enforceable by § 1983." Acknowledging that § 1396r was not meant to benefit nursing homes, but rather their individual residents, the court held that Plaintiff established the first *Blessing* element that he was an intended beneficiary of the FNHRA given that Plaintiff was a resident at the nursing home at the time of his injury.

The court determined that Plaintiff also met the second *Blessing* element because § 1396r(b)(a)(A) and (b)(1)(A) contain language using mandatory terms (*i.e.* that a facility *must* care for its residents in a manner that promotes the residents' quality of life…), and therefore "it does not strain judicial competence to evaluate whether a facility has adequately provided services to achieve the goals set forth in a written plan." Finally, the court held that Plaintiff established the third *Blessing* factor given that the repeated use of the word "must" indicates that the obligations outlined in FNHRA are mandatory rather than advisory provisions that are binding on the states and nursing facilities.

Determining that Plaintiff met all three *Blessing* factors, the court next determined whether Congress explicitly foreclosed a § 1983 remedy. Acknowledging that § 1983 does not contain any express language barring a nursing home resident from seeking a remedy through § 1983 but instead states that "*[t]he remedies* provided… *are in addition to* those otherwise available under State or Federal law and shall not be construed as limiting such other remedies including *any* remedy available to an individual *at common law*," the court held that this provision reflected Congress' intent not to foreclose any available remedy including § 1983.

Recognizing that "courts should not find a federal right based on a rigid or superficial application of the *Blessing* factors where other considerations show that Congress did not intend to create federal rights actionable under § 1983," the court next analyzed whether permitting Plaintiff to bring his cause of action under § 1983 would contravene Congress' intent. Noting that the Defendant carries the burden to demonstrate that permitting the Plaintiff to bring his cause of action under § 1983 "would be inconsistent with Congress' carefully tailored scheme," the court stressed the difficulty in meeting that burden, given that only three statutes have been held to be "a remedial scheme comprehensive enough to foreclose a 1983 action."

The court stressed that although the FNHRA contains several provisions setting forth enforcement options, nothing in these provisions operates to bar individuals from enforcing their rights through § 1983. Finally, the court noted that the overarching principle guiding the court's analysis is congressional intent and upon a review of the statute's legislative history, the court held that the FNHRA's core function was to improve the quality of care received by nursing home residents, ensuring that residents were protected from the very sort of negligence alleged by Plaintiff. As a result, the court held that preventing residents from enforcing the rights afforded to them under the FNHRA would disregard Congress's intent in enacting the statute.

Three-Year Statute of Limitations Applies to Alleged Violation of Public Health Law Article 27-F, Which Protects the Confidentiality of HIV-Related Information

Doe v. Belmare, Kings County Hosp. Ctr., NYC Health and Hosp. Corp., 920 N.Y.S.2d 623 (Sup. Ct., Kings County, 2011). Plaintiff, a patient at King's County Hospital Center, sued Defendants Gloria Belmare, the Kings County Hospital Center, and the New York City Health and Hospitals Corporation ("HHC"), for breaching Article 27-F of the New York Public Health Law and the regulations promulgated thereunder, and for breach of their fiduciary duty to maintain the confidentiality of her HIV-related information.

Plaintiff alleged that on or about June 25, 2007, after Plaintiff called her former boyfriend and the son of Defendant Gloria Belmare, Joseph Belmare ("Joseph"), to inform him she was admitted to the hospital, Defendant Belmare, a Kings County Hospital Center employee, improperly accessed Plaintiff's confidential information in the King's County Hospital medical records. Upon discovering from Plaintiff's medical records that Plaintiff was HIV-positive, Defendant Belmare allegedly disclosed Plaintiff's HIV-positive status to her son, Joseph. Plaintiff claims that this disclosure resulted in Joseph and his friends harassing her and threatening her, ultimately resulting in her obtaining an order of protection against him. Plaintiff further claims that as a consequence of the unauthorized disclosure, she lost friends, suffered threats and menacing behavior, and suffered emotional harm and mental anguish.

Defendant HHC filed a motion to dismiss on statute of limitation grounds, failure to comply with a condition precedent prior to suit and failure to state a cause of action.

Defendant argued that Plaintiff's action was an attempt to reframe a tort action as a statutory action in order to save the claim from time bar dismissal. HHC characterized Plaintiff's claims of harassment, emotional harm and mental anguish as an action for damages for injuries to, or destruction of, real or personal property, or personal injuries pursuant to NY Unconsolidated Laws § 7401, which requires a notice of intention to commence an action to be filed within 90 days and has a statute of limitations of one year plus 90 days. Plaintiff did not file a notice of intention, and filed her claim nearly or exactly three years following when the alleged cause of action occurred.

Plaintiff argued that her claim was timely commenced because Section 7401 applies only to actions for injury to real or personal property, or personal injuries, and not all tort claims. Plaintiff analogized her claims under the Public Health Law to civil rights claims under the Executive Law, which are not subject to § 7401 requirements and have a statute of limitations of three years.

Addressing this issue of first impression, the court held that the statute of limitations for bringing a claim for breach of confidentiality of HIV-related information in New York is three years, regardless of the entity sued, and that the Plaintiff did not have to file a notice of intention to commence an action within 90 days. In reaching its decision, the court agreed with Plaintiff that Article 27-F was similar to civil rights actions and dissimilar to tort actions because Article 27-F was enacted to protect a vulnerable class of individuals against discrimination and violations of privacy. The court also noted that the provision of civil and criminal penalties for violation of Article 27-F lends credence to Plaintiff's claim being statutorily derived, rather than based in common law.

Appellate Division Holds That Hospital's Statements Regarding Physician Made During an Internal Employment Review Were Not Defamatory

Panghat v. New York Downtown Hospital, __ N.Y.S.2d __, 2011 WL 2225386 (1st Dep't June 9, 2011). Plaintiff physician is a medical resident employed by New York Downtown Hospital. He sued the Hospital for defamation based on purported statements made by his supervisors in the context of an internal employment review. The Hospital filed a motion to dismiss the complaint based on defenses of truth and privilege. The Appellate Division affirmed the motion Court's dismissal of plaintiff's complaint on those grounds.

One of plaintiff's defamation claims addressed statements made by his supervisors about his Internal Medicine-In Training Examination ("IM-ITE") score. [Ed. Note: The IM-ITE is a practice examination developed by the American College of Physicians to assess the level of knowledge achieved by internal medicine residents and is generally taken in the second year of training]. The Court ruled that because plaintiff did not contest that he received a very low score on that exam, the truth or substantial truth of the statements served as a complete defense to a claim of defamation.

In dismissing plaintiff's claim for "breach of confidentiality" for the Hospital's failure to keep his IM–ITE score entirely confidential, the Court reasoned that plaintiff did not cite to any law, statute or contract that would prohibit his supervisors from discussing the score internally in connection with his employment review.

The Court also affirmed dismissal of plaintiff's defamation claim based on statements made by his supervisors, in the context of an internal employment review, regarding plaintiff's poor performance. The Court held that these statements were non-actionable opinions and were also protected by the common interest privilege. Moreover, plaintiff's conclusory allegation that the statements were made with malice was insufficient to overcome the privilege.

Lastly, the Court ruled that the Hospital's statements to the New York State Division of Human Rights in response to plaintiff's filing of a human rights complaint were also privileged pursuant to the judicial proceeding privilege.

Treatment Facility's Operating Certificate Revocable Without Prior Opportunity to Implement Corrective Action Plan

Cmty. Related Servs., Inc. v. Carpenter-Palumbo, 923 N.Y.S.2d 261, (3d Dep't, 2011). Petitioner was certified in 1998 by respondent Office of Alcohol and Substance Abuse Services ("OASAS") as an alcohol and substance abuse counseling treatment facility. As a facility certified by OASAS, petitioner was subject to regular inspections and recertification reviews to ensure its compliance with the provisions of 14 NYCRR (Department of Mental Hygiene). In late 2005 or early 2006, petitioner came under scrutiny by OASAS's Bureau of Enforcement because of aberrant Medicaid billings practices, length of patient stay and number of patient visits per year, among other factors. An OASAS investigation found petitioner to be in violation of 45 sections of 14 NYCRR. In September 2006, OASAS informed the facility of its findings and intention to revoke facility's operating certificate and impose fines for such violations. After the facility's counsel responded, in late October 2006, OASAS's investigators revisited the facility. Upon finding no improvements, in November 2006, OASAS revoked petitioner's operating certificate and imposed fines in excess of $16 million.

Petitioner thereafter requested a hearing pursuant to Mental Hygiene Law § 32.21 to challenge OASAS's determination. After a multi-day hearing was conducted, the Hearing Officer issued a report and recommendations that found petitioner in violation of 33 sections of 14 NYCRR. The Commissioner of Alcohol and Substance Abuse Services adopted the Hearing Officer's recommendations, revoking petitioner's operating certificate and imposing nearly a half million dollars in fines for violations occurring after the date of petitioner's last recertification inspection.

The Petitioner thereafter commenced an Article 78 proceeding, which was then transferred to the Appellate Division by order of the Supreme Court. The Appellate Court rejected petitioner's argument that it should have been afforded an opportunity to implement a corrective action plan ("CAP") to cure any violations prior to revocation of its operating certificate. Although the regulations provide that with respect to biannual inspections and reviews commenced pursuant to 14 NYCRR 810.14, "[t]he on-site review process shall include appropriate reporting and corrective action follow-up subsequent to the review," giving deference to the Commissioner's reasonable interpretation of the statutes, the court maintained that such regulations were inapplicable to the investigation of the petitioner's facility because that investigation was conducted pursuant to Mental Hygiene Law § 32.13, which does not require a facility under investigation to be provided with an opportunity to implement a CAP.

The court also rejected petitioner's contention that the Commissioner's determination to revoke the operating certificate without according the petitioner the opportunity to implement corrective measures violated its substantive due process rights. Although the petitioner had a protected property interest in its operating certificate, it failed to demonstrate that the governmental action was not legally justified. Further, petitioner was provided the requisite notice and an opportunity to be heard, as required by Mental Hygiene Law § 32.21 (a), in conjunction with the investigation and ultimate

determination. The Court also rejected petitioner's claim that its equal protection rights were violated based on selective enforcement and ruled that, given the multitude of violations found, the penalty of revocation of the petitioner's operating certificate was not an abuse of discretion.

District Court *Sua Sponte* Orders Supplemental Briefing and More Definitive Statement Before Dismissing Plaintiffs' FLSA and NYLL Claims for a Third Time

Wolman, et al., v. Catholic Health Systems of Long Island, Inc., et al., 2011 WL 1741905 10-cv- 1326 (JS)(ETB) (E.D.N.Y. May 5, 2011).

Plaintiffs commenced a putative collective action alleging that Defendants failed to pay them for all hours they worked and asserted statutory claims under the Fair Labor Standards Act ("FLSA") and the New York Labor Law ("NYLL"), along with a host of state common law claims. Previously, the court dismissed Plaintiffs' FLSA and NYLL claims asserted in Plaintiffs' Complaint and Amended Complaint for Plaintiffs' failure to meet the pleading requirements established under *Ashcroft v. Iqbal*, 129 S. Ct. 1937 (2009) and *Bell Atl. Corp. v. Twombly*, 550 U.S. 544 (2007). The court also previously dismissed Plaintiffs' Racketeer Influenced and Corrupt Organization (RICO) claims with prejudice. (*Wolman*, 2010 WL 5491182 (E.D.N.Y., Dec. 30, 2010).

Plaintiffs' Third Amended Complaint alleges that Defendants' timekeeping policy, to automatically deduct a 30-minute break from Plaintiffs' shift, while not *per se* illegal, violates the FLSA because the policy does not ensure a meal break. The court held that although this theory is "colorable" it may not be ultimately be meritorious. The court cited a case from the Western District of Tennessee, *Frye v. Baptist Memorial Hosp.*, 07-cv-2708, 2010 WL 3862591, at * 7, which held that no FLSA violations existed where defendant-hospital "shifted the burden" to employees by requiring them to take "affirmative action" to report interrupted or missed meal breaks. *Frye*, 2010 WL 3862591 (defendant-hospital's policy that employees were required to report interrupted or missed meal breaks cannot be a basis for an alleged FLSA violation because the FLSA permits automatic deduction policies). Since the parties did not brief this issue thoroughly, the court afforded the parties an opportunity to submit supplemental briefing within fourteen days of the Decision and Order.

Plaintiffs' second theory of liability is that Defendants violated the FLSA by allegedly telling their employees that they could not receive compensation for work performed during lunch breaks or off-shift, and that they had been fully compensated under the law. Initially, the Court held that these allegations were sufficient to state a FLSA and NYLL claim under the *Iqbal/Twombly* plausibility standard. 129 S. Ct. 1937; 550 U.S. 544. In their Third Amended Complaint, however, Plaintiffs admitted, and in derogation of prior allegations, that although they define twelve separate entities as "Defendants," they only worked for one defendant. Thus, the Court held that it need not accept as true Plaintiffs' "bald allegations" that "Defendants" told Plaintiffs anything, let alone made misrepresentations. Rather than dismiss Plaintiffs' Third Amended Complaint without prejudice, the court ordered Plaintiffs to provide a more definitive statement as to this theory. Specifically, Plaintiffs had affirmatively, but vaguely, represented in their Third Amended Complaint that Plaintiffs had "conversations," on a "number of occasions," that they were "being fully paid," and that they were "not allowed" to record time for off-shift work. The court held that Plaintiffs could and should substantiate and specify these allegations, since such facts are wholly within their knowledge. The court stated that the more definitive statement should provide the following information for *each* Plaintiff: (1) the specifics regarding who made the representations that the plaintiffs were being fully paid; (2) the nature and basis for the allegation that they were "not allowed" to record or receive certain compensation; and (3) whether they were discouraged or informed that they could not receive compensation for certain meetings and training.

Court Dismisses Physician's Claims for Age Discrimination, Retaliation and Hostile Work Environment

Mejia v. Roosevelt Island Medical Assoc., 2011 WL 1260111 (Sup. Ct. N.Y. County, 2011). Plaintiff, a 70-year old physician, employed by Coler-Goldwater Specialty Hospital, sued the Hospital alleging age discrimination, retaliation, hostile work environment and violation of his right to privacy. The court granted Defendants' motion to dismiss Plaintiff's age discrimination, retaliation and hostile work environment claims.

The court concluded that Plaintiff's allegations of age discrimination failed to state a claim because he did not suffer an adverse employment action. The court concluded that a transfer to another unit within the hospital while still retaining the same title and salary, denial of vacation leave, unproved allegations of being assigned a greater patient case load or higher-risk patients than other physicians, receiving negative peer reviews and heightened scrutiny without tangible consequences, and the failure to promote Plaintiff to Assistant Chief of Service, a position for which he never applied, did not constitute adverse employment actions.

The court also held that Plaintiff failed to make out a prima facie case for retaliation. Plaintiff alleges that Defendants retaliated against him by delaying his reappointment application, assigning him unequal patient case loads and higher-risk patients and by falsely criticizing his performance. In contrast to a claim for discrimination, the threshold to establish a claim for retaliation is lower. Nevertheless, the court held that

Plaintiff failed to establish an adverse employment action even under this lower standard given that "reassignment, enhanced scrutiny and negative evaluations of work performance which had no tangible consequences do not constitute adverse employment actions in a retaliation context."

Finally, the court held that Plaintiff failed to make out a claim for a hostile work environment, defined as a workplace "permeated with discrimination, intimidation, ridicule, and insult that is sufficiently severe or pervasive to alter the conditions of the victim's employment and create an abusive working environment" (quoting *Forrest v. Jewish Guild for the Blind*, 3 N.Y.3d 295, 310 (2004)). Given that Plaintiff did not allege any instances of insult or intimidation, the court dismissed Plaintiff's hostile work environment claims.

Appellate Division Affirms Determination by Board for Professional Medical Conduct to Annul Certificate of Incorporation of Medical P.C.

Tribeca Medical, P.C. v. New York State Dept. of Health, 83 A.D.3d 1135, 920 N.Y.S.2d 473 (3d Dep't, 2011). Petitioner, a professional corporation engaged in the practice of medicine, ("P.C.") sought Article 78 review of a determination by the Administrative Review Board for Professional Medical Conduct (the "Board"), which annulled the P.C.'s certificate of incorporation. That penalty was imposed for the P.C.'s failure to comply with New York's statutory prohibition of non-physician ownership or control of medical service corporations. The Appellate Division affirmed the Board's determination.

The Bureau of Professional Medical Conduct charged the P.C. with professional misconduct under Education Law § 6530(16), for failing to comply with the provisions of Business Corporation Law § 1503. BCL § 1503 prohibits non-physicians from owning or controlling medical service corporations. A notice of hearing and statement of charges were then served on the P.C. via the Secretary of State, as petitioner's authorized agent for that purpose. The P.C. failed to submit an answer or to appear at either the prehearing conference or the hearing before a Hearing Committee of the State Board for Professional Medical Conduct. The Hearing Committee sustained the charge of misconduct and, as a penalty, directed that the P.C.'s certificate of incorporation be annulled.

The P.C. thereafter sought review before the Board, arguing that it had been unaware of the charge against it, and as a result, the Hearing Committee's determination should be nullified and petitioner should be permitted to serve an answer. The Board denied petitioner's request and affirmed the Hearing Committee's decision.

The court found no merit to the P.C.'s contention that the Board unreasonably refused to open the default and allow the P.C. to answer. The court noted that nothing in the record indicated that the P.C. had any meritorious defense to the charge. Accordingly, the court concluded that the Board's denial of such relief was not "arbitrary and capricious, affected by an error of law or an abuse of discretion."

The court also found that the penalty of annulment of petitioner's certificate of incorporation was not so disproportionate to the complained-of conduct as to shock one's sense of fairness. Significantly, the Board found that the record proof "demonstrated that unqualified persons incorporated and operated" petitioner, and thus, the annulment constituted an appropriate penalty under the circumstances.

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

In the New York State Legislature

By James W. Lytle

Who Guards the Guardians?

The 2011 Regular Session of the New York State Legislature has, at least for now, come to an end with a host of significant health care-related legislation either already enacted or on Governor Andrew Cuomo's desk awaiting his consideration.

The session ended with the passage of a number of high priority issues for Governor Cuomo, including a cap on property taxes, the extension of rent control, strengthened ethics laws, and, in a dramatic vote, marriage equality—a bill that will certainly clarify once and for all the ability of persons in committed same-sex relationships to make health care decisions for their marital partners.

The health care bills passed by both houses complement the significant health care reforms that were already enacted as part of the State Budget's Medicaid Redesign initiative and touch upon a variety of issues, including the scopes of practice of health care professionals, hospice care (including a bill to extend the Family Health Care Decisions Act (FHCDA) to hospice (A. 7343-A (Gottfried) / S. 5259-A (Hannon)), mandated insurance coverage for autism, prescription drugs (including bills that would extend coverage for oral chemotherapy and fertility drugs and would preclude mail order-only insurance requirements), and a host of other issues. These significant achievements are, as always, accompanied by less profound public health initiatives, including a bill that requires notices on potential health care risks posed by baby "sippy cups" (A. 7232 (Pheffer) / S. 5317 (Fuschillo)) and a bill that increases penalties on licensed barbers that serve alcohol to minors (A. 6324-B (Castro) / S. 1880 (Espaillat).

At the very end of the session, a bill that would have established a structure for health benefit exchanges

in New York, as envisioned by federal health reform, was not enacted, having sparked a debate within the State Senate over the extent to which the bill might be viewed as endorsing the Patient Protection and Affordable Care Act. As of this writing, it remains possible that the Senate may reconsider the bill when it returns to Albany to consider confirmations and other matters later this year.

A subsequent column will summarize the health care bills that are ultimately signed by Governor Cuomo. One bill, relating to the operations of the Office of the Medicaid Inspector General, warrants special attention.

OMIG Reform (A. 5686-A (Gottfried, et al./S. 3184-A (Little, et al.): Fueled by persistent complaints by the health care industry over the tactics and practices of the Office of the Medicaid Inspector General (OMIG), legislation passed both houses that would enact modest but important changes to how the Medicaid fraud and auditing agency carries out its work. The fate of the legislation before the Governor's office is not yet certain: if the bill is viewed by the Executive branch as hobbling OMIG's ability to achieve ambitious Medicaid recoupment targets, it may be vetoed. It also arrives on the Governor's desk at a time when OMIG is expected to be transitioning to new leadership, with the departure of James Sheehan, who served as the State's Medicaid Inspector General since Governor Spitzer appointed him to the post in 2007.

Last year, State Senate Committee on Investigations hearings convened by the former Chair, Senator Craig Johnson, focused on what health care providers viewed as the overly aggressive, hyper-technical and dollar-driven auditing approach undertaken by OMIG in recent years, motivated, at least in part, by Medicaid recovery targets mandated by the Federal-State Health Reform Partnership (F-SHRP) agreement, which requires $644 million in Medicaid recoveries during the federal fiscal year ending this September 30. State fiscal plan requirements have, moreover, set targets for Medicaid recoupments at or above $1 billion in the last two fiscal years.

Comprehensive legislation, advanced by Assembly Health Committee Chair Richard Gottfried and Senator Johnson, was considered but not passed last year. Toward the close of this legislative session, the bill (now sponsored by Mr. Gottfried and Senator Betty Little) was amended substantially to satisfy concerns, both in the Legislature and the Executive, that the bill, as initially drafted, would compromise OMIG's ability to collect large amounts of Medicid revenue.

As passed, the bill would:

- Clarify that the Legislature intends that OMIG "balance the ability of the state to ensure the integrity of the medical assistance program with the need to afford due process to providers and recipients" and endorse "the need for established statutory standards regarding the conduct of investigations, audits and recovery of payments and other actions";
- Preclude the recovery of overpayments before sixty days after the issuance of a final audit report and require OMIG to provide health care entities with at least ten days' notice of such recoupments;
- Prohibit OMIG from re-reviewing "contracts, cost reports,

claims, bills or expenditures" that had been the subject of prior OMIG reviews within the past three years, except where OMIG receives new information, believes that the prior audit was erroneous or where the scope of the new review was significantly different from the prior review;

- Require OMIG to apply the laws, regulations, policies, guidelines, standards and interpretations of the relevant agency that were in place when the reviewed Medicaid claims were filed;
- Prevent OMIG from making any recovery based on "administrative or technical defect in procedure or documentation made without intent to falsify or defraud" without affording the provider "an opportunity to correct the defect and resubmit the claim within thirty days of notice of the defect";
- Mandate that the sampling and extrapolation methodologies used by OMIG be "statistically reasonably valid for the intended use" and be established in regulation;
- Establish reasonable protections for Medicaid recipients that may be the subject of an investigation, including written notice of the investigation, which must include its basis, the potential for criminal consequences, the right to be accompanied by an attorney, friend or a family member during questioning and the right to a fair hearing to contest the investigation's findings;
- Require OMIG to provide providers with sufficient information concerning any alleged deficiencies in their compliance programs and the opportunity to address those shortcomings before being penalized.

No one disputes the importance of having vigilant oversight of the Medicaid program: OMIG was created when it appeared that Medicaid fraud and abuse in New York was not being adequately policed. The issue of how to "guard the guardians"—*Quis custodiet ipsos custodes*—is as old as democracy itself.

The Legislature concluded that some additional constraints over the approach taken by OMIG to Medicaid audits and investigations was warranted. Governor Cuomo has already obtained legislative authorization, as part of the Medicaid Redesign Team recommendations, to control overall Medicaid spending without undue reliance on OMIG for Medicaid recoveries and has entered into an extension of the F-SHRP agreement with the federal government that does not include new Medicaid recoupment targets. Whether, in this context, the bill may be viewed as placing acceptable limitations on OMIG practices remains to be seen.

Jim Lytle is a partner in the Albany office of Manatt, Phelps & Phillips, LLP.

In the New York State Agencies

By Francis J. Serbaroli

Potentially Preventable Readmissions

Notice of Adoption. The Department of Health amended section 86-1.37 of Title 10 NYCRR to implement a revised reimbursement policy related to hospital readmissions that are determined to be potentially preventable. Filing date: February 8, 2011. Effective date: February 23, 2011. *See* N.Y. Register February 23, 2011.

Prenatal Care Assistance Program (PCAP)

Notice of Adoption. The Department of Health repealed sections 85.40 and 86-4.36 of Title 10 NYCRR to repeal a Prenatal Care Assistance Program (PCAP) provision that is no longer in existence. Filing date: February 15, 2011. Effective date: March 2, 2011. *See* N.Y. Register March 2, 2011.

Hospital Inpatient Reimbursement

Notice of Adoption. The Department of Health amended Subpart 86-1 of Title 10 NYCRR to modify current reimbursement for hospital inpatient services due to the implementation of APR DRGs and rebasing of hospital inpatient rates. Filing date: March 1, 2011. Effective date: March 16, 2011. *See* N.Y. Register March 16, 2011.

Audited Financial Statements

Notice of Adoption. The Department of Insurance repealed Part 89 and added a new Part 89 (Regulation 118) to Title 11 NYCRR to implement provisions of Insurance Law section 307(b), and add provisions required pursuant to the federal Sarbanes-Oxley Act of 2002. Filing date: March 1, 2011. Effective date: March 16, 2011. *See* N.Y. Register March 16, 2011.

Financial Statement Filings and Accounting Practices and Procedures

Notice of Adoption. The Department of Insurance amended Part 83 (Regulation 172) of Title 11 NYCRR

to update the regulation to conform to NAIC guidelines, statutory amendments, and to clarify existing provisions. Filing date: March 1, 2011. Effective date: March 16, 2011. *See* N.Y. Register March 16, 2011.

Mt. Sinai-Queens Merged Rates

Notice of Emergency Rulemaking. The Department of Health amended section 86-1.31 of Title 10 NYCRR to no longer require that a merger, acquisition or consolidation needs to occur on or after the year the rate is based upon. Filing date: March 2, 2011. Effective date: March 2, 2011. *See* N.Y. Register March 23, 2011.

Ambulatory Patient Groups (APGs) Payment Methodology

Notice of Proposed Rulemaking. The Department of Health proposed to amend Subpart 86-8 of Title 10 NYCRR to refine the APG payment methodology. *See* N.Y. Register March 23, 2011.

Children's Camps, Swimming Pools, Bathing Beaches

Notice of Proposed Rulemaking. The Department of Health proposed to amend Subparts 7-2, 6-1 and 6-2 of Title 10 NYCRR to incorporate PHLs, including a new day camp definition, and amend standards for swimming and camp cabins. *See* N.Y. Register March 30, 2011.

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

Notice of Adoption. The Department of Insurance amended Part 52 (Regulation 62) of Title 11 NYCRR to establish standards for an internal appeal procedure for long-term care insurance. Filing date: March 14, 2011. Effective date: March 30, 2011. *See* N.Y. Register March 30, 2011.

NYS Newborn Screening Panel

Notice of Emergency Rulemaking. The Department of Health amended section 69-1.2 of Title 10 NYCRR to add Severe Combined Immunodeficiency (SCID) to New York State Newborn Screening Panel. Filing date: March 16, 2011. Effective date: March 16, 2011. *See* N.Y. Register April 6, 2011.

Sexually Transmitted Disease (STD) Reporting and Treatment Requirements

Notice of Revised Rulemaking. The Department of Health revised section 2.10 and Part 23 of Title 10 NYCRR regarding reporting of cases or suspected cases or outbreaks of communicable disease by physicians, listing and reporting of STDs. *See* N.Y. Register April 6, 2011.

Early Intervention Program

Notice of Proposed Rulemaking. The Department of Health amended Subpart 69-4 of Title 10 NYCRR to revise reimbursement methodology for early intervention program. *See* N.Y. Register April 13, 2011.

Efficiency Adjustment for HCBS Waiver Respite Services

Notice of Proposed Rulemaking. The Department of Insurance proposed amending section 635-10.5 of Title 14 NYCRR to implement an efficiency adjustment by modifying the price methodology for HCBS waiver respite services. *See* N.Y. Register April 13, 2011.

April 2011 Ambulatory Patient Groups (APGs) Payment Methodology

Notice of Emergency Rulemaking. The Department of Health amended Subpart 86-8 of Title 10 NYCRR to refine the APG payment methodology. Filing date: March 31,

2011. Effective date: March 31, 2011. *See* N.Y. Register April 20, 2011.

Distributions from the Health Care Initiatives Pool for Poison Control Center Operations

Notice of Emergency Rulemaking. The Department of Health amended section 68.6 of Title 10 NYCRR to revise the methodology for distributing HCRA grant funding to Regional Poison Control Centers (RPCCs). Filing date: March 31, 2011. Effective date: March 31, 2011. *See* N.Y. Register April 20, 2011.

Consumer Directed Personal Assistance Program

Notice of Adoption. The Department of Health added section 505.28 to Title 18 NYCRR to establish regulations for the administration and operation of the Consumer Directed Personal Assistance Program (CDPAP). Filing date: March 31, 2011. Effective date: April 20, 2011. *See* N.Y. Register April 20, 2011.

Cost of Examinations—Medicaid

Notice of Adoption. The Department of Health amended 360-5.5 of Title 18 NYCRR to note a change in citation referenced within existing regulation. Filing date: April 4, 2011. Effective date: April 20, 2011. *See* N.Y. Register April 20, 2011.

Efficiency Adjustment for HCBS Waiver Community Habilitation Services

Notice of Proposed Rulemaking. The Office for People With Developmental Disabilities proposed to amend section 635-10.5(ab) of Title 14 NYCRR to implement an efficiency adjustment by modifying the fee schedule for HCBS waiver community habilitation services. *See* N.Y. Register April 20, 2011.

Reimbursement of Clinic Treatment Facilities ("Article 16 Clinics")

Notice of Proposed Rulemaking. The Office for People With Developmental Disabilities proposed to amend Part 679 of Title 14 NYCRR to effect a new reimbursement methodology for clinic treatment facilities and to achieve consistency with other State agencies. *See* N.Y. Register April 20, 2011.

Efficiency Adjustment for HCBS Waiver Supported Employment Services

Notice of Proposed Rulemaking. The Office for People With Developmental Disabilities proposed to amend section 635-10.5(d) of Title 14 NYCRR to implement an efficiency adjustment by modifying the fee schedule for HCBS waiver supported employment services. *See* N.Y. Register April 20, 2011.

Reimbursement of Specialty Hospitals

Notice of Proposed Rulemaking. The Office for People With Developmental Disabilities proposed to amend section 680.12 of Title 14 NYCRR to modify the reimbursement methodology for Specialty Hospitals and make associated changes. *See* N.Y. Register April 20, 2011.

Inappropriate Use of Cesarean Deliveries and Audits of Institutional Cost Reports (ICR)

Notice of Emergency Rulemaking. The Department of Health amended Subpart 86-1 of Title 10 NYCRR to limit payments for cesarean deliveries to the hospital's average Medicaid payment for vaginal deliveries. Impose a fee schedule re: ICRs. Filing date: April 6, 2011. Effective date: April 6, 2011. *See* N.Y. Register April 27, 2011.

Medicaid Benefit Limits for Enteral Formula, Prescription Footwear, and Compression Stockings

Notice of Emergency Rulemaking. The Department of Health amended Parts 505 and 513 of Title 18 NYCRR to implement mandatory provisions of SSL, section 365- a(2)(g), as amended by Chapter 59 of the Laws of 2011. Filing date: April 6, 2011. Effective date: April 6, 2011. *See* N.Y. Register April 27, 2011.

Chemical Analyses of Blood, Urine, Breath or Saliva for Alcoholic Content

Notice of Emergency Rulemaking. The Department of Health amended Part 59 of Title 10 NYCRR to update technical standards for blood and breath alcohol testing conducted by law enforcement. Filing date: April 18, 2011. Effective date: April 18, 2011. *See* N.Y. Register May 4, 2011.

Changes to Prescribed Uses of Health Care Adjustment/Health Care Enhancement Funds

Notice of proposed rulemaking. The Office for People With Developmental Disabilities proposed amending sections 635-10.5, 671.7, 679.6, 681.14, 686.13 and 690.7 of Title 14 NYCRR to allow providers to exercise broader discretion in the allocation of these funds. *See* N.Y. Register May 4, 2011.

Implementation of Medicaid Fee Reductions in Various OMH Licensed Programs

Notice of Emergency Rulemaking. The Department of Insurance amended Parts 512, 588 and 591 of Title 14 NYCRR to reduce rates for various non-State-operated programs consistent with the 2011-2012 enacted State budget. Filing date: May 23, 2011. Effective date: May 23, 2011. *See* N.Y. Register June 8, 2011.

Compiled by Francis J. Serbaroli. Mr. Serbaroli is a shareholder in the Health & FDA Business Group of Greenberg Traurig's New York office. He is the former Vice Chairman of the New York State Public Health Council, writes the "Health Law" column for the *New York Law Journal*, and is the Chair of the Health Law Section. The assistance of Whitney M. Phelps, Of Counsel, and Caroline B. Brancatella, Associate, of Greenberg Traurig's Health and FDA Business Group in compiling this summary is gratefully acknowledged.

New York State Fraud, Abuse and Compliance Developments

Edited By Melissa M. Zambri

New York State Department of Health OMIG Audit Decisions

Compiled by Eugene M. Laks

Essex Street Corp*. (DOH administrative hearing decision dated April 29, 2011, James F. Horan, Administrative Law Judge).* In this pharmacy audit of prescriptions filled for deceased persons, the ALJ sustained the audit findings and Medicaid recovery amount. The ALJ found that the pharmacist had filled the prescriptions at issue in good faith with no way of knowing at the time that the person was deceased. The ALJ held that this was not a defense to the audit findings. The prescriptions had been picked up by relatives / friends. The Medicaid system paid the claims.

New York State Attorney General Press Releases

Compiled by Charles Z. Feldman

Pharmacist Pleads Guilty to Illegally Dispensing Prescriptions—3/17/11—The supervising pharmacist of a Rochester area Tops Market pled guilty to defrauding Medicaid of $191,000 in claims. The former pharmacist had been excluded from the Medicaid program and was operating under a suspended license yet continued to distribute prescription medication to Medicaid recipients.

Doctor Convicted of Selling Vaccines Provided by the State for Free to Ineligible Patients—3/14/11—The MFCU secured a conviction of a Western New York physician for administering New York State-sponsored vaccines to ineligible patients. The doctor falsely reported how many eligible participants had been given the free vaccines, and then sold the free vaccines to patients who were not eligible for the State program. The physician will pay $179,000 in restitution to the State for the vaccines, and could face a sentence of up to four years in prison.

Woman Jailed for Colluding with Home Health Aides—3/10/11—A Fulton County woman was sentenced to 45 days in jail, five years probation, and $15,000 restitution for falsifying the time sheets of her home health aides in exchange for a cut of the unearned wages. The woman was a participant in the Medicaid-funded Consumer Directed Personal Assistant Program which supplied the aides.

Erie County Workers Caught on Hidden Camera During Nursing Home Investigation—3/7/11—A hidden camera investigation at an Amherst Nursing Home resulted in the conviction of several health care workers. Footage from the investigation revealed caregivers who never performed some of the treatments that they had documented in the patients' records. The videos also showed improper transfers of patients using a mechanical lift. Two LPNs and two CNAs surrendered their licenses / certificates after pleading guilty, and were sentenced to conditional discharge and community service. Matters are pending for at least four other workers.

Additional Guilty Plea for Neglect and Endangerment at Troy Nursing Home—2/25/11—Another nurse pled guilty to the neglect and endangerment of nursing home patients at the Northwoods Rehabilitation and Extended Care Facility in Troy, NY. The LPN admitted that she falsified medical records to cover up that she had failed to administer medication and did not provide adequate treatment to patients. The LPN was one of the nine caregivers indicted after a 2009 hidden camera investigation revealed that residents of the nursing home were not provided with appropriate treatment. Some of the other caregivers involved have pled guilty and surrendered their licenses / certificates.

Drug Company Settles with State for $2.5 Million for Inflated Pricing—2/18/11—Pharmacia Corporation settled with Medicaid and the Elderly Pharmaceutical Insurance Coverage (EPIC) Program for inflating its wholesale drug prices. Medicaid and EPIC relied upon those inflated prices to set reimbursement rates, which resulted in overpayment for Pharmacia-manufactured medication. Pharmacia agreed to pay $2.45 million to the programs, as well as pay $50,000 to the State for its investigation costs. Attorney General Schneiderman also announced that his office will continue to target contractors that waste taxpayer dollars through the recently formed Taxpayer Protection Unit (TPU). The TPU will seek to prosecute large scale, multi-state tax fraud schemes and corrupt contractors.

Sloppy Record Keeping By a LHCSA Nets MFCU a $397,000 Settlement—2/10/11—A licensed home care services agency in Mount Vernon settled with MFCU for $397,000 for failing to maintain proper records, such as time sheets and nurses' notes, required for Medicaid reimbursement between February 2002 and September 2007.

Dental Practice with Several Offices Across the State Pays $376K in Settlement of Medicaid Fraud—2/10/11—A statewide dental practice agreed to pay $376,560 for failing to show medical necessity for dental fillings during a six-year period (January 2002—February 2008).

Queens Oncology Practice Settles for Failing to Properly Submit Claims for Injectible Drugs—2/10/11—Doctors at Queens Medical Associates, P.C. improperly submitted claims for "J Code Claims" by allegedly overbilling for injectible drugs they administered, a practice forbidden by law. The practice paid $851,927 to settle with MFCU. MFCU investigated the practice as part of an ongoing effort to ensure compliance with "J Code Claims" requirements. The practice also billed Medicaid as the primary insurance on claims that were 80% covered by Medicare.

Mother Forged Time Sheets of Daughter Who Was Hired to Care for Disabled Son—2/8/11—A mother hired her daughter as the personal care assistant for the mother's disabled son under the Consumer Directed Personal Assistant Program (CDPAP). Over $59,000 was fraudulently billed to Medicaid when the mother forged the daughter's name on the time sheets submitted to Medicaid via the Southern Tier Independence Center (STIC) for payment. STIC made restitution to Medicaid, and the mother pled guilty and received a three year conditional discharge. The daughter has not been charged.

New York State Office of the Medicaid Inspector General Update

Compiled by the Editor

- Press Release—June 3, 2011—Doctor Indicted for Prescribing HIV Medication to HIV-Negative Patients—doctor allegedly prescribed HIV medication without testing for the virus, and billed for visits that never occurred.
- OMIG Compliance Webinar #10: Responding to Medicaid Inspector General Audits and Compliance Reviews of Home Health and Personal Care Services—May 25, 2011—Still Available on the OMIG Website—covered the new Home Health Legislation Requirements of 2011 regarding conflict and exception reports for home health, personal care, consumer-directed care, and housekeeping services, as well as provided example reports and explanations.
- Press Release—May 18, 2011—Physical Therapist Pleaded Guilty to Unnecessary Treatments and False Claims—physical therapist allegedly billed for unnecessary treatments and for services not provided.
- OMIG has continued to issue periodic Compliance Alerts. In May 2011, three Compliance Program Assessment Tools were issued as supplements to OMIG's 2010-02 Alert for Self Assessments. Focused review forms include a General Form (2011-02), Pharmacy Form (2011-03), and Transportation Form (2011-04). Alert 2011-05 was also issued for Compliance Program Requirements for New Medicaid Providers.
- OMIG Compliance Webinar #9: New York State Pre-School/School Supportive Program Medicaid Compliance—April 27, 2011—Still Available on the OMIG Website—covered billing and claiming guidance for school districts, exclusions, audit standards, third party billing, and how these issues impact services provided to students.
- OMIG Compliance Webinar #8: Program Obligations for New York State Early Intervention Program Providers and Municipalities—March 30, 2011—Still Available on the OMIG Website—covered excluded parties, overpayments, effective compliance programs, and third-party billing.
- Press Release—February 28, 2011—Federal Medicare Strike Force Indicts 111 People for Over $225 million in False Claims—NYS OMIG staff participated in Medicare Strike Force investigations across nine cities. Brooklyn cases accounted for $91.3 million in alleged fraud.
- OMIG Compliance Webinar #7: How Effective Compliance Programs Address Whistleblower Issues—February 23, 2011—Still Available on the OMIG Website—covered whistleblower protections under New York State and federal laws and provided examples of relevant cases.
- OMIG Compliance Webinar #6: Third-Party Billing in the New York Medicaid Program—January 12, 2011—covered New York State regulation on third-party billers and key questions to ask regarding these arrangements.

The Editor would like to thank Hiscock & Barclay, LLP Summer Associate Laura L. Mona for her assistance with this issue.

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In the Journals

Compiled by Melissa Ann Dizon and Nicholas A. Battaglia

- *A Living Wage for Research Subjects*, Trisha B. Phillips, 39 J.L. Med. & Ethics 243 (2011).
- *Abortion Politics in the Courts: New Judicial Federalism or the Federal Courts*, Jason Jagemann, 36-WTR Vt. B.J. 46 (2011).
- *An Examination of Contemporary Financing Practices and the Global Financial Crisis on Nonprofit Multi-Hospital Health Systems*, Louis J. Stewart, 37 (No. 3 J. Health Care. Fin. (Aspen) 1 (2011).
- *Are You a Hospital Inpatient or Outpatient?*, Joseph Baker Medicare Rights Center, 210 PLI / NY 269 (2011).
- *Caging the 800-Pound Gorilla: Medicare's Right of Reimbursement After* Bradley v. Sebelius, Eric H. Faddis, 85-MAY Fla. B.J. 12 (2011).
- *Can This Information Be Disclosed?*, Robert B. Miller & Tegan Schlatter, 40-SPG Brief 32 (2011).
- *Capital Punishment, Psychiatrists and the Potential "Bottleneck" of Competence*, Jacob M. Appel, 24 Cleveland-Marshall J.L. & Health (2011).
- *The Case for Legal Regulation of Physicians' Off-Label Prescribing*, Philip M. Rosoff, 86 Notre Dame L. Rev. 649 (2011).
- *Cause for HIPAANOIA? OCR Seems to Be Sending a Message That It Will Continue to Enforce HIPAA*, Rebecca L. Williams, 13 No. 3 J. Health Care Compliance 5 (2011).
- *Commercial Reasonableness: The New Target*, David B. Pursell, 13 No. 2 J. Health Care Compliance 59 (2011).
- *Complying with the Centers for Medicare and Medicaid Services Visitation Rule*, Fay A. Rozovsky, 13 No. 2 J. Health Care Compliance 15 (2011).
- *Congress Exempts Doctors, Lawyers from Red Flags Rule*, 24 No. 9 Health Care Collector 3 (2011).
- *Constitutional Challenges to the Patient Protection and Affordable Care Act*, Elizabeth J. Bondurant, 78 Def. Couns. J. 249 (2011).
- *Contract, Warranty, and the Patient Protection and Affordable Care Act*, Adam Candeub, 46 Wake Forest L. Rev. 45 (2011).
- *Cost and End-of-Life Care*, edited by Thaddeus M. Pope, Robert M. Arnold, & Amber E. Barnato, 39 J.L. Med. & Ethics (2011) (Symposium).
  - *Constitutional Right to Informational Health Privacy in Critical Condition, Mark A. Rothstein, 39 J.L. Med. & Ethics 280 (2011).*
  - *Health Care Accessibility for Chronic Illness Management and End-of-Life Care: A View from Rural America, Kathryn E. Artnak, Richard M. McGraw, & Vayden F. Stanley, 39 J.L. Med. & Ethics 140 (2011).*
  - *Just Caring: Health Care Rationing, Terminal Illness, and the Medically Least Well Off, Leonard M. Fleck, 39 J.L. Med. & Ethics 156 (2011).*
  - *Making the Case for Talking to Patients About the Costs of End-of-Life Care, Greer Donley & Marion Danis, 39 J.L. Med. & Ethics 183 (2011).*
  - *Personal Reflections on Teaching Health Law in a School of Public Health, Peter D. Jacobson, 39 J.L. Med. & Ethics 285 (2011).*
  - *Testing Public Health Ethics: Why the CDC's HIV Screening Recommendations May Violate the Least Infringement Principle, Matthew W. Pierce, Suzanne Maman, Allison K. Groves, Elizabeth J. King, & Sarah C. Wyckoff, 39 J.L. Med. & Ethics 263 (2011).*
  - *The Ethical Implications of Health Spending: Death and Other Expensive Conditions, Dan Crippen & Amber E. Barnato, 39 J.L. Med. & Ethics 121 (2011).*
- *Determining Best Interests Under the Mental Capacity Act 2005*, Mary Donnelly, 19 Med. L. Rev. 304 (2011).
- *Develop Your Audit Plan for Medicaid Integrity Contractors*, Judy I. Veazie, 24 No. 12 Health Care Collector 5 (2011).
- *Do Hospital Chief Executive Officers Extract Rents from Certificate of Need Laws?*, Traci L. Eichmann, 37 No. 4 J. Health Care Fin. (Aspen) 1 (2011).
- *Economic Factors Converge: Force Hospitals to Review Pricing Strategies*, Sandra J. Winterhalter 37 No. 4 J. Health Care Fin. (Aspen) 15 (2011).
- *Employer-Sponsored Health Plans Under Non-Privacy Health Plan Provisions of HIPAA*, Roberta Casper Watson & Douglass A. Farnsworth, SS030 ALI-ABA 459 (2011).
- *Ensuring So Grave a Choice Is Well Informed": The Use of Abortion Informed Consent Laws to Promote State Interests in Unborn Life*, Kaitlain Moredock, 85 Notre Dame L. Rev. 1937 (2010).
- *Even More Important HIPAA Penalty News*, Kirk J. Nahra, 1048 PLI / Pat 365 (2011).

- *The Evolving Role of Physicians in a Reformed American Health Care System*, Howard Dean, 39 Hofstra L. Rev. 9 (2011).
- *Exposing the Underground Establishment Clause in the Supreme Court's Abortion Cases*, Justin Murray, 23 Regent U. L. Rev. 1 (2011).
- *Facebook, Twitter, Linkedin and Compliance: Results of a 2009 Survey by the Society of Corporate Compliance and Ethics and the Health Care Compliance Association*, Adam Tureltaub, 1886 PLI/Corp 351 (2011).
- *Family Involvement, Independence, and Patient Autonomy in Practice*, Roy Gilbar, 19 Med. L. Rev. 192 (2011).
- *Fetal Pain, Abortion, Viability and the Constitution*, Glenn Cohen & Sadath Sayeed, 39 J.L. Med. & Ethics 325 (2011).
- *First HIPAA Civil Monetary Penalty Causes Concern*, Kirk J. Nahra, 1048 PLI/Pat 371 (2011).
- *Focusing on Effective HIPPA Security*, Kirk J. Nahra, 1048 PLI/Pat 401 (2011).
- *Front-end Discounting in Today's Market*, Irene Barron, 25 No. 1 Healthcare Registration 3 (2011).
- *Government Imposes First Ever Penalty for HIPAA Privacy Violation*, 24 No. 11 Health Care Collector 5 (2011).
- *Grassroots Marketing in a Global Era: More Lessons from BiDil*, Britt M. Rusert and Charmaine D.M. Royal, 39 J.L. Med. & Ethics 79 (2011).
- *Harmonization of Ethics Policies in Pediatric Research*, Valarie Blake, Steve Joffe, and Eric Kodish, 39 J.L. Med. & Ethics 70 (2011).
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  - *Experimental Wounds: Science and Violence in Mid-Century America, Susan Lindee, 39:1 J.L. Med. & Ethics 8 (2011).*
  - *Going for the Burn: Medical Preparedness in Early Cold War America, Susan E. Lederer, 39 J.L. Med. & Ethics 48 (2011).*
  - *Representations and Reproductive Hazards of Agent Orange, Leslie J. Reagan, 39 J.L. Med. & Ethics 54 (2011).*
  - *Surviving Wartime Emancipation: African Americans and the Cost of Civil War, Leslie A. Schwalm, 39 J.L. Med. & Ethics 21 (2011).*
  - *Toxic Legacy: Mustard Gas in the Sea Around Us, Susan L. Smith, 39 J.L. Med. & Ethics 34 (2011).*
  - *Veterans' Welfare, the GI Bill and American Demobilization, Laura McEnaney, 39 J.L. Med. & Ethics 41 (2011).*
  - *Waiting to Exhale: Chaos, Toxicity and the Origins of the U.S. Chemical Warfare Service, Andrew Ede, 39 J.L. Med. & Ethics 28 (2011).*
- *Health Research, Data Protection, and the Public Interest in Notification*, Mark J. Taylor, 19 Med. L. Rev. 267 (2011).
- *HIPAA 5010 and ICD-10: Don't Put this Off*, Bob Brown, 13 No. 1 J. Health Care Compliance 39 (2011).
- *HIPAA Privacy Rule: Maintaining the Confidentiality of Medical Records, Part 2*, Sarah S. Mir, 13 No. 3 K. Health Care Compliance 35 (2011).
- *HIPAA Privacy Rule: Maintaining the Confidentiality of Medical Records, Part 1*, Sarah S. Mir, 13 No. 2 J. Health Care Compliance 5 (2011).
- *The Hospital-Acquired Condition Initiative: Two Years Later*, Melinda S. Stegman, 13 No. 2. J. Health Care Compliance 63 (2011).
- *Hospital Collectors' Earnings Stable*, 25 No. Healthcare Registration 1 (2011).
- *Laboratory Compliance in a Hospital Setting*, Christopher Young, 13 No. 2 Health Care Compliance 67 (2011).
- *Limits on Hard-to-Reproduce Inventions: Process Elements and Biotechnology's Compliance with the Enablement Requirement*, Dmitry Karshtedt, 3 Hastings Sci. & Tech. J.L. 109 (2011).
- *Making Language Access to Health Care Meaningful: The Need for a Federal Health Care Interpreters' Statute*, Alvaro DeCola, 24 Cleveland-Marshall J.L. & Health (2011).
- *Measuring Profitability of a Hospital Pulmonary Function Laboratory: A Case Study*, Mehmet C. Kocakulah, 37 No. 4 J. Health Care Fin. (Aspen) 36 (2011).
- *Med Mal Numbers Show Health Care ADR Works—Even Without Doctors*, 29 Alternatives to High Cost Litig. 107 (2011).
- *Medicaid Increases Home Equity Value of Homestead for 2011*, Douglas J. Chu, 210 PLI/NY 89 (2011).
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- *Medical Abortion and the 'Golden Rule' of Statutory Interpretation*, Kate Greasley, 19 Med. L. Rev. 314 (2011).
- *Medicare Basics: Your Rights Under Medicare*, Joseph Baker Medicare Rights Center, 210 PLI/NY 251 (2011).
- *Multi-Professional Recommendations for Access and Utilization of Critical Care Services: Towards Consistency in Practice and Ethi-*

cal Decision-Making Processes, Laura Hawryluck, Redouane Bouali, and Nathalie Danhoux Mex, 39 J.L. Med. & Ethics 254 (2011).

- *The Mystery of the HIPAA Breach Notice*, Kirk J. Nahra, 1048 PLI / Pat 385 (2011).
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Melissa Ann Dizon recently graduated from Albany Law School. Nicholas Battaglia is a third-year student at Albany Law School. Melissa was, and Nicholas is, a member of the Law School's Health Law Society.

For Your Information

By Claudia Torrey

The following informational highlights are items of interest:

1. Accountable Care Organizations. Accountable to whom? As of March 31, 2011[1] the answer to this question, according to the United States Department of Health and Human Services ("HHS"), is **the patient!** March 31, 2011 is the day HHS released proposed new rules for the creation of Accountable Care Organizations ("ACOs"); participation by patients and providers is voluntary.

The goal of ACOs is to improve both the coordination of care for Medicare patients and the communication between physicians, hospitals, and other providers. The results should lead to lower health care costs and improved quality of care, thereby enabling ACO provider participants to "share in the cost savings."

The proposed rule identifies five key areas concerning patients: patient/caregiver experiences; patient safety; preventive health; care coordination; and population risks/frail elderly health.

Needless to say, the Centers for Medicare & Medicaid Services ("CMS") is the agency administering the ACO program; CMS will also be exploring a nexus between alternative payment models for ACOs and the new Center for Medicare & Medicaid Innovation (testing ground for "innovative care" and service delivery models). Other agencies that have joint statements with CMS regarding ACO creation are: Office of Inspector General, Department of Justice, Federal Trade Commission, and the Internal Revenue Service.

2. HealthGrades, Inc. HealthGrades, Inc. ("HG"),[2] located in Denver, Colorado, is considered a leading, independent health care ratings company that provides profiles of physicians, hospitals, and nursing homes. The company goal is to be a resource for health care decisions that are primarily based upon quality and care costs.

Of interest to health care consumers, HG recently released the results of two surveys—a patient satisfaction survey concerning hospital care, and the fifty "best" hospitals in America. This author contends with the advent of ACOs such ratings will be viewed with increased scrutiny by patients.

3. HealthCareandYou.org. Several organizations, including the American Medical Association and the American Association for Retired Persons, have joined together and created the website **HealthCareand You.org.** The website is suppose to be a site for "easy-to-understand" and up-to-date information about the healthcare reform law (aka The Affordable Care Act), including a provisions timeline, and a state-by-state list of coverage options for potential consumers. It is hoped that the site will be utilized by patients, healthcare professionals, and health care providers.

Endnotes

1. www.ofr.gov/inspection.aspx.
2. *See* www.healthgrades.com.

Claudia Torrey, Esq is a Charter member of the Health Law Section and a Sustaining Member of the Association.

New York State Medical Indemnity Fund: Frequently Asked Questions

By Susan Waltman, for Greater New York Hospital Association

Effective April 1, 2011, New York State created a medical indemnity fund (fund) to pay the future medical costs associated with birth-related neurological injuries in order to reduce the cost of malpractice coverage for providers. The creation of the fund is a major milestone not only in reducing the unsustainably high costs of medical malpractice coverage, but in recognizing that many adverse outcomes are not caused by provider negligence. Greater New York Hospital Association (GNYHA) and its members had long advocated for adoption of such a fund.

GNYHA has prepared this frequently asked question (FAQ) document to provide an overview of the fund, answer some of the commonly asked questions that members have raised, and highlight some of the interpretational issues that have been presented to date.[1]

1. How was the medical indemnity fund created?

Article VII of the New York State 2011–2012 budget creates the "New York State Medical Indemnity Fund" by amending the State's Public Health Law to add a new title (Title 4) to Article 29-D.[2]

2. What is the fund's purpose?

The fund is intended to: 1) pay or reimburse the costs necessary to meet the future health care needs of "qualified plaintiffs" as defined by the law; 2) reduce expenses associated with medical malpractice litigation; and 3) reduce the cost of malpractice coverage for providers in New York State. Sections 2999-g and 2999-j (6).

3. How does the fund reduce provider costs and what is the rationale for creating the fund?

A significant portion of hospital malpractice coverage costs stems from a hospital's obstetric (OB) service, due in great part to cases of neurologically impaired newborns. While devastating, these cases are often not the result of provider negligence. Yet the full cost of defending and paying for such cases has historically been borne by providers. This is because research shows that the greatest predictor of compensation in malpractice cases is not the presence of provider negligence, but the degree of patient disability.

Creating the fund helps to share some of the costs associated with neurological injuries more broadly and equitably by requiring the fund—rather than the defendants or their insurers—to pay the cost of all future medical expenses related to such injuries as they are incurred. The defendants and their insurers remain responsible for all other components of a settlement or award as well as for that portion of the plaintiff's attorney fee attributable to the future medical damages component of a settlement or award. Section 2999-j (6). (See question 13 regarding payment of attorney fees.)

Given that future medical expenses are often estimated to be at least one-half of a settlement or award, the fund alleviates a significant portion of the expenses of such cases, thereby reducing malpractice premiums, reserves, and/or payouts for providers depending on their coverage arrangement.

4. Does the fund change how claims or lawsuits are filed or pursued?

The fund does not change the way claims are brought or lawsuits are pursued. However, if 1) a jury or court finds that a child sustained a birth-related neurological injury as a result of malpractice or 2) a child has sustained a qualifying neurological injury as a result of alleged malpractice and his or her claim or lawsuit is settled, then the fund will pay for the future medical expenses of the qualifying plaintiff as those expenses are incurred over time, rather than the defendants or their insurers paying those costs as part of the settlement or award. Section 2999-j (6).

5. Who qualifies for coverage by the fund?

An individual who qualifies for the fund is referred to as a "qualified plaintiff," which is defined as "every plaintiff or claimant who (i) has been found by a jury or court to have sustained a birth-related neurological injury as the result of medical malpractice, or (ii) has sustained a birth-related neurological injury as the result of alleged medical malpractice, and has settled his or her lawsuit or claim therefore." Section 2999-h (4).

6. What is a "birth-related neurological injury?"

The statutory definition of a "birth-related neurological injury" is "an injury to the brain or spinal cord of a live infant caused by the deprivation of oxygen or mechanical injury occurring in the course of labor, delivery or resuscitation or by other medical services provided or not provided during delivery admission that rendered the infant with a permanent and substantial motor impairment or with a developmental disability as that term is defined by section 1.03 of the mental hygiene law, or both. This definition shall apply to live births only." Section 2999-h (1).

7. Is the definition of "birth-related neurological injury" limited only to the birth process?

No. The definition includes qualifying injuries during labor, delivery, or resuscitation or by "other medical services provided or not provided during delivery admission." The definition is broader than just the birth process, and the last category of "other services provided or not provided during delivery admission" was added because

there are frequently allegations that injuries arise, for example, while a newborn is in a neonatal intensive care unit as part of the delivery admission. Section 2999-h (1).

8. Does the term "delivery admission" extend to transfers of newborns to other facilities?

GNYHA assumes that the term "delivery admission" should extend, in general, to transfers to other facilities that are necessitated by the problems presented by a newborn during the initial delivery admission and that are more appropriately addressed by the facility to which the newborn is transferred. GNYHA has raised this issue with the State Department of Health (DOH) and the State Department of Insurance, the key agencies charged with overseeing the fund.[3]

9. How does the settlement or award process take into account the operation of the fund? Does the presence of the fund change the amount of the settlement or award?

The presence of the fund is not intended to change the process leading up to a settlement or an award. In general, settlements and awards are to be entered and made as they have in the past. In addition, the total amount of the settlement or award should not increase in any way from what the settlement or award amounts have been in the past.

However, once the settlement or award amount is identified for a qualified plaintiff, and the plaintiff is accepted by the fund, any payments for future medical expenses are to be made by the fund as those expenses are incurred and in lieu of a payment by the defendants or their insurers. In other words, the fund is not intended to be additive to a settlement or award but rather to replace a portion of the settlement or award amount, specifically the future medical expenses portion. Section 2999-j (6).

10. Settlement agreements do not typically allocate the settlement amount among the components of the settlement. How would the parties identify what portion of the settlement is to be paid by the defendants or their insurers and what portion is to be paid by the fund?

The parties will have to agree to the allocation of the settlement amount between future medical expenses and all other, non-fund damages, which will be paid by the defendants or their insurers. Although each case is different, some insurers have estimated that, based on past awards and settlements, typically at least one-half of an award or settlement for individuals intended to be covered by the fund is attributable to future medical expenses. In many cases, the proportion is much higher. It may be of value to defendants, their insurers, and their counsel to review past cases having similar disabilities and future needs to support the allocation of a settlement between fund and non-fund damages. In addition, the judge handling the settlement of the case or the approval of the minor compromise is presumably available to be of assistance in the allocation of the damages. See Appendix A for a sample allocation and calculation of damages.

11. What language should appear in the settlement agreement to ensure that future medical expenses are covered by the fund?

The law requires that every settlement agreement for claims arising out of birth-related neurological injuries subject to the fund and that includes payment of future medical expenses must provide that in the event the fund administrator determines that the plaintiff or claimant is a qualified plaintiff, all payments for future medical expenses shall be paid from the fund in lieu of that portion of the settlement agreement that provides for payment of such expenses. When a settlement agreement does not include such a provision, the law states that the court shall direct the modification of the agreement to include such a term as a condition of court approval. Section 2999-j (6)(a).

DOH advises that applicable settlement agreements and judgments provide that all payments for future medical expenses will be paid in accordance with Title 4 of Article 29-D of the Public Health Law, in lieu of that portion of the settlement agreement (or judgment) that provides for payment of such expenses.

It should be noted that all settlements involving minors require court approval. Therefore, the court will be involved in any event. The New York State Office of Court Administration (OCA) has issued a memorandum to administrative judges throughout the State and to the presiding judge of the Court of Claims that provides the following example of language that could be used for this purpose.

> The [judgment / settlement] is based, *inter alia*, on a [finding / stipulation] that the [plaintiff / claimant] has suffered a birth-related neurological injury subject to the provisions of Title 4 of Article 29-D of the Public Health Law (PHL §2999-g *et seq.*), and the [judgment / settlement] includes provision for payment of future medical expenses addressed by that Title. In the event that the Administrator of the Medical Indemnity Fund determines that [plaintiff / claimant] is a qualified plaintiff, all payments for future medical expenses shall be paid in accordance with Title 4, in lieu of that portion of this [judgment / settlement] that provides for the payment of such expenses.

12. What language must appear in the jury or court award to reflect the operation of the fund?

With respect to a jury or court award for future medical expenses arising from birth-related neurological injuries, any party may make an application to the court that the judgment reflect that, in lieu of that portion of the

award that provides for payment of such expenses, and upon acceptance of the plaintiff by the fund, the future medical expenses shall be paid from the fund. Upon a finding that the applicant has made a prima facie showing that the plaintiff is a qualified plaintiff, the court shall ensure that the judgment so provides. Section 2999-j (6) (b). See sample language issued by OCA that appears in response to question 11.

13. How are plaintiff's attorney fees to be paid given that a plaintiff typically pays the fees from the amount received in settlement or pursuant to an award?

The law specifically provides that a plaintiff's attorney fee shall be based upon the entire sum awarded by the jury or the court or the full sum of the settlement, as the case may be. (With respect to jury or court awards, GNYHA assumes that the fee will be calculated on the amount of the award ultimately agreed upon or upheld on appeal, as applicable.) Section 2999-j (14).

The plaintiff's attorney fee is to be calculated pursuant to Section 474-a of the State Judiciary Law, which contains the contingent fee provisions applicable to medical malpractice cases. The medical indemnity fund law states that the defendants and / or their insurers are required to pay the attorney fee amount in a lump sum. The law then directs the defendants and / or their insurers to deduct that portion of the attorney fee attributable to the non-fund damages from the amount of the non-fund damages paid. Section 2999-j (14).

The effect of this provision is that the plaintiff's attorney will receive his or her full fee even though a part of the damages will be paid by the fund. The defendants and / or their insurers will be responsible for the fee attributable to the fund portion of the damages. The plaintiff will effectively be responsible for the fee attributable to the non-fund damages, given the defendant's deduction of this amount when it pays the non-fund damages, a step that is consistent with the fact that the plaintiff typically pays his or her attorney fee from the amount received from the defendants in any event. An illustration of how the attorney fee is to be calculated and paid appears in Attachment A.

14. How does someone become enrolled in the fund once there is a settlement or award involving a qualified plaintiff?

The law provides that either 1) the plaintiff or someone authorized to act on behalf of the plaintiff or 2) any of the defendants may make an application for enrolling a plaintiff in the fund by providing the fund administrator with a certified copy of the judgment or the court-approved settlement agreement. In either case, the applying party must give the other parties notice of the application. The fund administrator must then determine, based on the judgment or the settlement agreement and any additional information the administrator may request, that the plaintiff is a qualified plaintiff. Section 2999-j (7). Based on conversations with the State Department of Insurance and DOH, GNYHA anticipates that the fund administrator will rely on the application form and either the judgment or the court-approved settlement agreement, as applicability for determining eligibility.

Additional information requested will be used for providing appropriate health care coverage to the qualified plaintiff.

15. What is the effective date of the fund provisions?

Section 111 (q) of Article VII of the State budget provides that the fund provisions shall apply to birth-related neurological injury lawsuits "as to which no judgment has been entered and no settlement agreement has been entered into by the parties before the date of enactment[.]" Given that Governor Cuomo signed Article VII of the budget on March 31, 2011, the fund provisions are therefore applicable to all qualifying lawsuits "as to which no judgment has been entered and no settlement agreement has been entered into by the parties" before March 31. For simplicity, the State is treating April 1 as the effective date of the fund provisions.

16. When will the fund actually be operational?

Section 111 (q) of Article VII of the State budget provides that the fund will "commence" operations on October 1, 2011.

17. What happens to cases settled or tried after March 31, 2011, when the fund is not operational until October 1, 2011?

Section 111 (q) of Article VII of the State budget provides mechanisms for the coverage of qualifying health care costs that may be required before the fund commences operation and specifically permits qualified plaintiffs to obtain medical services through the State Medicaid program or in private physician practices. If the costs of these services are qualifying costs under the fund, then the fund will eventually cover such costs. Section 111 (q) authorizes the DOH Commissioner to promulgate regulations as necessary to implement the fund provisions prior to the commencement of the fund, including on an emergency basis.

18. What types of costs are covered by the fund?

The costs covered by the fund are "future medical, hospital, surgical, nursing, dental, rehabilitation, custodial, durable medical equipment, home modifications, assistive technology, vehicle modifications, prescription and non-prescription medications, and other health care costs actually incurred for services rendered to and supplies utilized by qualified plaintiffs, which are necessary to meet their health care needs as determined by their treating physicians, physician assistants, or nurse practitioners and as otherwise defined by the commissioner in regulation." Section 2999-h (3).

The feature of requiring that the qualified plaintiff's treating physician, physician assistant, or nurse practitioner determine the services or supplies necessary to meet the qualified plaintiff's health care needs is designed to facilitate coverage of needed care.

19. Who is responsible for administering the fund?

The Superintendent of the State's new Department of Financial Services or his or her designee has responsibility for administering the fund and is given all powers necessary and proper to carry out the fund's purposes. To ensure that the fund can begin operation on October 1, the law gives the Superintendent the authority to enter into a contract or contracts to administer the fund for the first year of operation without a competitive bid or request for proposals. Section 2999-i (2).

20. What efforts will be made to ensure that qualified plaintiffs will have appropriate access to needed care?

The law provides a number of safeguards intended to ensure that qualified plaintiffs have access to needed care.

Minimal prior authorization: First, the law provides that the provision of qualifying health care shall not be subject to prior authorization except as may be described in regulations promulgated by the DOH Commissioner. The law states that the regulations may not prevent a qualified plaintiff from receiving care or assistance that would, at a minimum, be authorized under the Medicaid program. In addition, the law states that, to the extent that any prior authorization may be required by regulation, the regulation must require that requests for prior authorization be processed within a reasonably prompt period of time as well as identify a process for prompt review of any denial of a request for prior authorization. Section 2999-j (2).

Access to private physician practices: Second, as a general proposition, the law states that the fund shall pay providers on the basis of Medicaid rates of payment. However, in order to ensure access to care in "private physician practices," the law states that private physician practices will be paid on the basis of 100% of "usual and customary rates, as defined by the (DOH) commissioner in regulation." Section 2999-j (4).

Acceptance of assignment: Third, all health care providers shall accept assignment of the right to receive payments from the fund for qualifying health care costs. Section 2999-j (11).

Determination of need for health care services: Finally, as noted in the answer to question 18, the law provides that the services and supplies necessary to meet a qualified plaintiff's health care needs are to be determined by the qualified plaintiff's treating physician, physician assistant, or nurse practitioner, thus facilitating coverage of needed services specific to each qualified plaintiff.

21. What happens if a qualified plaintiff has insurance coverage?

Under the law, health insurers other than Medicaid and Medicare shall be the primary payers of qualifying health care costs of qualified plaintiffs. Payments will be made from the fund only to the extent that the insurers are not obligated to make payments for such services. In addition, the law provides that the insurers shall have no right of subrogation or recovery against the fund. Section 2999-j (12).

22. What is the fund's size and source of funding?

The State's fiscal year 2011–2012 budget provides that the State will deposit $30 million in the fund. See Section 52-b of Article VII of the State budget. The source of the funds is the Health Care Reform Act (HCRA).

Neither the law nor the State's 2011–2012 budget states a specific funding amount for future years. However, based on conversations GNYHA has had with the State Executive both during the development of the fund provisions and subsequently, GNYHA understands that the State is committed to providing adequate funding to cover the estimated future needs of the fund each year. Estimations of future funding needs are based on estimates of the anticipated number of qualified plaintiffs who will enroll in the fund over time and their anticipated medical needs during the relevant time frames. The State Executive has expressed a strong commitment to making sure that the fund serves the purposes for which it has been established. In addition, GNYHA has requested that stakeholders be kept informed of the progress of the fund to help ensure that it is adequately funded.

23. Is it possible that the fund will be suspended?

The law requires that, following the required annual deposit, the Superintendent of Financial Services will conduct an actuarial calculation "of the estimated liabilities of the fund for the coming year resulting from the qualified plaintiffs enrolled in the fund." The law also provides that the administrator will "adjust" such calculation "from time to time." If the "total of all estimates of current liabilities [for the coming year] equals or exceeds eighty percent of the fund's assets," then the fund may not accept new enrollments until a new deposit has been made into the fund and / or the fund's liabilities no longer exceed 80% of the fund's assets. Section 2999-i (6)(a).

When a new deposit has been made and / or the fund's liabilities no longer exceed 80% of the fund's assets, the fund administrator will enroll new qualified plaintiffs in the order that applications were filed. Section 2999-i (6)(a).

24. How will people be informed of the suspension of the fund?

Whenever suspension of new enrollment occurs, both DOH and the Department of Financial Services will post this information on their Web sites. In addition, the fund

administrator will inform applicants and all parties in the action as well. Section 2999-i (6)(b).

25. What happens to cases settled or in connection with which there are verdicts while the fund is suspended?

Under the law, judgments or settlements for individuals for whom applications are denied due to the suspension of the fund are to be satisfied as if the fund were not in existence. Section 2999-i (6)(b).

26. What happens to qualified plaintiffs already accepted into the fund if the fund is suspended to new enrollment?

The law specifically provides that the suspension of enrollment shall not affect payment under the fund for qualified plaintiffs already enrolled in the fund. Section 2999-i (6)(d).

27. I have heard about a number of large settlements that are expected to be covered by the fund. Does that mean the fund may be suspended soon after it becomes operational?

Based on assumptions regarding the projected number of qualified plaintiffs who might enroll in the fund and their anticipated medical needs each year, it is not currently anticipated that the fund will be suspended. It should be kept in mind that the fund is intended to pay only the qualifying health care costs that are actually incurred by each qualifying plaintiff each year. In contrast, a settlement includes the total amount of agreed upon non-fund as well as fund damages over the lifetime of the plaintiff. Thus, a settlement in the total amount of $4 million, for example, might anticipate expenditures for health care costs in the range of only $100,000 per year for the qualified plaintiff involved. Given that the deposit for the fund's first year is slated to be $30 million, it would take a large number of settlements or awards to trigger suspension of the fund, which is currently not expected to occur. As noted in the answer to question 22, the State is committed to ensure us that the fund meets its intended purposes.

28. I understand that the Medicaid program will save money from the fund. How does this occur?

The Medicaid program has historically provided Medicaid coverage to many children who, moving forward, will be qualified plaintiffs under the new law. The high rate of Medicaid coverage begins at birth, with the Medicaid program covering approximately 50% of all births in the State, 60% of all births in New York City, and 70% of all births in the Bronx and Brooklyn. Studies undertaken by the State indicate that the Medicaid program covers an even higher proportion of children who would presumably be qualified plaintiffs pre-settlement or award—nearly 80% of these children. This is not surprising given the large medical expenses associated with their disabilities.

The State Medicaid program also has historically covered many of these children even post settlement and award because many families of these children take the proceeds of the settlements and awards and deposit them in supplemental needs trusts. The children then continue to receive Medicaid for health coverage purposes. The State has estimated that as many as 50% of all children who would be qualified plaintiffs have continued on Medicaid in the past.

Moving forward, the fund will assume responsibility for future medical services of qualified plaintiffs as those costs are incurred. This will eliminate the need for the Medicaid program to provide coverage and thus will save the Medicaid program money.

29. I understand that the fund helps to eliminate what have been referred to as over-recoveries as well as double recoveries. How does that occur?

Under the current judicial system, future medical expenses are often estimated or projected based on a wide array of potentially needed health care services. It is believed that this approach often over-estimates what might be needed by a plaintiff. Because the fund will pay for such services only as they are needed, the operation of the fund will eliminate some of the over-projections and over-payments that are thought to occur under the current system.

With respect to double recoveries, the prior question discussed how the Medicaid program often continues coverage of plaintiffs even though the defendant and / or an insurer pays the settlement or award, which includes payments for future medical expenses. The fund will eliminate this double recovery because the fund alone will pay for future medical expenses.

30. What regulations regarding the operation of the fund might be expected?

The law prescribes a number of regulations that are to be developed.

DOH is required to develop regulations regarding:

- The definition of qualifying health care costs [Section 2999-h (3)]
- When prior authorization may be required, the process for reviewing requests for prior authorization when required, and the administrative review of denials [Section 2999-j (2)]
- Usual and customary rates for "private physician practices" and rates when no Medicaid rates are available / applicable [Section 2999-j (4)]
- Proper fund administration, including payment of claims and actuarial calculations, in coordination with the Department of Financial Services [Section 2999-j (15)]

The Department of Financial Services is required to develop regulations regarding:

- The mechanism for providers to submit claims [Section 2999-j (5)]
- In coordination with DOH, regulations necessary for proper administration of the fund including payment of claims and actuarial calculations [Section 2999-j (15)]

31. What other regulatory assistance might be expected?

DOH and the Department of Insurance have developed FAQs to assist providers, plaintiffs, and other stakeholders with implementing the law. The State's FAQs are available on both DOH's and the Department of Insurance's Web sites. They will also be posting information on their respective Web sites regarding the law, future regulations, and guidance as they become available.

32. Will there be education of the judges who will hear medical malpractice cases?

OCA has distributed a memorandum summarizing the law to the administrative judges of each county and the presiding judge of the Court of Claims. OCA will also offer education to judges. In addition, it is expected that some judges will release decisions that may help provide guidance to other judges and litigants.

33. The law calls for providers to pay a "quality contribution" to the State. How is that calculated and what is its purpose?

Section 52-c of Article VII of the State budget imposes a "quality contribution" on hospitals equal to 1.6% of their inpatient OB revenue, with the intent of generating $30 million each State fiscal year. DOH has indicated that it will impose the fee on maternity and normal newborn revenues from all payers. For the State fiscal year 2011–12, the assessment of the fee begins July 1 and, since the program will run over only 8 months (instead of 12 months) for the first fiscal year, the assessment will be adjusted to 2.4% to achieve the $30 million target. The State will monitor collections throughout the fiscal year and will adjust the assessment accordingly so the full $30 million is collected.

The contribution is intended to help reduce the State's budget deficit and was not proposed for the purpose of funding the fund, notwithstanding that the amount to be deposited into the fund for year one is the same amount as the quality contribution amount. The contributions will be deposited in the HCRA resources fund. The quality contribution in future years remains at $30 million and does not increase, other than by an inflation factor, even though the deposits into the medical indemnity fund are expected to increase in future years.

34. Although the creation of the fund recognizes that many adverse events are not caused by provider negligence, what efforts are being made to reduce avoidable adverse events?

Section 52-a of Article VII of the State budget creates the New York State Hospital Quality Initiative, which will bring together experts and others to oversee the dissemination of initiatives, guidance, and best practices for general hospitals, focusing heavily on ways to improve obstetrical care outcomes and quality of care. The law states that the initiative will identify and implement "evidence based practices, and clinical protocols that can be standardized and adopted by hospitals."

35. What steps is GNYHA taking to support hospitals in reducing avoidable adverse outcomes?

Many of the best practice examples set forth in the law's New York State Hospital Quality Initiative reflect those that have been implemented as part of GNYHA's Perinatal Safety Collaborative, which was formed in 2007. This Collaborative brings together more than 40 hospitals for the purpose of improving perinatal care using evidence-based clinical protocols and safety practices. Collaborative hospitals come together with a commitment to identify and implement the best practices for care delivery that can be standardized and implemented across a region, with the goal of reducing adverse events, enhancing patient safety, and improving the quality of obstetrical and perinatal care for patients. The Collaborative is led by a Perinatal Safety Collaborative Advisory Panel that includes representatives of the American Congress of Obstetricians and Gynecologists (District II / New York), DOH, the Healthcare Association of New York State, OB and neonatal clinical leaders from GNYHA member institutions, risk management professionals from medical malpractice carriers, and consumer organizations. Additional information regarding GNYHA's Perinatal Safety Collaboration can be accessed at http://www.gnyha.org/perinatal.

Endnotes

1. GNYHA has prepared these FAQs for the purpose of facilitating its members' understanding and implementation of the New York State Medical Indemnity Fund. They are not intended to replace, however, a member's consultation with its own counsel or insurer with respect to the application of the fund to the member's cases or in assessing the impact of the fund on the member's premiums or future payouts.
2. Statutory references throughout these FAQs are to new Title 4 of Article 29-D of the Public Health Law unless noted otherwise. All references to Article VII of the State budget pertain to the State's 2011–2012 budget.
3. As of October 3, 2011, the State Department of Insurance will become part of the State's new Department of Financial Services, which will have responsibility for implementation of the fund under the law.

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Appendix A

New York State Medical Indemnity Fund—Frequently Asked Questions—ATTACHMENT

EXAMPLE OF MEDICAL INDEMNITY FUND CALCULATIONS FOR $2M SETTLEMENT

STEP 1

Allocate settlement based on facts of case

- Future medical expenses (fund damages): $1.1M or 55%
- All other damages (non-fund damages): $900,000 or 45%

STEP 2

Calculate plaintiff attorney fee on settlement amount ($2M) using fee schedule: $350,000

STEP 3

Allocate $350,000 attorney fee based on settlement allocation

- Percent attributable to future medical expenses: 55% or $192,500
- Percent attributable to all other damages: 45% or $157,500

STEP 4

Deduct attorney fee attributable to all other damages (non-fund damages) from all other damages amount:
$900,000 - $157,500 = $742,500

STEP 5

Make payments

- Step 5 (a): Fund pays all future medical expenses, as incurred
- Step 5 (b): Defendants pay attorney fee: $350,000
- Step 5 (c): Defendants pay plaintiff "all other damages" less attributable attorney fee: $900,000 - $157,500 = $742,500

TOTAL PAYMENTS BY DEFENDANTS:
$350,000 + $742,500 = $1,092,500

TOTAL SAVINGS FOR DEFENDANTS:
$2M - $1,092,500 = $907,500

PREPARED BY THE GREATER NEW YORK HOSPITAL ASSOCIATION

Understanding Subpoenas: Guidance for Medical Providers

By Frances A. Ciardullo, for Medical Liability Mutual Insurance Company

Medical providers, as well as hospitals and other healthcare facilities, are frequently presented with subpoenas to either appear in court or to provide copies of patient records. How one should respond to a subpoena depends upon the type of subpoena, the information being requested, and the place where the subpoena is returnable. This outline will examine the legal principles governing subpoenas issued by New York state courts, tribunals, and officials.[1]

What is a subpoena?

A subpoena is simply a legal command. A subpoena commands a person to show up and give testimony at a certain place on a certain date and time. A "judicial subpoena" is returnable in a court. A "subpoena *duces tecum*" requires production of books, papers, and / or other things, and is commonly used to request patient medical records. New York law allows a subpoena *duces tecum* to be served either separately or joined with a subpoena for testimony.[2]

Technically speaking, a subpoena *duces tecum* requires the personal appearance of the custodian of the records to give testimony sufficient to authenticate the documents being produced. The requirement of a personal appearance has largely been substituted by the acceptance of certified copies, so that now, in most cases, the issuer of a subpoena *duces tecum* is satisfied with receiving copies of the documents requested with a certification by the custodian.

In New York practice, subpoenas are generally governed by Article 23 of the Civil Practice Law and Rules (CPLR) or Article 610 of the Criminal Procedure Law (CPL).

Who may issue a subpoena?

A subpoena is not an independent legal process, but is always connected with some type of legal action, administrative proceeding, or governmental investigation. Subpoenas may be issued (i.e. signed) by an attorney at law under the authority of the court, by a clerk of a court, by administrative and governmental officials, by an arbitrator, or by a judge.

What information is contained in the subpoena?

When you receive a subpoena, you should read it carefully. At the top of the subpoena, it will state the name of the court or administrative body, the names of the parties to the action or the proceeding, and, perhaps, a case reference number. This is commonly referred to as the "caption." The subpoena will state to whom it is directed, which may be a physician, a hospital, a medical practice or simply "custodian of the records." In the case of a subpoena *duces tecum*, it will describe what documents are being sought. The subpoena will set a date, time and place for an appearance to give testimony or for production of the records. The face of the subpoena will bear a warning that failure to comply may be punished by contempt of court. Finally, the subpoena should be signed by the issuer under the authority of the appropriate court or administrative body.

Where the subpoena commands a personal appearance, it will often contain a note to call the attorney who issued it. The attorney may simply wish to schedule your testimony at the most convenient time. It is appropriate to call the attorney's office to facilitate this scheduling. Sometimes the attorney will request a telephone conference to discuss your testimony before your appearance. Be aware that you are not required to participate in a discussion with the attorney about your testimony and, more importantly, you should not do so without the patient's explicit authorization.

The subpoena is most often returnable at the courthouse or the offices of the administrative body. A subpoena may also be returnable at an attorney's law office, usually in connection with a deposition or arbitration on the date listed on the subpoena.

A note of caution: an out-of-state subpoena, i.e. one that is issued from a sister state court or tribunal, is **not valid** in New York.[3] You have no obligation to respond and, more importantly, you cannot provide any patient information to the out of state issuer, unless the subpoena is accompanied by the patient's HIPAA-compliant authorization. If the subpoena is accompanied by a properly executed authorization for medical records, you may honor it as you would any other request for records.

How should a subpoena be served?

A subpoena must be served in the same manner as a summons.[4] This means that it must be served by 1) personal delivery; or 2) by delivery to a person of suitable age and discretion with a second copy mailed to either your place of business or last known residence; or 3) delivery to a designated agent; or 4) if service by any of the above methods cannot be made by due diligence, then by affixing a copy to the door of either your actual place of business or residence and mailing a second copy.[5]

Because subpoenas are frequently time sensitive, most are delivered in person. Service by fax is *not* sufficient.

Service by first class mail is not generally valid with one specific exception: if the subpoena is mailed, it must be accompanied by two copies of a *Statement of Service by Mail and Acknowledgement of Receipt* and a return postage prepaid envelope.[6] If you receive a subpoena in the mail, you should contact legal counsel to verify that the statutory Statement and Acknowledgment procedure has been properly followed.

Subpoenas may be served statewide in proceedings in the higher courts and state administrative agencies. In the lower courts (city, town and village courts), service is geographically limited to the county where the court is located, unless the court issues an order permitting service in an adjoining county.[7]

Witness fees

Subject to certain limited exceptions,[8] a person subpoenaed is entitled to receive in advance travelling expenses and one day's witness fee. The dollar amounts are specified in the law. At present, the New York state witness fee is $15.00 plus 23¢ per mile for travel outside of a city.[9] Usually, the subpoena is accompanied by a check, but payment may be made within a reasonable time after service. You should never ignore a subpoena, even if witness fees are not tendered.

State law does not require payment for copying the medical records to be produced in response to a subpoena, nor is there any provision for payment of other expenses.[10] If production of records is unduly burdensome or unusually expensive, such that you wish to receive reimbursement, then you must raise those matters with the presiding judge or official by means of a formal motion to quash the subpoena, modify it, or fix conditions.[11]

Advance notice

Some subpoenas have specific notice requirements. A subpoena issued in connection with a deposition must be served with 20 days notice.[12] Subpoenas for hospital records must give at least 3 days notice.[13] Outside of these situations, there is no stated minimum or maximum time period. A subpoena should, however, give "reasonable notice" to appear in court or produce documents. What is "reasonable notice" may vary with the circumstances, but it could be as little as 24 hours.

Confidentiality issues

Subpoenas should not be blindly obeyed. A subpoena cannot command the release of legally privileged information.[14] Personal health information is legally privileged under New York law, and therefore specific rules apply to its release.[15] In addition, personally identifiable health information (PHI) is also subject to HIPAA privacy rules.[16] Therefore, you should release information only when there has been full compliance with both New York state law and HIPAA requirements.

HIPAA rules. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes strict procedural requirements regarding disclosure of PHI pursuant to a subpoena. A subpoena will be HIPAA-compliant if it complies with one of the following requirements:

1) the subpoena is accompanied by an authorization permitting disclosure and signed by the patient or the patient's legal representative; or

2) the issuer provides, in writing, satisfactory assurance that the patient has been placed on notice of the issuance of the subpoena in time to object to it, and no objection was made; or

3) the issuer provides, in writing, satisfactory assurances that reasonable efforts have been made to secure a qualified protective order. "Satisfactory assurance" in this case means either a written statement and documentation that either the parties to the dispute have agreed upon a protective order limiting the use and disclosure of the PHI and its destruction or return to the covered entity at the end of litigation, or that the requesting party has asked the court to issue such an order; or

4) the subpoena is court-ordered.[17]

Under these rules, a subpoena which is accompanied by the patient's signed authorization will always be HIPAA-compliant. Further, under CPLR § 2303(a), each party who has appeared in a civil action should receive a copy of any subpoena for medical records. Therefore, if the patient whose record is requested is a party to the proceeding, he or she (or his or her lawyer) should receive a copy of the subpoena, and HIPAA would be satisfied.

It is not enough, however, to determine whether the subpoena is HIPAA-compliant. You must also determine whether the subpoena complies with New York state law.

New York rules. Prior to the enactment of HIPAA, New York permitted release of patient medical records pursuant to subpoena only in situations where the patient had waived his or her physician-patient (or other related) privilege. There had to be evidence that the patient waived the privilege either by an affirmative act (i.e. signing an authorization to release information) or by law according to the circumstances.[18]

In 2003, New York law was changed to promote compliance with HIPAA requirements. CPLR § 3122(a) now states that any subpoena for medical records must be accompanied by the patient's signed HIPAA authorization, and further,

> [a] medical provider served with a subpoena duces tecum requesting the production of a patient's medical records pursuant to this rule need not respond or object to the subpoena if the subpoena is not accompanied by a written authoriza-

> tion by the patient. Any subpoena served upon a medical provider requesting the medical records of a patient shall state in conspicuous bold-faced type that the records shall not be provided unless the subpoena is accompanied by a written authorization by the patient.

Stated another way, a subpoena for medical records should be accompanied by an authorization and should also state in **bold-faced type** that the records should **not** be produced if no authorization is supplied. As a result of this legislation, most subpoenas are now accompanied by a HIPAA-compliant authorization and, therefore, there are fewer issues regarding compliance.[19]

Unfortunately, CPLR § 3122-a does not clearly address all situations. The wording of the statute applies to subpoenas for *medical records*, leaving open the question as to whether the law was intended to cover situations where *verbal testimony* is sought from a provider. In addition, CPLR § 3122-a technically applies to the pre-trial phase of a legal action and not the trial phase. Although the question has not been entirely settled, the weight of authority has held that CPLR § 3122-a should apply to all civil subpoenas, at all stages of litigation.[20]

Subpoenas without authorizations. If the subpoena is ***not*** accompanied by a written authorization, you should contact the issuer and request that he/she provide one. You always have the option of contacting the patient yourself to obtain an authorization. If you cannot obtain an authorization, and the issuer insists upon compliance, then legal counsel should be consulted for an appropriate response to the subpoena.

Subpoenas seeking non-confidential information. It is possible that a subpoena could ask for information related to a patient which is not legally privileged. There are a number of exceptions to the privilege. Some are in the form of mandatory reporting requirements.[21] Other circumstances may exist where the information does not fall within the New York state privileges. If one of the HIPAA requirements has been met, the subpoena may be valid without an authorization. You should *always* consult with legal counsel before releasing any information under these circumstances.

How should you respond to a subpoena?

Subpoenas requesting testimony require you to show up at the specified time and place. Quite often, the subpoena also requests that you bring with you the patient's medical record. Generally, the subpoena will ask for certified copies of the records, because in most cases certified copies will suffice for legal purposes. The custodian of the record should complete a certification form and attach it to the record. The certification is simply a statement that the medical record was maintained in the ordinary course of business and that the copies being produced are true, accurate, and complete.

The law states that where a subpoena asks for hospital records regarding the condition or treatment of a patient, certified copies are sufficient.[22] If original records are sought instead, the issuer must make a motion to the court upon one day's notice to the hospital. A subpoena for original hospital records must be signed by a judge.[23] Producing the original record in court is risky because it is likely that the record will be marked as an exhibit and will not be returned. In any case where the original record is requested, you should contact the issuer of the subpoena and ask if a certified copy will suffice. If the issuer insists upon the original record and will not agree to accept a copy, make a complete copy of whatever is produced to keep in your files.

All records delivered to the court should be placed in a sealed envelope, with a copy of the subpoena attached on the outside.[24] It is recommended that you send the records via certified mail, courier, or other service which will provide a delivery confirmation.

You may contact the attorney and discuss any questions you have about the subpoena, or any logistical and administrative matters (fees, time of appearance, etc). **Do not discuss** any protected health information without the patient's authorization.

When a subpoena is not enough

Certain information must ***never*** be released pursuant to a subpoena. HIV information (which basically includes any reference to HIV) can only be released if there is a court order or a specific authorization by the patient.[25] All written disclosures of confidential HIV-related information must also be accompanied by a statement prohibiting re-disclosure.[26]

Psychiatric information is another area demanding careful attention. Both the Mental Hygiene Law and the CPLR state that clinical records of patients or clients maintained by facilities licensed or operated by the Office of Mental Health or the Office of Persons with Developmental Disabilities (formerly OMRDD) may only be released pursuant to an order of *a court of record*.[27] Although these statutes do not explicitly apply to physician office records, case law has indicated that because of the sensitive nature of psychiatric records, heightened protections should apply.[28] Therefore, the safest course is to treat all psychiatric records according to the same rules.

Records of alcohol and drug abuse rehabilitation facilities are also highly protected. Federal law states that clinical records maintained by such facilities cannot be released without an appropriate court order.[29] In all of these situations, you must have either a court order or the patient's specific written consent.

Be aware that, for these purposes, a subpoena signed by a judge containing the words "SO ORDERED" is ***not*** a sufficient "court order" to obtain HIV, psychiatric, or alcohol / drug treatment records. Both federal and state law require that the patient be notified and that a court hearing be held to determine the necessity of releasing the confidential information. After the hearing, the court should issue an order which specifically describes the information to be produced with an explicit finding that the need to disclose the information outweighs the patient's right to privacy. A subpoena which contains the words "so ordered" on the bottom together with a judge's signature does not comply with these requirements.

Motion to quash

If it appears that the subpoena was improperly issued, or if it requests information which you believe to be privileged, you cannot remain silent but must act to avoid potential legal consequences. Willful failure to comply with a valid subpoena may make you liable for contempt of court, which could mean a fine, or even imprisonment.

If the subpoena is not returnable in a court, New York law requires that you first contact the issuer and make a request to withdraw or modify the subpoena.[30] If the issuer will not agree, then you should contact legal counsel who will make a determination whether a motion must be made to quash the subpoena.

Common agency and criminal subpoenas

You may receive a Grand Jury subpoena or judicial subpoena in a criminal matter. While HIPAA would permit the release of information in response to these subpoenas,[31] *note that there is no exception under New York law to the physician-patient privilege for Grand Jury proceedings or criminal investigations*.[32] Therefore, the stricter New York rule must be followed. If the subpoena is not accompanied by an authorization from the patient, and there is no court order, **you should not release any information**. Instead, you should contact legal counsel to prepare a response to the subpoena.

New York law permits health oversight agencies, such as the Department of Health, the Department of Mental Hygiene and the Office of Professional Medical Conduct, to issue subpoenas for patient information without providing a patient authorization.[33] A county coroner, coroner's physician, or medical examiner also has the power to subpoena and examine witnesses under oath to investigate a person's death without an authorization on behalf of the deceased.[34] Investigatory subpoenas from these agencies are generally valid, but it is always a good idea to check with legal counsel first. Because HIPAA also contains an exception for health oversight activities, these subpoenas are exempt from HIPAA requirements.[35]

State agencies or officials authorized to investigate Medicaid fraud may issue subpoenas for patient information, and may even do so under a Grand Jury subpoena. Courts have held the physician-patient privilege does not apply to Medicaid fraud investigations.[36] Thus, investigators need not provide an authorization, and they are usually entitled to access the medical records of Medicaid recipients *unless* the information is exceptionally sensitive and is unnecessary to the Medicaid investigation. If you feel the subpoena asks for such information, you should consult with legal counsel for an appropriate response.

In sum, the rules governing release of information to governmental agencies can be complicated, depending on the nature of the proceeding or investigation. When you receive a subpoena from an administrative agency, it is best to contact legal counsel to determine its validity and whether you may release the information requested.

Subpoena checklist

When you receive a subpoena for a patient's medical records, you should always follow these steps:

1. Verify that the subpoena has been appropriately served according to the rules set forth in this article.
2. Review the caption to obtain as much information as you can regarding the nature of the legal proceeding. Determine whether the subpoena was issued by an administrative agency, a court, or a governmental official.
3. Verify the identity of the person or entity to whom the subpoena is directed.
4. Determine whether the subpoena calls for verbal testimony or records.
5. Check to see if the patient signed an authorization. Review any accompanying authorization for HIPAA compliance.
6. If no authorization was supplied, ask for one. If you do not believe an authorization is required under the circumstances, check with legal counsel.
7. Call the issuer with any questions concerning the validity of the subpoena or how to comply.
8. Review the medical records to determine if there is any highly sensitive information which requires a court order or a specific patient authorization for release (HIV, psychiatric, drug / alcohol rehabilitation). If such information exists, do not comply with the subpoena, and check with legal counsel for an appropriate response.

In short, when it comes to subpoenas, you should always exercise caution. If you are not certain as to whether

you may release the patient's information under the specific circumstances, always check with legal counsel.

Endnotes

1. The information contained in this article is primarily directed to New York State subpoenas, although subpoenas may be issued on behalf of Federal courts and administrative agencies. Federal subpoenas are governed by the Federal Rules of Civil Procedure and have different requirements. If you receive a subpoena from a Federal tribunal you should contact legal counsel to determine its validity.
2. CPLR § 2305(b).
3. A federal court subpoena bearing the name of a U.S. District Court outside of New York may be valid and you should always contact legal counsel when you receive one.
4. CPLR § 2303.
5. CPLR § 2303(a), CPLR §§ 307-312-a.
6. CPLR § 312-a.
7. UJCA § 1201, UCCA § 1201.
8. For example, a witness subpoenaed by the defendant in a criminal action is not entitled as a matter of right to witness and mileage fees except by court order. CPL § 610.50.
9. CPLR § 8001. A person who is not a party to an action but is subpoenaed for a pre-trial deposition is entitled to an additional $3.00 per day for each day's attendance.
10. CPLR § 8001(c) allows a charge of 10¢ per folio when a *transcript* of records is required to comply with a subpoena. Producing a copy of the record is not the same as preparing a transcript.
11. CPLR § 2304.
12. CPLR § 3106.
13. CPLR § 2306.
14. *Matter of Grand Jury Investigation v. Morgenthau*, 749 N.Y.S.2d 462 (2002); *Matter of Grand Jury Investigation in Onondaga County*, 59 N.Y.2d 130 (1983).
15. Privileged information includes information provided to physicians, nurses, dentists, podiatrists, chiropractors and medical practices, as well as psychologists, social workers and rape crisis counselors. CPLR §§ 4504, 4507, 4508 and 4510.
16. HIPAA privacy rules are found at 45 CFR Parts 160 and 164, effective on April 14, 2003.
17. 45 CFR § 164.512(e). The HIPAA subpoena rules will not apply if the disclosure is otherwise permitted under HIPAA without the patient's authorization.
18. For example, a person who commenced a lawsuit to recover money for his or her personal injuries was deemed to have waived the physician patient privilege with respect to those injuries. E.g., *Hoenig v. Westphal*, 52 N.Y.2d 605 (1981). Therefore, prior to HIPAA, release of the plaintiff's medical record in response to a subpoena in an action claiming compensation for injuries was held to be appropriate.
19. The Worker's Compensation Board has also adopted this requirement in an official memorandum published on its website. *Procedures for Subpoenaing Medical Records in Worker's Compensation Proceedings*, Subject 046-129, issued April 12, 2004, accessed at: http://www.wcb.state.ny.us/content/main/SubjectNos/sn046_129.jsp.
20. *Campos v. Payne*, 2 Misc. 3d 921 (Civ. Ct. Richmond Co. 2003), Worker's Compensation Board Bulletin, *Procedures for Subpoenaing Medical Records in Worker's Compensation Proceedings*, Subject 046-129, *supra*.
21. For example, under § 265.25 of the Penal Law, every case of a wound apparently inflicted by a firearm and every knife wound which is likely to result in death must be reported to law enforcement. In addition, a medical provider is required to disclose suspected cases of child abuse or maltreatment (Social Services Law §§ 413 and 415) and information which tends to show that a minor under the age of 16 has been the victim of a crime (CPLR § 4504(b)). The Family Court Act states that there is no privilege in child abuse or neglect proceedings (Family Court Act, § 1046(a)(vii)).
22. CPLR § 2306(a).
23. CPLR § 2302(b).
24. CPLR §§ 2301, 2306(b).
25. Public Health Law § 2785.
26. Public Health Law § 2782(a).
27. Mental Hygiene Law § 33.13(c)(1), CPLR § 2302(a). Judiciary Law § 2 and Article 6, § 1 of the New York State Constitution narrowly define the term "courts of record." The definition does not include administrative agencies such as the Workers' Compensation Board. As such, an order signed by an officer of an administrative agency is not sufficient to effectuate the release of HIV-related records or the clinical records maintained pursuant to MHL § 33.13.
28. *Cynthia B. v. New Rochelle Hospital Medical Center*, 60 N.Y.2d 452 (1983).
29. 42 C.F.R. Part 2.
30. CPLR § 2304.
31. HIPAA allows release of PHI to comply with a court order or court-ordered warrant, a subpoena or summons issued by a judicial officer, or a grand jury subpoena. 45 CFR § 164.512(f)(1)(ii)(A)-(B).
32. *Matter of Grand Jury Investigation in Onondaga County*, 59 N.Y.2d 130 (1983).
33. Mental Hygiene Law § 31.13, Public Health Law § 12-a, Public Health Law § 230(10).
34. County Law § 674(4).
35. 45 CFR § 164.512(b) allows covered entities to disclose, without individual authorization, protected health information to public health authorities "…authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, including, but not limited to, the reporting of disease, injury, vital events such as birth or death, and the conduct of public health surveillance, public health investigations, and public health interventions…".
36. *E.g., Matter of Grand Jury v. Kuriansky*, 69 N.Y. 2d 232 (1987).

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Federalism and the Individual Mandate: Reflections on Constitutional Limitations

By James J. Barba, J.D.

Lawsuits challenging the legality of the Patient Protection and Affordable Care Act (better known to you and me as the "Health Care Reform Act") abound. Whether they are the suits brought by states' attorneys general, by associations or by individuals, litigation has found its way into the federal courts. The central theme of the suits alleges that the Act violates various provisions of the federal Constitution, and so it must be nullified by the courts. Constitutional challenges, while not rare, are always difficult to sustain. And they will be especially difficult here, since there was considerable debate in Congress, giving rise to the presumption that Congress considered the Constitution before passing the Act, and that the Act is adequately founded in sound Constitutional principles.

Yet the lawsuits are real, and their impact may have a profound effect on American citizens, on business (particularly small business) and on the economy itself. Given that impact, it is the purpose of this analysis to consider what I believe to be the major Constitutional challenge—the challenge to the "individual mandate," requiring all citizens who have no health care insurance coverage to purchase that coverage by 2014, or pay a penalty for failure to do so. (There is a plethora of other challenges which I consider to be unlikely to succeed.)

Before doing so, however, there are a few critical concepts of American civics that must be understood as a foundation to this undertaking. Two of them are philosophical principles, and three are political practicalities. But each is essential to an understanding of what the Supreme Court of the United States is likely to do with this Act. That is where this analysis must begin, and I begin it with:

The Two Bedrock Principles of Federalism

1. The Declaration of Independence is more than a letter to King George III informing him that the American colonies would no longer be saluting the British flag. Indeed, it is an elegant statement of the rights of individuals to be free to live their lives without the interference of a sovereign. The Declaration clearly announces that it is the people, themselves, who are the "sovereign," and only the people can decide what rights they wish to assign to a government that they create for the purpose of protecting themselves and their families. It then goes beyond that notion to assert that, whenever a government created by the people becomes destructive of their sovereign rights, "it is the right of the people to alter or abolish it." That was pretty heady stuff for 1776; yet these are the very notions that have formed and informed the American psyche, and its culture, for the last two hundred and thirty plus years. This philosophy is never far from how the Supreme Court decides cases, because it led directly to the U.S. Constitution.

2. Only twelve years, and one disastrous attempt to form a central government, later, many of the same leaders who wrote the Declaration of Independence agreed on the principles for creating the federal government. True to their philosophy that only the people could agree to delegate their inherent rights, the Constitution was written as a careful blueprint for the three-part system of government that we have always known. Each part is "given" *defined* powers; and each part can exercise only the powers that it is given.

   Since the Framers could not foresee the future, in some cases the specific powers were broadly written—as in the clause in Article I, Section 8 that allows Congress to make all laws "necessary and proper" to carry out the other *specific* powers that are given to it. In other cases, the Framers wrote clear prohibitions—as in the clause in the next Section prohibiting states from entering into treaties or coining money.

   After the document was finished, it could not gain the needed votes of the states to adopt it, until a further statement of the rights of the people was added as the first ten amendments. The so-called "Bill of Rights" is an added demonstration that the people of the new country were determined not to cede their rights and liberties to any type of government, unless they agreed to do so, and put that agreement in writing. The Bill of Rights makes it absolutely clear that they were not agreeing to give up their rights to freedom of speech, of religion, of the right to trial by a jury of their peers, and of many others that are engraved in the stone of the Bill.

   The takeaway here is that Framers of the Declaration and the Constitution, and the members of the state legislatures who adopted the Constitution, were serious about the notion of individual rights and liberties. Some may regard that as a quaint expression of Eighteenth Century philosophy, but the fact remains that the words of the Constitution continue to enshrine that expression; the docu-

ment has been amended only rarely, and the Bill of Rights, never. Over the last two centuries, it has been the job of the Supreme Court to make certain that the directions of the Constitution are followed (but not exceeded) and that they are given appropriate meaning despite the nature of the times, and the modernity of American society. How they have managed to do that suggests:

The Three Political Practicalities

1. It is well said that the Supreme Court "follows the election returns." By this is meant that, irrespective of the times, the Justices of the Court understand that their responsibilities, in part, include reflecting the current sentiment of the voting public in their decisions. There may be no better example of this than the Court during the Franklin Roosevelt administrations. Originally, the Court held that many of the programs of the New Deal could not pass constitutional muster, and declared them void. But as the economic crisis worsened, the President was resoundingly re-elected, and there was a threat to "pack" the Court with additional Justices. The Court came around and heard the voters. The Court "found" in the Constitution ways around what had been perceived to be barriers, and the President (and the nation) got his way. There are innumerable other examples of the Court listening to public opinion. More recently, the Pentagon Papers were allowed by the Court to be published at the height of the criticism against the Vietnam war; and the Court forced Nixon to hand over his tapes to prosecutors at a time when it was clear that popular sentiment had turned against the President.

   Applying this "principle," one might predict that the Court will not be able to turn a blind eye to the results of the general election of 2010. The sweeping from office of those Members of the House of Representatives, and even a few Senators, who voted for the health care Act may very well have signaled to the Court that individual opinion has already ruled on the Act, and that should be given considerable weight. Moreover, should the cases challenging the Act not reach the Court until after the 2012 Presidential election, the outcome of that contest could weigh heavily in the Court's decision of the Act's constitutionality. Clearly, were President Obama to lose his bid for reelection, the Court would read that result as a repudiation by the electorate not merely of the man, but also of his policies. Conversely, should the result in 2012 be the opposite that, too, would penetrate the quiet corridors of the Court.

2. A second concept is that "the Constitution means what the Supreme Court says it does." Interestingly, the Constitution merely creates a Supreme Court, but it does *not* give it the power to declare laws, passed by Congress and signed by the President, unconstitutional. That power was taken by the Court for itself early in the Nineteenth Century.[1] Since neither remaining branch of government disputed that taking, it soon became well accepted that the Court possessed it. This was the first, fairly startling indication that the Court was a powerful third branch of government and would interpret the Constitution as it saw fit.

   The notion that the Framers of the Constitution could not foresee the future has been established on countless occasions over the last two centuries. What does free speech mean? How should Congress "regulate Commerce among the several states?" Can the United States legally have an Air Force (the Constitution mentions only an Army and a Navy?). Does the right to be free from illegal searches and seizures mean that all evidence obtained as the result of one cannot be used at a trial? The list is endless. And, as our society advances, it only grows. Not only could the Framers not foresee an invention like the Internet, they did not foresee the steamboat. So, some body must interpret and adapt and advance. By common consent, that body is the Supreme Court.

   The Court is not completely unfettered in what it does. If the Court declares a federal law unconstitutional, either in whole or part, as is being requested by the lawsuits growing out of the health care Act, Congress can rewrite the law and fix the infirmities (often a fairly easy exercise); or it can begin the process to amend the Constitution (a near impossibility). Beyond that, the Court must give some regard to precedent—that body of its own decisions over the years that bear on a point at issue, and help guide the way to a decision. But even here, precedent means what the Court says it does. And, while it does not happen routinely, the Court does overrule its own precedent. Perhaps the most notable example of this was in the area of school desegregation. In 1896, the Court famously ruled that "separate but equal" school facilities were constitutional. Fifty-eight years later, it held, unanimously, that such facilities were inherently unconstitutional. A firm precedent fell to a different Court and different times.[2]

   The principle of precedent is critical to predicting the outcomes of lawsuits. It will figure importantly in the suits brought challenging the Act. But what is precedent? Simply (and perhaps cynically) stated, precedent is what the Supreme Court says it is, until the time comes that it says it is something else.

3. The final concept concerns pure politics. Certainly, few Americans would refer to the Justices of the Supreme Court as "politicians." Indeed, codes of judicial ethics expressly forbid most judges from participating in any form of partisan politics.

   That said, the process by which a Supreme Court Justice is selected is among the most politically charged that one can imagine. Initially, a candidate is screened by a large cadre of White House staffers to assure that the nominee can pass a variety of tests, everything from moral and religious background to consistency with the views that the President wishes to have represented by a new Justice. Over the years, so called "litmus tests" have been developed around politically difficult issues. Potential Court candidates must pass the tests to be considered worthy of nomination (said to be among the most important responsibilities of any President). And, once that rigorous procedure is completed, an even more highly political process awaits the nominee in the U.S. Senate, where, in theory, a fifty-one vote majority is needed for confirmation. In reality, sixty votes are often needed to break a filibuster by the party opposing the President. Thus, to sit on the Supreme Court, the nine non-political Justices are put through a political meat grinder unlike any other.

   To most of the Justices, the politics of the confirmation process is nothing new. Virtually all of them have come from a political background at some point in their careers. Only a few come from a pure legal background—the practice of law, or seats on state and lower federal courts, without ever having held political office. However, whether they have had political careers or not, every Justice brings to the Court a "philosophy," and that word is merely a proxy for the word "politics." So, today, the Court has four Justices who tend to vote as Conservatives, and four who tend to vote as Liberals, on most issues. The ninth Justice, Anthony Kennedy, tends toward neither, and so has become the critical swing vote, the vote that determines the outcome of a case, 5-4. (Confer *Bush v. Gore*, 531 U.S. 98 (2000), wherein the Presidential election, itself, was decided by a 5-4 vote.)

Each of the five foregoing principles is important, because in deciding any particular case, Justices do not do so in a vacuum. They are the product of their experiences. Those experiences include politics and watching the nation as it expresses its opinions. They are constrained—or sometimes liberated—by the words of the founding Documents, and by the Court's previous decisions. They are highly intelligent individuals who accept their stabilizing role in American society. And, they clearly understand that the Court is the final arbiter of every matter that comes before it.

Applying the Principles to the Court and Applying the Court to the Act

It is only against this significant background that the constitutionality of the Patient Protection and Affordable Care Act can be considered. In performing that consideration, it is not my goal to produce a "law review quality" assessment. Rather I wished to take a practical look at the major issues that the Act presents and attempt to theorize how the Supreme Court will deal with them. Once all of the rhetoric surrounding the current legal challenges has been removed, most experts seem to agree that those issues are only two in number. Both focus on the "individual mandate." Politically, when Congress could not get the votes to put a, so-called, "public option" in the Act—a government-run health insurance agency that would sell insurance to the uninsured and thus compete with private insurers—it substituted the "individual mandate" for it.

The first, and critically important, issue is the legal issue: can the Commerce Clause of the Constitution be deemed to allow Congress to mandate that individuals purchase health insurance and penalize someone who refuses?[3] Some would expand this question slightly by asking: can the Commerce Clause, when read together with the "Necessary and Proper" clause, cited above, allow Congress to mandate that purchase and impose such a penalty for failure? In plainer English, I think the question can be posed this way: does the Constitution give Congress the right to punish an individual who refuses to purchase a product, and so refuses to participate in commerce?

Second is the practical issue: if the Court holds that the mandate is unconstitutional, is the entire Act undone, because it cannot work without the insurance mandate and its associated penalty?

The Practical Issue

The practical issue is the easier to address. An important theme of the Act is that citizens with pre-existing medical conditions should not be priced out of the health insurance market, but should have such coverage available and reasonably priced. This is a very risky provision, and one tied inextricably to the mandate to purchase. If there is no mandate to purchase health insurance, then it is reasonable to expect that many (most?) will not purchase it. Instead, such individuals will wait until they need medical care, possibly serious and expensive care, and then force insurers to sell them reasonably priced policies, because the Act does not permit that they be turned down for pre-existing conditions. Moreover, once the care has been delivered, and the health crisis is resolved, most who purchased the coverage can be expected to drop it.

This possibility will have dire financial consequences for the insurance carriers. They will pay large medical bills for a small and soon discontinued premium. In fact,

we already have two dramatic examples of the pernicious effect of this possibility.

The first occurred in the late 1980s, when policymakers in New York convinced Empire Blue Cross/Blue Shield, then the largest health insurer in the nation, to sell policies to those with pre-existing conditions, and to do so on a community-rated (i.e., low cost) premium basis. It took only a few years for this approach to result in financial disaster for the company. In 1991 and 1992, the company's medical claims for its community-rated policies so far exceeded expectation that it was forced to expend $300 million of its capital reserves and $100 million of its investment income to pay them. It happened just that fast. By early 1993, with the company close to bankruptcy, the same policymakers were forced to create a special Commission to save it.[4]

Moreover, it appears that the relatively new Massachusetts health reform law suffers from similar problems. In that state, there is a mandate requiring uninsured individuals to buy health insurance. The rates are not unreasonable, but the penalty for failure to purchase the coverage is small, and many have done the math. It can be less expensive to pay the penalty, forgo the coverage until it is needed, and then purchase it, despite pre-existing conditions, at a reasonable price. Insurers in Massachusetts are already suffering the financial results and are asking for steep premium increases, which, so far, the State has denied.[5]

Given the dramatic experience of Empire, and the unfolding, similar experience in Massachusetts, it appears reasonable to conclude that legislation such as the Act can only succeed if there is an individual mandate to purchase health insurance, coupled with an enforceable (and enforced) significant penalty to do just that. Without those, the pre-existing condition prohibition will either have to be eliminated, thus gutting the Act, or, if left in place, can be expected to result in financial chaos for the insurers.

The Legal Issue

And so it is that the first issue, the constitutionality of the mandate to buy insurance, becomes the hook upon which the federal Act will hang. Attempting to predict what the Supreme Court will do with an issue as publicly debated and as volatile as the Act is very dangerous. As mentioned earlier, the current Court appears to be split 4 and 4 (liberals and conservatives), with Justice Kennedy able to swing in either direction on any given issue. That noted, let me go into harm's way.

From an understanding of the Court's history on similarly difficult matters, the Court can decide the constitutionality of the public mandate in one of two ways. It can be decided either politically, or it can be decided as a matter of federalism—namely the first two principles enunciated in the beginning of this analysis.

If the Court is intent on upholding the mandate (and thus the Act), it can get there politically. Indeed, several federal district courts and the Sixth Circuit Court of Appeals have already upheld it although the Eleventh Circuit has determined that the mandate is not constitutional. Upholding the individual mandate will require a majority of the Justices to expand, significantly, the Commerce Clause's reach. That expansion would likely go something like this: it is clear that both the health of our citizens and the manner in which they pay for health care (i.e., insurance) has a significant impact upon the nation's economy, and so upon its commerce. The *decision* of any citizen not to buy health insurance, when taken in the aggregate with all similar *decisions*, rises to the level of an "activity" that affects interstate commerce. Since Congress has the power to legislate in the area of "activities" impacting interstate commerce, the mandate to buy health insurance is an appropriate exercise of that power. Decisions = Activity.

This political solution will mean that the four liberal-leaning Justices (Ginsburg, Breyer, Sotomayor and Kagan) will have worked through an arrangement to have Justice Kennedy concur with their conclusion, if not actually agree with their reasoning. That will not be an easy lift for Justice Kennedy, but he might get there just as New Deal Justices finally agreed to uphold Roosevelt's legislation. In this scenario, I would expect the conservative-leaning Justices (Scalia, Thomas, Alito and Roberts) to dissent, and dissent strongly.

Achieving such a political solution will not be easy, and in the end, I believe that it will not be possible. The magnetic attraction of the federalism issue will, and ought to, prove too strong in a matter such as this, particularly given recent precedent of the Court in Commerce Clause cases, and the undeniable impact of the 2010 election results.

If the Act is subject to the full scrutiny of principles of federalism, upholding the individual mandate becomes much, much more difficult. (This is the point at which I will try to have this analysis not sound like a law review article. However, some basic understanding of Constitutional precedent is required. I'll attempt to provide it in plain English.)

As suggested, in determining the matter of constitutionality, the meaning of the Commerce Clause alone, or the interplay between that Clause and the "Necessary and Proper" Clause of the Constitution, will be central.

Congress may exercise only those powers enumerated in the Constitution. The Commerce Clause (Article I, Section 8, Clause 3) gives Congress the power "to regulate Commerce…among the several States." This power has been widely interpreted by the U.S. Supreme Court to allow Congress to regulate persons, *activities* or things that use the channels of interstate commerce. The Court has held, generally, that commerce that is purely intrastate

may not be regulated. Does the Act's mandating a single individual to purchase insurance rise to the level of interstate commerce, or is it something lesser? The question will turn on the concept of what constitutes "activity" and what does not.

As suggested, those who support the mandate view the matter as one, clearly, of interstate commerce, either as applied to a single individual, or in the aggregate, as applied to all individuals whose refusal to purchase health insurance would have measurable economic impact: "Far from inactivity, by choosing to forgo insurance (these individuals) are making an economic decision to try to pay for health care services later, out of pocket… collectively shifting billions of dollars…onto other market participants."[6]

Those who argue to overturn the mandate maintain that Congress is attempting to regulate *not* economic activity that substantially affects interstate commerce, but *inactivity*; that the regulated individual, with no health insurance, is doing nothing but living and breathing in his own home: "Neither the Supreme Court nor any other federal circuit court of appeals has extended the Commerce Clause to compel an individual to involuntarily enter the stream of commerce by purchasing a commodity in the private market."[7]

This is a critical distinction, and it will prove difficult for the Supreme Court to resolve. The Court has never ruled that doing nothing rises to the level of activity constituting interstate commerce. In all of its cases, even those few in which the Court has said that many individual acts of *activity* that are all intrastate in nature can be aggregated, and interstate commerce can be derived from the aggregation, there still has to be *activity*. There has never been a ruling that doing nothing, or adding together many acts of doing nothing, can rise to become *activity*, and thus become interstate commerce. In fact the Court has ruled that it will not "pile inference on inference" in an attempt to create interstate commerce.[8]

The Constitution gives Congress the power to regulate interstate commerce. If there is no such commerce, Congress has no such power. That's federalism. That's the meaning of the people giving to a central government only those powers specifically set forth in the Constitution, and retaining all others to themselves or to their states. As noble as one might consider the aims of the individual mandate to be, if it cannot be squared with the Constitution, it is a nullity.

Imagine where the Court's holding that an individual's *deciding* to do nothing might lead. For example, if citizens *decide* not to buy automobiles in any given year, can Congress legislate that they must? The impact of the auto industry on the economy and interstate commerce is indisputable. What if citizens *decide* not to spend any of their discretionary income at local malls, or decide not to spend any of it at all? Can Congress legislate that they must spend a percentage of it every year? What about *deciding* not to take a vacation? The examples could go on and on, and they lead to some extraordinarily unpleasant intrusions into personal liberties—the types of liberties that the people were careful not to give away when the Constitution was written.

Said succinctly, deciding to "do nothing" cannot in any but the most tortured way be said to be the equivalent of "doing something." And, the Supreme Court precedent is clear—if Congress wants to legislate in the area on interstate commerce—someone must "do something." There has to be some *activity* to regulate.

Finally, if the Commerce Clause cannot get the Court to the constitutionality of the mandate, then the Court will get little help from the "Necessary and Proper" Clause. While that Clause has been widely interpreted by the Supreme Court, many legal scholars understand that it can be used *only* when it can be linked to a constitutionally enumerated power (and also does not violate a constitutional prohibition). If the Supreme Court rules that the individual mandate cannot be linked to the Commerce Clause powers (e.g., inactivity cannot be regulated), then there is nothing to which to attach the "necessary and proper" authority. "Necessary and Proper" is not additive. It does not create an additional new power for Congress. It exists only to help Congress legislate in those areas in which it has specific powers under the Constitution.

Other legal scholars refute this interpretation of "necessary and proper," saying that it eviscerates the power. This opposing point of view would aggregate all of the important reasons that Congress might have to pass the health reform legislation, and suggest that, taken together, they can be related to Congress' "necessary and proper" powers to include the mandate as an essential part of that legislation. This type of aggregation was employed by the Court recently in *United States v. Comstock*.[9] However, that opinion (on very different facts) was such a mix of concurrences and dissents that it is safe to consider its approach not to be reliable precedent. It is also exactly the same type of "bootstrapping" logic that would conclude that doing nothing is the equivalent of doing something.

Far more reliable, indeed, and the time-tested way to view the "necessary and proper" power was given to us in 1819 by Chief Justice John Marshall in the seminal case, *McCulloch v. Maryland*.[10] He wrote "let the end be legitimate, *let it be within the scope of the Constitution*, (then) all means which are appropriate, …which are not prohibited, but consistent with the letter and spirit of the Constitution, are constitutional" (emphasis added). This application of the "necessary and proper" powers of Congress has withstood the test of time. And, if the Court uses it, the individual mandate will fall, because it is not "within the scope of the Constitution" (again, inactivity cannot be regulated by Congress under the Commerce Clause).

As dangerous as it is to predict what the Supreme Court might do on any given issue (and, frankly, as much as I might like the result to be different), the Court should rule that the individual mandate is unconstitutional. Whether it will go as far as a district court case in Florida that came to this conclusion,[11] and also rule that the entire Act, itself, must be declared null and void, because the entire purpose of the Act is invalidated when the individual mandate falls, is beyond my scope here. Moreover, it is really not necessary to reach the issue of the legality of the entire Act. As explained earlier, without the mandate, without being able to assure that all citizens will have health insurance at all times, the insurers will not be able to withstand the economic assault on their businesses. If the mandate must be excised, Congress will have to re-address the remaining provisions of this far-reaching law.

I think that we can all predict how anxious Congress will be to do that.

Endnotes

1. Marbury v. Madison, 5 U.S. (1Cranch) 137 (1803).
2. Plessy v. Ferguson, 163 U.S. 537 (1896); Brown v. Board of Education of Topeka, Kansas, et al., 347 U.S. 483 (1954).
3. Except for the Commerce Clause, there is no other Constitutional power given to Congress that might, completely, support its power to create the individual mandate.
4. For purposes of full disclosure, I was the Chairman of that Commission. While Empire's problems were vast and varied, this single problem, left unaddressed, would have brought down the Company.
5. There is no question of the constitutionality of the Massachusetts mandate under its State Constitution. States can justify such measures under their broad police powers, a power that is not available to Congress under the U.S. Constitution.
6. Thomas More Law Center et al. v. Obama, 720 F. Supp 882, 894 (E.D. Mich. 2010).
7. Virginia v. Sebelius, 728 F. Supp. 768, 782 (E.D. Va. 2010).
8. United States v. Lopez, 514 U.S. 549, 567 (1995).
9. Unites States v. Comstock, 560 U.S. __ (2010); 130 S. Ct. 1949.
10. McCulloch v. Maryland, 17 U.S. 316, 421 (1819).
11. State of Florida, et al. v. United States Department of Health and Human Services (U.S. District Court for the Northern District of Florida, January 31, 2011).

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Common Sense Suggestions to Reduce Legal Barriers Facing New Yorkers Who Wish to Choose an Agent to Help Them in Obtaining and Paying for Their Health Care

By Albert Feuer

New York law unduly limits the ability of individuals to have an agent they choose help them in obtaining and paying for their health care.[1] This article shows how attorneys may enable individuals to overcome these barriers by preparing HIPAA authorizations and modifying the New York statutory templates for health care proxies and powers of attorney. This article also suggests how the New York Unified Court System Office of Court Administration ("OCA") and the New York State legislature may reduce questions about the intended authority of the agents by changing the rules applicable to powers of attorney, health care proxies, and the privacy of health care information. The suggested changes are so intuitive and beneficial that the New York State Department of Health ("NYSDOH") and many well-meaning health care providers and health plans treat the changes as if they all had been adopted. However, not all providers and plans are well-meaning or willing to act contrary to the law or legal documents. It is particularly important to adopt these changes because when questions about an agent's authority arise, the principal often finds it difficult or impossible to request the health information on one's own, or to execute new agency agreements.

I. HIPAA—The Federal Law Governing Access to Health Care Records

In 1996, the Congress enacted the federal health-privacy law known as Health Insurance Portability and Accountability Act ("HIPAA").[2] HIPAA has two major privacy goals. First, the law enhances an individual's access to his or her health information by requiring the disclosure to the individual of a broad definition of health information. Second, the law diminishes the access of others to the same information by limiting the condition under which such access is available.

HIPAA governs access to an individual's health information, which is defined very broadly as

> any information, whether oral or recorded in any form or medium, that– (A) is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and (B) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual.[3]

The general HIPAA rule is that individuals have the right to access their own health information[4] and to determine who else may do the same. Covered entities are those entities for which HIPAA governs the use and disclosure of health information, such as health care providers and health care plans.[5] Covered entities need not give an individual access to that individual's health information if: (1) the information is reasonably likely to endanger the life or personal safety of the individual or another person;[6] (2) the information was obtained under an agreement of confidentiality;[7] (3) the information is psychotherapy notes;[8] or (4) the information was prepared in anticipation of litigation.[9]

HIPAA permits access to a principal's health information which is not at the direction of the principal or the principal's agents.[10] Access may be required by law, *i.e.*, a "mandate contained in law that compels a covered entity to make a use or disclosure of health information[11] and is enforceable in a court of law."[12] A simple request by an attorney at law, or even an attorney's subpoena,[13] does not provide such access because those requests are not automatically enforceable in a court of law.[14]

There are two general ways in which individuals may give agents they choose access to their individually identifiable health information that a covered entity holds. In one, covered entities must provide access, and in the other the covered entities may choose whether to grant access. Principals often provide such access because principals find such delegations relieve the principal of a burdensome task and provide for the possibility that the principal may be unable to request the information when it may be useful to the agent.

A. HIPAA Personal Representatives Have the Right to Access Health Information

First, if the agent is treated under HIPAA as an individual's personal representative,[15] the agent must be given the same access as the individual,[16] i.e., the right to discuss the individual's health information with representatives of the covered entities, and the right to inspect and receive copies of records with covered entities.[17] An agent is treated as an individual's personal representative if under applicable law the agent "has authority to act on behalf of an individual who is an adult or an emancipated minor in making decisions related to health care."[18] These agents require access to an individual's health informa-

tion to exercise their authority prudently. Three kinds of decision-makers are generally relevant. Those who make health care decisions pursuant to health care proxies.[19] Those who make health care finance decisions pursuant to powers of attorney.[20] Finally, an executor, who is chosen by the principal to act on behalf of the principal's estate, is also a personal representative.[21]

There is one important limit on the extent to which covered entities must treat an individual's personal representative as the individual for HIPAA purposes.[22] HIPAA personal representatives are entitled only to "information relevant to such personal representation."[23] For example, if the decision-maker responsible for health care decision-making is considering alternative treatments for the individual's coronary condition, it may be argued that information about a broken leg treated several years ago by physicians not then treating the individual is not relevant to the agent's limited responsibility.[24] Similarly, if the decision-maker is not responsible for paying the individual's health care bills, it may be argued that information about the individual's insurance coverage or health condition is not relevant to the agent's limited responsibility.[25] To avoid such questions, individuals may wish to provide their chosen personal representatives with broader HIPAA authority, as discussed *infra*.

HIPAA does not affect state law limits on the selection by a principal of an agent to make decisions related to the principal's health care.[26] State law may limit the persons who are eligible to be a personal representative and their authority. For example, the health care agent under the New York health care proxy law may not simultaneously act as a principal's attending physician.[27] State law may also limit the extent of the decision making by the personal representative. For example, New York statutory short form powers of attorney[28] may not be used for health care decision-making, but only for health care finance decision-making.[29]

Principals may further limit the authority of their personal representatives. For example, the principal may choose to have a health care agent be responsible only for certain decisions, such as those pertaining to the provision of all life-sustaining treatment other than artificial hydration or nutrition. Similarly, the principal may choose to have a health care finance agent responsible only for paying the principal's health care bills, but not for obtaining health insurance benefits.

A principal's attorney at law representing a principal in a dispute pertaining to the principal's health care does not thereby become the principal's personal representative with respect to such litigation because such representation does not generally give the attorney the authority to make decisions related to health care on behalf of their principals. However, there appears to be one exception in practice. ERISA plans generally treat an attorney at law, who shows that he or she is representing an ERISA benefit claimant, particularly with respect to a claims denial, as entitled to the same plan information as the principal, including the principal's health information. The latter is consistent with the ERISA claims regulation mandate.[30]

State law also allows persons not chosen by the principal to make decisions related to health care on their behalf. Those persons are also HIPAA personal representatives. For example, if no will is probated for a decedent, the affairs of a decedent estate are taken care of by an administrator usually chosen from among the decedent's next of kin.[31] Such administrators may address the decedent's health care payment obligations and health care benefit entitlements. Similarly, if an individual with capacity to choose a health care agent does not do so before becoming incapacitated, a person is given such authority as the individual's health care surrogate under the Family Health Care Decisions Act ("FHCDA").[32] As with estate administrators, first priority is generally given to next of kin.[33] These HIPAA personal representatives are not the subject of this article, so they will not be discussed extensively.

B. HIPAA Authorized Agents Do Not Have the Right to Access Health Information but May Be Given Access to Such Information

Second, access, which presumably does not exceed the principal's right to discuss his or her health information and to copy and review records,[34] may, but need not, be provided[35] if the individual executes a written authorization for the agent that satisfies the HIPAA criteria.[36] Unlike disclosures to individuals or their personal representatives, a covered entity must make reasonable efforts to limit disclosures in response to HIPAA authorizations to the minimum necessary to accomplish the intended purpose of the disclosure.[37]

HIPAA authorizations may not generally be made with compound documents, *i.e.*, they may not be combined with another document.[38] The documents must be written in plain language[39] and may only be revoked with a writing.[40] The authorization must contain the following elements:

(i) A description of the information to be used or disclosed that identifies the information in a specific and meaningful fashion;

(ii) The name or other specific identification of the person(s), or class of persons, authorized to make the requested use or disclosure;

(iii) The name or other specific identification of the person(s), or class of persons, to whom the covered entity may make the requested use or disclosure;

(iv) An expiration date or an expiration event that relates to the individual or the purpose of the use or disclosure;

(v) A statement of the individual's right to revoke the authorization in writing and the exceptions to the right to revoke, together with a description of how the individual may revoke the authorization;

(vi) A statement that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by this rule;

(vii) Signature of the individual and date; and

(viii) If the authorization is signed by a personal representative of the individual, a description of such representative's authority to act for the individual.[41]

Documents, such as health care proxies, powers of attorney, or wills,[42] which, as discussed above, make an agent chosen by an individual the HIPAA personal representative of the individual, do not have to satisfy any of these conditions.

C. Federal Enforcement of HIPAA Privacy Rights

HIPAA requires covered entities to have appropriate administrative, technical, and physical safeguards to protect the privacy of protected health information.[43] The U.S. Department of Health and Human Services ("HHS") may review such safeguards.[44] Individuals who have complaints about whether they have received information to which they are entitled under HIPAA or that their information was disclosed contrary to HIPAA may complain to the Office of Civil Rights at the HHS ("OCR at HHS").[45] If the OCR at HHS finds there was a HIPAA violation, the OCR at HHS may move for the imposition of civil penalties[46] or criminal penalties.[47] HIPAA provides no private right of action.[48] However, there may be a private right of action under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), against ERISA plan fiduciaries who improperly disclose a participant's health information.[49] State attorneys general also may enjoin HIPAA violations or move to obtain damages in the amounts of the penalties that the HHS could have obtained. The HHS was required to establish a procedure by February 17, 2012 by which victims of HIPAA violations may receive a fraction of the monetary penalties or settlements collected with respect to such violations.[50] No such procedure has been established. Some commentators have criticized the lack of private right of action for those individuals whose identifiable health information was improperly released.[51] There appears to be little commentary on the lack of a private cause of action by a HIPAA personal representative who is unable to obtain information to which he or she is entitled under HIPAA. This access is the principal focus of this article.

II. Using New York Health Care Proxies and Associated HIPAA Authorizations to Access a Principal's Health Records

New York State permits any competent adult to appoint an agent to make health care decisions on his or her behalf [52] using a document called a health care proxy.[53] The statute describes such agent as the adult's health care agent.[54] The agent, however, is only empowered to make health care decisions if and when there is a determination by an attending physician that the principal lacks the capacity to make health care decisions.[55] If the principal objects to the lack of capacity determination a court must decide if the principal has the capacity.[56]

The statute, after setting forth the requirements for the content and the execution of a health care proxy, sets forth an illustrative proxy form:[57]

Although this format is not required,[58] many practitioners prefer to use either this format or the slightly different one issued by the NYSDOH.[59] This choice minimizes questions about statutory compliance. The most common change to this template is the addition of a revocation provision, thereby minimizing any confusion by the principal about how to do so,[60] such as the following:

> I may revoke this proxy at any time in its entirety by (a) executivng a new proxy, (b) notifying a health care provider orally or in writing of such revocation; or (c) notifying any Agent orally or in writing of such revocation. In addition, at any time when I am able to make my own health care decisions I may revoke the appointment of a specific Agent by notifying such Agent or a health care provider orally or in writing of such revocation.[61]

The health care agent appointed in a health proxy is a HIPAA personal representative because the statute gives the agent the requisite authority[62] as follows:

> Subject to any express limitations in the health care proxy, an agent shall have the authority to make any and all health care decisions on the principal's behalf that the principal could make.[63]

Thus, this provision gives the agent access to all health information relevant to the agent's making any and all the health care decisions on behalf of the principal, subject to the express limitations of the proxy. However, the proxy statute also explicitly describes the authority of a health care agent to obtain the principal's health care records as follows:

> **Right to Receive Information**. Notwithstanding any law to the contrary, the agent shall have the right to receive medical information and medical and clinical

> records necessary to make informed decisions regarding the principal's health care.[64]

This provision arguably substantially reduces the personal representative's HIPAA authority that otherwise results from the agent's decision making rights.[65] The provision may not include the authority to obtain records regarding the principal's health care bills, past or future, or the principal's health care benefits, which many agents would want to consider in making health care decisions. Similarly, using the phrase "medical information and medical and clinical records" rather than the broader HIPAA phrase "health information" may also reduce the HIPAA authority of the agent otherwise provided in the decision making section. For example, dental information is health information which may not be regarded as medical information.

Questions may arise about whether the health care agent is requesting health care information that is not "necessary to make informed decisions regarding the principal's health care" and thereby exceeding his or her authority.[66] Such questions arise most often from health care providers who are no longer treating the principal, and may be concerned about challenges to the quality of their treatment.[67]

Many principals prefer to avoid any of the above questions about their health care agent's HIPAA authority by giving their health care agent access to all their health information with a supplemental HIPAA authorization.

These supplemental HIPAA authorizations are not usually included in current health care proxies. Even if they did not endanger the acceptability of health care proxies,[68] it would be unwise to include a HIPAA authorization within the health care proxy. HIPAA authorizations, which provide access to health information, may only be revoked in writing.[69] Principals, however, often want the ability to revoke health care proxies, which provide health decision-making authority, by an oral statement to a health care provider or a named agent. Thus, a typical health care proxy would not satisfy the written revocation part of the HIPAA authorization requirements. Although it is possible to have distinct revocation provisions for different parts of the proxy, it would probably make the health proxy unduly complex for most principals.

Many principals also wish to have assistance from the health care agent named in their health care proxy when the principal is infirm but still capable of making health care decisions. With the diminution in the number of trusted family doctors who coordinate health care treatment, patients and their advocates often have to take more control over their health care, particularly if they have multiple current and former treating physicians. Advocates can often remove a considerable burden from an ill person by obtaining and distributing health care records among the different physicians. For example, by maintaining copies of health care tests, they can often eliminate the need for tests to be repeated. Moreover, with such involvement the named agent will be aware of the principal's health care providers and health condition in the event the named agent becomes the principal's health care agent.

These supplemental HIPAA authorizations are usually effective immediately. As with a financial power of attorney, the principal and agent usually decide in concert whether to have the authorization exercised immediately or to wait for the principal's loss or diminishment of capacity. In any case, in accord with the prohibition on compound HIPAA authorization described above, the document may not reference the health care proxy. If the HIPAA authorization covered all providers, the principal would not need to execute one for each provider.[70] The authorization provisions would also include the right of the agent to discuss the patient's health care and information, which is often omitted, such as the following provisions:

> I MARY ROE residing at 123 Any Avenue, Brooklyn, New York 11201, authorize JOHN DOE, residing at 888 Any Street, New York, New York 10011, to have the same rights I have under the Health Insurance Portability and Accountability Act ("HIPAA") regarding the use and disclosure of all my individually identifiable health information[71] that is with any of my past, present and future health care providers or with any of my past, present and future health plans.
>
> I authorize all my past, present and future health care providers, and all my past, present and future health plans to discuss my health care and individually identifiable health information with JOHN DOE.
>
> I understand any information disclosed pursuant to this authorization may be redisclosed by the recipient and no longer be protected by HIPAA.

The HIPAA authorization would also contain a brief description in plain language of (1) its indefinite duration and how to revoke it, and (2) the right of the principal to refuse to execute such a broad authorization, or any authorization, such as the following:

> This HIPAA authorization shall be effective immediately upon execution and remain in effect indefinitely.
>
> I may revoke this authorization at any time by delivering a signed and dated

> writing to JOHN DOE, either in person or by first-class mail, FEDEX, UPS or courier, to JOHN DOE's last known address. My revocation shall be effective upon such delivery, but will not be effective to the extent that JOHN DOE, health care provider, or a health plan has acted in reliance upon this authorization.
>
> I understand I may refuse to sign this authorization, and instead may sign an authorization directed only at a named health care provider or health plan.
>
> I understand I may refuse to sign this authorization, or refuse to sign an authorization directed only at a named health care provider or health plan, and instead may sign no authorization.

These HIPAA authorizations, unlike many HIPAA authorizations, do not have limited durations, such as a one-year period, because they are associated with health care proxies are intended be in effect when the proxies are in effect, and perhaps prior to such time. However, health proxies may remain in effect during an indefinite disability. Thus, it would not be practical to give the principal the right to decide periodically whether to renew the proxy and associated proxy. Of course, the principal could revoke the proxy and HIPAA authorization at any time he or she has the capacity to do so.

III. Using New York General Powers of Attorney and Associated HIPAA Authorizations to Access a Principal's Health Records

Powers of attorney, which are written documents by which a principal with capacity designates an agent to act on his or her behalf,[72] are governed by GOL Title 15 of Article 5 unless there is an applicable exclusion.[73] There is an applicable exclusion for powers created pursuant to other statutes.[74] The exclusion specifically includes powers to make health care decisions, *i.e.*, health care proxies.[75] HIPAA (health care information) authorizations are implicitly included because they are created pursuant to HIPAA, a federal statute.[76] Title 15, however, governs powers of attorney appointing agents to make health care finance decisions.

Title 15 powers of attorney must meet three major requirements.

First these powers must meet requirements about the style and execution of the form. They govern the size and clarity of the type face, and how the principal and the principal's agent, known as the principal's attorney, may execute the power.[77]

Second, these powers must contain specific warning language for the principal, which describes the ability to revoke such powers and the inability of these powers to grant the authority to make health care decisions.[78]

Third, these powers must describe an agent's fiduciary responsibilities under a power of attorney.[79]

None of these requirements is applicable to health care proxies, which are not Title 15 powers of attorney.[80]

A principal may use one of two approaches to authorize an agent to make his or her health care finance decisions.

The first approach uses the general purpose template set forth in the statute as the New York Statutory Short Form of Power of Attorney (the "Short Statutory POA").[81] This form permits the principal to check item (K) and thereby give the agent authority with respect to "health care billing and payment matters; records, reports, and statements." A construction statute specifically addresses the access to health care records by this language gives as follows:

> the language conferring authority with respect to "records, reports and statements," must be construed to mean that the principal authorizes the agent:
>
> 1. To access records relating to the provision of health care and to make decisions relating to the past, present or future payment for the provision of health care consented to by or on behalf of the principal or the principal's health care agent authorized under state law. In so doing the agent is acting as the principal's personal representative pursuant to sections 1171 through 1179 of the Social Security Act, as added by sections 262 and 264 of Public Law 104-191 [HIPAA], and applicable regulations. This authority shall not include authorization for the agent to make other medical or health care decisions for the principal;[82]

As with the similar health care proxy section this explanation is unnecessary and arguably reduces the HIPAA authority of the personal representative. Why is the authority to access records limited to those pertaining to certain consented health care? It is not clear if it is sensible to require consent. For example, emergency care is often provided without consent. More important, item (K) does not give the agent any authority to determine or obtain any health benefit payments to which the principal may be entitled, and the construction statute makes no attempt to imply such authority.[83]

The other items that may be checked on the template do not unambiguously provide the requisite authority to obtain health care benefits payments from health care insurers, government programs or employers. Those items

also require the principal to give far more authority to the health care agent than the principal may prefer. Checking item (O), which gives the attorney authority over all other matters,[84] may not work. The difficulty is that the billing construction statute explicitly provides that item (K) authorizes the "health care decisions" described,[85] which is an exception to the rule that Title 15 powers of attorney may not authorize health care decisions.[86] Checking item (F), which gives the agent authority with respect to "insurance transactions," may not authorize the pursuit of benefit claims (including learning of pretreatment coverage) under health care insurance plans, although the right to choose health care policies is set forth in the pertinent construction statute.[87] The difficulty is that the pertinent claims section of the construction statute seems to be limited to obtaining "the proceeds of any contract of insurance."[88] This phrase is usually associated with life insurance, rather than health care insurance. In fact, some health insurers have reportedly taken the position that section (F) is not applicable, and it is questionable why it should be necessary to give the intended health care finance agent responsibility for life insurance matters. Similar questions arise with respect to whether the reference to "government programs" in item (J) encompasses government health insurance plans, because the pertinent construction statute is totally silent about the significance of the phrase.[89]

Many attorneys thus add a modification to the Short Statutory POA addressing the authority of the health care finance agent with respect to benefit entitlements, to benefit disputes and to discussions with relevant parties, such as the following:

> Authority to (1) determine and make the appropriate payments, if any, for my health care; (2) determine and obtain my health care insurance benefits, if any; (3) determine and obtain my government health care benefits, if any; (4) determine and obtain my employer health care benefits,[90] if any; (5) represent me in any disputes, administrative proceedings and/or litigation with respect my health care payment obligations or my health care benefit entitlements, and (6) obtain appropriate care for me (as determined by me, my health care agent, guardian, my health care surrogate, or any other person authorized to make my health care decisions).
>
> Authority to (1) review and obtain copies of my health care records that is relevant to the authority set forth in the above paragraph, and (2) discuss my health care information that is relevant to the authority set forth in the above paragraph with any of my health care providers, employers or health plans. My agent may delegate this authority to any attorney at law retained to assist in these matters related to my health care.
>
> I understand that this authority does not authorize my agent to make health care decisions for me.

Under applicable law, the first paragraph gives the agent authority to make a decision related to the principal's health care.[91] Thus, the agent is a HIPAA personal representative.[92] Therefore, under HIPAA the agent has the right to inspect and receive copies of the health care records described in the second paragraph.[93]

The second paragraph explicitly confirms that right (but does not change that right), so the principal knows that he has given the agent such rights. Moreover, the principal explicitly grants the agent the right to discuss health care information, which is often omitted,[94] so that the agent may fulfill his health care responsibilities most efficiently.

However, as with the health care proxy, the limits on the agent's representation may generate questions whether individually identifiable information being sought is "relevant to the representation." Such questions tend to arise most often when (1) the health care finance agent is disputing the principal's payment obligation or benefit entitlement; (2) the health care finance agent is seeking information about different contemplated treatments to better determine their costs, after taking into account applicable health plan benefits, to assist the health care agent, who is responsible for deciding upon treatment.

Thus, supplemental HIPAA authorizations identical to those presented in the health proxy discussion are often used, although it is possible to include such authorizations as part of the power of attorney. The power of attorney often has revocation provisions similar to a HIPAA authorization, so the health proxy issue of distinct revocation provisions does not arise, although it would probably be advisable to present the HIPAA authority as a declinable option. The principal is far more likely to understand that he or she may decline to grant such additional authority if the authorization is a free standing document, rather than part of the extensive document that must be used for a power of attorney, even one limited to health care finance issues. Principals who choose one person to be their health care agent and another to be their health care finance agent often wish to limit the health information that the latter may obtain, so it is advisable to clearly permit such a limitation.

This approach has a serious disadvantage. Modifications undermine the very reason the statutory short form power was adopted. As with the health care proxy template, the aim is to eliminate the time and expense required to review non-standard grants of authority. Thus,

most practitioners try to include few if any substantive modifications of the statutory short form power.[95]

The second approach addresses this disadvantage by not using the Short Statutory POA but by one which contains a grant of authority, such as

> I grant my agent the authority to (1) determine and make the appropriate payments, if any, for my health care (including my health care plan premiums);[96] (2) determine and obtain my health care insurance benefits, if any; (3) determine and obtain my government health care benefits, if any; (4) determine and obtain my employer health care benefits, if any; (5) represent me in any disputes, administrative proceedings and / or litigation with respect my health care payment obligations or my health care benefit entitlements, and (6) obtain appropriate care for me (as determined by me, my health care agent, guardian, my health care surrogate, or any other person authorized to make my health care decisions).
>
> I grant my agent the authority to (1) review and obtain copies of my health care records that is relevant to the authority set forth in the above paragraph, and (2) discuss my health care information that is relevant to the authority set forth in the above paragraph with any of my health care providers, employers or health plans. My agent may delegate this authority to any attorney at law retained to assist in these matters related to my health care.

The power of attorney need not, but may, have additional grants of authority.

As with the first approach, the first paragraph gives the agent authority under applicable law to make a decision related to the principal's health care.[97] Thus, the agent is a HIPAA personal representative.[98] Therefore, under HIPAA the agent has the right to inspect and receive copies of the health care records described in the second paragraph.[99] Moreover, the principal explicitly grants the agent the right to discuss health care information, which is often omitted, so that the agent may fulfill his health care responsibilities most efficiently.

Principals often use the same considerations as with the first approach to decide whether to use the same supplemental HIPAA authorization used with the Short Statutory POA, namely whether such additional access is likely to be useful or necessary versus whether the principal wants to provide the particular agent with such unbridled access.

The second approach has two disadvantages. First, considerable time and money may have to be used to explain the significance of a power of attorney that is not generated from the state sanctioned template, even one limited to the narrow task of appointing a health care finance agent. Second, it is a burden for a principal to execute multiple powers of attorney each directed at specific issues, particularly if the principal wishes to delegate many responsibilities to a single agent.

IV. The Interaction between HIPAA and New York Health Care Privacy Rules

HIPAA applies three general preemption principles to state law. First, states may enhance HIPAA protections by making it easier for individuals to obtain their health information and harder for others to be permitted to obtain such information. Second, states may not diminish HIPAA protections either by making it harder for individuals to obtain their health information or by making it easy for others to be permitted to obtain such information. Third, states may require an individual's health information be provided to the individual or others.

HIPAA generally preempts all state law,[100] which includes common law.[101] However, there is an exception for "more stringent" provisions of state law that relate to the privacy of health information.[102] In a set of guidance in the form of FAQs available on the internet, the HHS declared:

> In general, a State law is "more stringent" than the HIPAA Privacy Rule if it relates to the privacy of individually identifiable health information and provides greater privacy protections for individuals' identifiable health information, or greater rights to individuals with respect to that information, than the Privacy Rule does.[103]

There is additional elaboration in the HIPAA definitions, which includes the phrase "more stringent."[104] The USDHHS will not make determinations regarding whether a state law is more stringent than HIPAA.[105] An October 15, 2002-memo from the NYSDOH discussed the relation between HIPAA and New York State laws.[106]

An example of a more stringent state law is PHL § 2782, which gives greater privacy protection to an individual by permitting only certain persons to obtain confidential HIV information,[107] and prohibiting general releases from being used to obtain such information.[108] Thus, HIPAA general authorizations must permit the principal to decide whether to include or exclude confidential HIV information if access to such information is sought. Moreover, those authorizations must include the following or substantially similar language:

> This information has been disclosed to you from confidential records which

> are protected by state law. State law prohibits you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law. Any unauthorized further disclosure in violation of state law may result in a fine or jail sentence or both. A general authorization for the release of medical or other information is NOT sufficient authorization for further disclosure.[109]

The statute explicitly permits agents under health care proxies to obtain confidential HIV information,[110] but exempts providers from using the statutory disclosure language when they disclose such information to those agents.[111] The statute and regulations are silent whether a proxy is considered a release which must contain specific language about HIV confidential information. However, even if, *arguendo*, the proxy is treated as a release for purposes of these rules, the "notwithstanding any other law" provision of the proxy law[112] would trump this requirement.

The statute authorizes another HIPAA personal representative chosen by a principal, an executor, to obtain confidential HIV information, but only if the information is needed to fulfill the executor's responsibilities.[113] Wills are not releases, so there would be no need to include language in it authorizing access to confidential HIV information. However, the provider may only disclose such information if it is accompanied by the requisite language.[114] Such a requirement, which may be satisfied together with HIPAA and does not pose an obstacle to HIPAA's purposes and objectives, is not contrary to HIPAA.[115] Thus, the requirement is not preempted.

The statute makes no mention of health care finance agents acting pursuant to Title 15 powers of attorney. HIPAA preemption provisions allow such personal representatives to obtain confidential HIV information. The exception to the general HIPAA preemption rules for more stringent state laws is inapplicable. Such laws may not make it more difficult for the individual or his personal representative, who is treated for HIPAA purposes as the individual,[116] to obtain health information than does HIPAA.[117] Similarly the statutory requirement that the power of attorney creating the health care finance agent specifically reference the right to obtain HIV confidential information would also be preempted. This is consistent with the treatment of third-parties who reimburse health care providers—general releases give them access to HIV confidential material.[118] As with executors, the requirement that the health providers only disclose confidential HIV information if the information is accompanied with the prescribed statutory language would not be preempted.

There is also a statute which imposes criminal and civil penalties for those who willfully disclose HIV information in violation of PHL § 2782.[119] As discussed, *supra*, HIPAA would preempt the law with respect to disclosures to health care finance agents who are HIPAA personal representatives. The statute explicitly imposes no criminal or civil penalties on a health care provider who fails to provide HIV information to a health care agent.[120] HIPAA penalties may, however, be imposed by the OCR at HHS.[121]

There is one major New York State general privacy statute, PHL § 18. It governs a subset of the HIPAA health care providers, and does not cover any health plans.[122] The section governs access to patient information, which is a subset of the health information that HIPAA addresses. Patient information essentially is information concerning or relating to the examination, health assessment or treatment of an individual.[123] It does not include billing records.

The statute provides access to an individual's patient information to persons called qualified persons,[124] which include the individual and some HIPAA personal representatives of the individual, but none chosen by the individual. This access is defined as the right to review or obtain copies of the individual's patient information not subject to a statutory exclusion.[125]

PHL § 18 gives qualified persons a private right of action to obtain an individual's private information, which is consistent with the HIPAA deference to disclosures required by state law.[126] A medical records access committee appointed by the New York State Health Commissioner may review denials to access.[127] Qualified persons may bring a special proceeding to appeal denials by this committee.[128]

PHL § 18 does not limit the disclosure of patient information to qualified persons. No provision prohibits its disclosure to other persons, unlike the prohibition in the section protecting confidential HIV information.[129] Instead, there is an acknowledgment that there may be disclosures that are "otherwise authorized by law"[130] because records of such disclosures must be included in a patient's records. The statutory words suggest that this includes, but is not limited to, a disclosure pursuant to certain written authorizations by the principal.

The NYSDOH has acted on the basis that the "otherwise authorized by law" phrase includes HIPAA authorizations by the individual or the individual's HIPAA personal representatives. In August 2005, the NYSDOH promulgated such a form entitled, HIPAA Compliant Authorization for Release of Medical Information and Confidential HIV* Related Information, which makes no mention of PHL § 18.[131]

The New York Law Revision Commission acted on the basis that the "otherwise authorized by law" phrase

included health care finance agents who are HIPAA personal representatives. Its final 2008 commentary on the recent legislation justified the addition of the current medical billing item to the statutory short power of attorney and the associated construction statute for that item on the basis that providers would not release patient information to health care finance agents unless "express language [were] added to the power of attorney document authorizing such release.[132] The prior statutory short power of attorney referred only to "[general] records, reports and statements."[133]

Much confusion may have been generated about the effect of PHL § 18 by its inappropriate HIPAA references. The statutory statement that qualified persons are deemed HIPAA personal representatives makes little sense.[134] An individual is a qualified person,[135] but is not his own HIPAA personal representative. A distributee is a qualified person if the individual's estate has no appointed personal representatives,[136] but is not the decedent's HIPAA personal representative because he has no decision-making authority related to the decedent's health care by sole virtue of being a distributee.[137] The access of qualified persons to patient information has nothing to do with whether they are HIPAA personal representatives, but stems solely from the state statute providing access which is enforceable in the courts. Moreover, unlike personal representatives who have the same access as their principals,[138] qualified persons have no right to discuss the principal's health information with the principal's health care providers but only the right to inspect and copy patient information.[139]

The apparent aim of the statute of providing a mechanism for access to patient information for persons with an appropriate interest would be better served by including as qualified persons those individuals authorized pursuant to HIPAA to request patient information, such as those seeking information pursuant to the supplemental authorizations discussed *supra*, than with a catch-all statement that the release of patient information is subject to HIPAA.[140]

The *Mougianis* decisions generated substantial confusion about the applicability of PHL § 18 to agents chosen by principals. A health care agent under his mother's health care proxy sought copies of his mother's medical records from a hospital from which he had withdrawn his mother. The lower court decided that the agent was entitled to a PHL § 18 review of his access to the records because an agent under a health care proxy is deemed a PHL § 18-qualified person.[141] The court did not ask why the requester needed to be a PHL § 18-qualified person even though as discussed above, PHL § 18 does not prohibit the distribution of medical records to other persons. The appellate court correctly held that such an agent is not a PHL § 18-qualified person, but also held the proxy has access under the health care proxy rules, which give access to the principal's health information "[n]otwithstanding any law to the contrary."[142] However, showing that PHL § 18 does not block access does not show that a proxy has an alternative right to compel the hospital to provide the patient information—the court presented no alternative private right of action. If the appellate court had mentioned the reference in PHL § 18.6 to "as otherwise authorized by law" discussed above or the HIPAA preemption of those state laws which attempt to limit the access of individuals or their personal representatives to individually identifiable health information, it may have been more apparent such a source was needed. Such references would have suggested that an individual's health care finance agent, or the executor of an individual's estate, may similarly access his or her patient information regardless of whether their authorizing statutes explicitly supersede other statutes.

Finally, no agent chosen by an individual was considered a qualified person until 2004, when the legislature added to the list "an attorney representing a qualified person or the subject's estate who holds a power of attorney from the qualified person or the subject's estate explicitly authorizing the holder to execute a written request for patient information under this section."[143]

The attorney has no decision-making authority related to health care, so he is not a HIPAA personal representative, but would presumably be able to make requests for patient information pursuant to an HIPAA authorization in the form of a power of attorney that mentioned PHL § 18. If the attorney could rely on a government form, the power of attorney would not have to be a Title 15 power.[144] The legislature appeared to expect that such a form would be issued.

The attorney addition to the qualified person list[145] was an apparent reaction to the 2004 Recommendations of the Advisory Committee on Civil Practice to "enhance the efficiency of the processing of medical malpractice cases" by having a plaintiff execute a single power of attorney authorizing his attorney to obtain all medical records rather than execute multiple authorizations.[146] The recommendations reported that the OCA planned to promulgate such a form so attorneys to obtain medical records in civil and criminal cases after the enactment,[147] but has never done so. Instead, on October 2, 2005, less than a year after the enactment the OCA promulgated a form entitled Authorization for Release of Health Information Pursuant to HIPAA.[148] However, the OCA authorization, like the above DOH form, does not mention PHL § 18 or permit the attorney to obtain all medical records, but instead directs a specified "health provider" to deliver specified records to a specified person, the attorney. Many attorneys nevertheless often use these authorizations, instead of subpoenas duces tecum.

New York common law also gives individuals private rights of action with respect to their health information.

There are a number of pre-HIPAA decisions, including a New York decision[149] that an individual has a property right to their health records, although the extent of the resulting access rights is often unclear.[150] As discussed, *supra*, PHL § 18 does not preclude such actions particularly for entities or health information that it does not address. HIPAA does not preempt this common-law right for the same reason it does not preempt the similar right to private action under PHL § 18—the HIPAA deference to disclosures required by state law.[151]

There is a far more extensive common-law finding a post-HIPAA private right to bring a common-law action against a health provider for breaching the duty not to disclose confidential health care information, although the New York courts did not discuss the applicability of HIPAA.[152]

The U.S. Supreme Court has held there is a strong presumption against the preemption of state causes of action.[153] The court stated that, "It is, to say the least, 'difficult to believe that Congress would, without comment, remove all means of judicial recourse for those injured by illegal conduct, ….'"[154] The California courts applied such principle to find that the federal Real Estate Property Settlement Act which required certain disclosure of loan costs but like HIPAA provided no private cause of action for those who suffered from such violations could bring state causes of actions for such violations because those causes promoted compliance with the federal statute.[155]

HIPAA, *a fortio*ri, seems to explicitly permit these common-law actions. The pertinent common-law is a state law related to health information privacy and provides penalties in addition to those of HIPAA and thus would not appear to be preempted by HIPAA.[156] Commentators have thus argued that state common law may be used to enforce HIPAA.[157]

V. Recommendations to the NYS Legislature and the OCA

In order that the person the principal wishes to be responsible for the principal's health care finances may best fulfill such responsibilities, it is advisable to amend Title 15 of the General Obligation Law (Financial and Estate Planning Powers of Attorneys) so that the Statutory Short POA, which is intended to be a widely used template, addresses all the principal's health care finance issues. Specifically it should include an explicit option that the attorney shall act on the principal's behalf not only with respect to health care billing, but with respect to health care benefits, and disputes with respect to such billing or benefits. It should also permit the agent to facilitate decisions by the principal's health care decision-maker on appropriate health care, which may depend on the availability of financial resources for different health care options.

This may be done by changing item (K) of the Short Statutory POA from "(K) health care billing and payment matters; records, reports, and statements" to "(K) health care payment and benefit matters; records, reports, and statements."

Similarly, the first sentence in Item 1 of the construction statute, GOL § 5-1502K, may be changed from:

> To access records relating to the provision of health care and to make decisions relating to the past, present or future payment for the provision of health care consented to by or on behalf of the principal or the principal's health care agent authorized under state law.

to:

> To determine and pay the principal's health care payment obligations, to determine and obtain the principal's health care benefit entitlements, to represent the principal in any dispute with respect to the principal's health care payment obligations or health care benefit entitlements, and to obtain appropriate care for the principal (as determined by the principal or the person with authority to make such decisions). To access all of the principal's health care information relevant to the representation described in the first sentence. To discuss with the principal's past, present, or future health care providers, employers and health plans any of the principal's health care information relevant to the representation described in the first sentence.

Similarly, the statute may provide that the health care finance agent's authority to obtain the principal's health care information, like that of the health care agent the principal selects pursuant to the Health Proxy Law, who is also a HIPAA personal representative of the principal, is not affected by any other state law, and that the health care agent is making no health care decisions, by changing the final two sentences in Item 1 of the construction statute, GOL § 5-1502K, from:

> In so doing the agent is acting as the principal's personal representative pursuant to sections 1171 through 1179 of the Social Security Act, as added by sections 262 and 264 of Public Law 104-191, and applicable regulations. This authority shall not include authorization for the agent to make other medical or health care decisions for the principal.

to:

> Notwithstanding any law to the contrary, the agent shall have the right to receive and discuss the principal's health care information relevant to the representation described in the first sentence. This authority shall not include authorization for the agent to make health care decisions for the principal.

So that there may be no question that the Title 15 power of attorney provisions do not interfere with the many HIPAA authorizations, such as, supplemental ones I propose that permit an agent to obtain health care records from the principal's health care providers or health plans, and to discuss the principal's health care with the principal's health care providers and health plans, such as the supplemental ones I propose, HIPAA authorizations should be explicitly excluded in item 11 of GOL § 5-1501C from the general power of attorney rules for estate and financial planning.

So that there may be no question that the power of attorney creating a health care finance agent gives the agent access to HIV confidential information under HIPAA, it is advisable to describe such person in PHL § 2782 as a qualified recipient in a manner similar to that applicable to executors. Both would have their access rights limited to that needed to fulfill his agent responsibilities. It is advisable not to limit the qualified recipients to those using item K of the Statutory Short POA, particularly if the item is not revised to provide responsibility for obtaining health care benefits as well as paying health care bills.

So that the person the principal wishes to be his health care agent may best fulfill such responsibilities as long as the principal wishes him to be his agent, it is advisable to amend the health care proxy statute to give health care agents access to either all of the health information that HIPAA otherwise provides to personal representatives, or to the more limited health information described in the FHCDA. Specifically:

- Amend the proxy statue by taking elements from PHL § 2994-d.3(c) to change PHL § 2982.2 from:

  > **Right to Receive Information**. Notwithstanding any law to the contrary, the agent shall have the right to receive medical information and medical and clinical records necessary to make informed decisions regarding the principal's health care.

  to:

  > **Right to Receive and Discuss Information**. Notwithstanding any law to the contrary, the agent shall have the right to discuss and receive health care information necessary to make informed decisions regarding the principal's health care, including information about the patient's diagnosis, prognosis, the nature and consequences of proposed health care, and the benefits and risks of and alternative to proposed health care.

  It is advisable to amend the corresponding FHCDA Section PHL § 2994-d.3(c) similarly.

- Insert a provision in the PHL § 2981(d) template so that the means to revoke the template health care proxies is apparent from the face of the documents, such as the following:

  > I may revoke this proxy at any time by (a) executing a new proxy, (b) notifying a health care provider orally or in writing of such revocation; or (c) notifying my agent orally or in writing of such revocation.

- Add a PHL § 2985(f), and a corresponding provision to § 2981(d) so that revocations of health care agent appointments, like revocations of the authority of attorneys are apparent from the face of the document are under Title 15 powers of attorneys, should be permitted, which may done by adding a PHL § 2985(f), and a corresponding provision to the § 2981(d) template, such as the following:

  > (f) A competent adult may revoke a health care proxy appointment of an agent by notifying the agent or a health care provider orally or in writing or by any other act evidencing a specific intent to revoke the appointment of the agent.

So that the individual the principal wishes to assist the principal in obtaining and / or paying for his or health care may best fulfill such responsibilities, it is advisable to add the following to the list of the qualified person under PHL § 18, who are the only persons who are explicitly permitted to obtain the principal's patient information from their health care providers with a court special proceeding, to include the following:

- any individual who has a HIPAA compliant authorization to the extent of such authorization, who is either their health care agent under Article 29-C of the Public Health Law-Health Care, Agents and Proxies or their health care finance agent under Title 15 of Article 5 of the General Obligations Law."

  Thus, there would be no question principals may, if they wish, give health care agents or health care finance agents access to all their health care information. Attorneys at law already have such authority with appropriate powers of attorneys. Other persons with HIPAA-compliant authorizations do

not need a private right of action to obtain health information.

- "estate executors and administrators,"

  Thus, so that there would be no question that the principal's estate need not incur the costs of retaining attorneys at law to obtain health care information pertaining to the decedent's health care payment obligations or benefit entitlements. If executors are so authorized, administrators should be granted the same authority as executors in the same manner that the health care surrogates under PHL § 2994-d have the same such authority as health agents under PHL § 2982.

To avoid any confusion, the provision in PHL § 18 that qualified persons are deemed HIPAA personal representatives, that phrase should be deleted.

Finally, it is advisable that the New York State Office of Court Administration issue a HIPAA-compliant template which may be used by attorneys at law to obtain health records from any of the principal's health care providers similar to the template it has issued permitting an attorney at law to obtain health care records from a specified health care provider [OCA-Official Form No. 960]. Attorneys could then do this without using the extensive power of attorney that would otherwise be required to comply with the general requirements of Title 15 of the General Obligations Law. The template like the current template could give clients the ability to decline to provide access to HIV information, mental health information, and substance abuse information. It is advisable that the template notify the client that he or she may instead direct specific providers to give their attorneys the health information, so the client would have a real choice whether to give the attorney so much authority.

Conclusions

New York authorizes individuals to choose health care decision-makers and health care finance agents, who are treated as HIPAA personal representatives able to act in the place of their principals. HIPAA also authorizes individuals to choose agents to obtain health information on their behalf. It is advisable that the state and practitioners take the following steps to remove undue burdens from principals who wish to choose such agents to help them in obtaining and paying for health care:

- the readily accepted Short Statutory POA be modified to give principals the option of checking a box to give an agent responsibility for all the principal's health care finance issues, not merely for the principal's health care payment obligations.
- the state health care proxy, the family health decisions, and power of attorney statutes be modified so that health care agents and health care finance agents are explicitly granted the authority to access their principal's health care records that HIPAA grants, or authority much closer to that granted.
- the readily accepted statutory health care proxy and NYS DOH health care proxy templates explicitly describe how the proxy may be completely revoked and how the appointment of an agent may be revoked.
- the state health care information privacy statutes explicitly acknowledge the right of HIPAA personal representatives to generally obtain the health care information that their principals could obtain.
- practitioners offer their clients (1) powers of attorney that permit the appointment of health care finance agents with full authority pertaining to the principal's benefit entitlements; (2) health care proxies that describe how they may be revoked, and (3) HIPAA authorizations that permit their client's agents to obtain the health care information that the principals prefer,
- the OCA prepare a template for attorneys at law whose clients prefer that their attorneys request and obtain health care information directly from any of their clients' health care providers, rather than having to execute authorizations on behalf of their attorney for each provider.
- the state health care information privacy laws explicitly address HIPAA authorizations, not only those for attorneys at law considering medical malpractice actions, so that agnets may more easily obtain but for those who, wish so that agents may more easily obtain health care information directly from the principal's health care providers and if necessary may invoke a private right of action.

Endnotes

1. For purposes of this article we will not consider an individual's health providers who in such capacity often act as the individual's agent for health care. Nor will we consider individuals who are not capable of choosing agents for matters relating to their health care, such as infants and the mentally retarded.
2. Sec. 1171 through 1179 of the Social Security Act (42 U.S.C. 1320d-1329d-8) as added by sec. 262 and sec. 264 of Pub. L. 104-191, 110 Stat. 2021-2031.
3. Section 1171(4) of the Social Security Act, 42 U.S.C. 1320d.
4. 45 C.F.R. § 164.524. For simplicity, this article will describe the information accessible by HIPAA as health information, rather than as the subset which is individually identifiable health information, or the further subset of protected health information, to which HIPAA actually provides access. 45 C.F.R. § 164.501 Definitions.
5. *See e.g.*, 45 C.F.R. § 164.103.
6. 45 C.F.R. § 164.524(a)(3).
7. 45 C.F.R. § 164.524(a)(2)(v).
8. 45 C.F.R. § 164.524(a)(1)(i).
9. 45 C.F.R. § 164.524(a)(1)(ii).

10. We are not considering how health care providers may access their patients' identifiable individual health information or the ability of public health authorities to obtain such access.
11. *See* n. 4.
12. *See* 45 C.F.R. § 164.512(a) and the definition of "required by law" set forth in 45 C.F.R. § 164.501.
13. New York Civil Practice Rule 2303(a) ("CPLR") provides that subpoenas duces tecum must be served on each party who has appeared in the action before the production of the documents, which means an individual would have notice his health care provider had been served.
14. *But see* 45 C.F.R. § 164.512(e)(1) for the steps the attorney may take in such circumstances. *Cf.* Andrew King, Comment, *HIPAA: its Impact on ex Parte Disclosures with an Adverse Party's Treating Physician*, 34 CAP. U. L. REV. 775, 792-798 (2006) (those steps are similar to getting a court order), CPLR § 3122(a), and David Horowitz, *HIPAA…Help*, N.Y.S. BAR J. 20 (June 2005) ("HIPAA… Help").
15. 45 C.F.R. § 164.502(g)(1).
16. *Id.*
17. 45 C.F.R. §§ 45 C.F.R. 164.502(a)(1), (a)(2), 164.524(a)(1) and (b)(1).
18. 45 C.F.R. §§ 164.502(g)(1), (2). There is an exception if the covered entity believes treating the agent as a personal representative would endanger the individual or had previously abused or neglected the individual. 45 C.F.R. § 164.502(g)(5).
19. *See e.g.*, N.Y. Public Health Law Article 29-C (PHL), which describes health proxies recognized within New York.
20. *See e.g.*, N.Y. General Obligations Law Title 15 (GOL), which describes power of attorneys recognized within New York which may provide such authority.
21. 45 C.F.R. §§ 164.502(g)(1), (4).
22. *See also* Kathleen M. Burke, Alice Herb and Robert Swidler, *Three Stubborn Misconceptions About the Authority of Health Care Agents*, NYSBA HEALTH L. J. 63, 64 (Summer 2005) (hereinafter designated as "Health Care Agent Misconceptions").
23. 45 C.F.R. §§ 164.502(g)(2), (4). There are two major limits on such access. First, the access may be denied if the provider has a reasonable belief that the individual has been or may be subject to abuse, neglect or would be endangered by the representative. 45 C.F.R. § 164.502(g)(5). Second, the access may be denied if the provider has a reasonable belief that substantial harm to the individual or another person may result from the access. 45 C.F.R. § 164.524(a)(3)(iii).
24. A conscientious treating physician of the individual may, however, learn of such injury and decide after review that the individual's treatment and degree of recovery are quite relevant.
25. Conscientious health care decision-makers often want to know the available financial resources because those resources may help the decision-maker determine the prudent treatment.
26. http://www.hhs.gov/ocr/privacy/hipaa/faq/personal_representatives_and_minors/219.html [August 24, 2011].
27. PHL § 2981.3(c).
28. GOL § 5-1513.
29. *Id.* Parts (a) and (f).
30. 29 C.F.R. § 2560.503-1(b)(4). There seems to be no reported litigation on the attorney's right to this information and little commentary on this point. *Cf.* Greta E. Cowart, *HIPAA'S Privacy Regulations and Their Impact on Group Health Plans*—ALI-ABA COURSE OF STUDY MATERIALS (Sept. 2009) which discusses safeguards an ERISA plan must adopt with respect to disclosures to its own attorneys, who are treated as the plan's HIPAA business associates.
31. *See* NYS SCPA § 1001. If there are no next-of-kin, a government official, the public administrator, takes on such responsibility.
32. PHL Article 29-CC.
33. PHL § 2994-d. However, in addition to next of kin, a domestic partner is not only considered but given high priority in selecting a surrogate. *Id.* 1(b).
34. 45 C.F.R. §§ 164.524(a)(1) and (b)(1).
35. 45 C.F.R. § 164.502(a)(1)(iv).
36. 45 C.F.R. § 164.508.
37. 45 C.F.R. §§ 164.502(b)(1) and (2).
38. 45 C.F.R. § 164.508(b)(3).
39. 45 C.F.R. § 164.508(c)(2).
40. 45 C.F.R. § 164.508(b)(5).
41. 45 C.F.R. § 164.508(c)(1).
42. A person named in a will as executor, however, unlike the other two HIPAA personal representatives, must be approved by a court. The local surrogate's court must approve probate of the will and find the nominee qualified. N.Y. Surrogate's Court Procedure Act § 1414 (SCPA).
43. 45 C.F.R. § 164.530.
44. 45 C.F.R. § 160.308.
45. 45 C.F.R. § 160.306 and Statement of Delegation of Authority to Office for Civil Rights, 65 Fed. Reg. 82,381 (Dec. 28, 2000).
46. 42 U.S.C. § 1320d-5.
47. 42 U.S.C. § 1320d-6.
48. *See e.g.*, CYNTHIA MARCOTTE STAMER, *Medical Privacy* in SUSAN J. STABILE AND JAYNE E. ZANGLEIN, ERISA LITIGATION at 1319 (3rd Ed. 2008 & Supp. 2010).
49. *Id.* at 1279-1280. *See also* Jamie Lund, *Comment, ERISA Enforcement of the HIPAA Privacy Rules*, 72 U. CHI. L. REV. 1413 at 1443 (Fall 2005).
50. 42 U.S.C. § 17939(c).
51. *See e.g.*, Joshua Collins, Comment, *Toothless HIPAA: Searching for a Private Right of Action to Remedy Privacy Rule Violations*, 60 VAND. L. REV. (2007) and Daniel J. Oates, Comment, *HIPAA Hypocrisy and the Case for Enforcing Federal Privacy Standards Under State Law*, 30 Seattle UNIV. L. R. 745 (2007).
52. PHL § 2981.1.
53. PHL § 2980 Def. 8.
54. PHL § 2980 Def. 5.
55. PHL § 2981.4. This section requires that the determination be made pursuant to PHL § 2983.1 which requires a writing. *See also Stein v. County of Nassau*, 2011 U.S. App. LEXIS 7296 at *5 (2nd Cir. April 8, 2011) (the court observed that there was no showing of such a determination—the issue before the court was whether the agent had established the existence of this authority to the police she had sought to persuade to direct an ambulance with the principal to a certain hospital).
56. PHL § 2983.5.
57. PHL § 2981.5(d).
58. *Id.*
59. See http://www.health.state.ny.us/forms/doh-1430.pdf [August 24, 2011]. An explanation of health care proxies is also provided at this site.
60. *Cf. In the Matter of University Hospital of SUNY Upstate Medical Center*, 194 Misc. 2d 372, 754 N.Y.S.2d 153 ((Sup. Ct. Onondaga Co. 2002). A hospital was prevented from issuing a DNR order pursuant to a health care proxy and associated living will because the court held they were revoked. Neither document seemed to describe how they could be revoked.
61. The health care proxy statute, unlike GOL § 5-1511.1(d) for powers of attorneys, does not mention revocations with respect to a

specific person named in the proxy. However, even if, *arguendo*, such revocations are not permitted for health care proxies, one would expect such a named agent to decline to serve following such an attempted revocation by the principal.

62. 45 C.F.R. §§ 164.502(g)(1), (2). There is an exception if the covered entity believes treating the agent as a personal representative would endanger the individual or had previously abused or neglected the individual. 45 C.F.R. § 164.502(g)(5).

63. PHL § 2982.1.

64. PHL § 2982.3.

65. One may also argue that HIPAA preemption prohibits this state statute from limiting the HIPAA authority that results from the decision-making authority granted by a different part of the same statute.

66. *But cf.* Corine A. Carey, *Protecting Patient Privacy in the Era of Health Information Exchange*, NYSBA Health Law Section Meeting at 103 (Jan. 26, 2011) who argued that such limits be imposed on the access rights of health providers to protect the privacy of patients. It is unlikely that a principal would have a similar concern about a personal representative the principal selects to make his or her health care decisions, but in such case the supplemental HIPAA authorization would be inappropriate.

67. *See e.g.*, *Mougiannis v. North Shore-Long Island Jewish Health Systems*, 25 A.D.3d 230, 806 N.Y.S.2d 623 (2nd Dep't 2005) (Hospital had to be compelled to provide medical records to health care agent after the agent withdrew principal [her mother] from hospital because of concern about the quality of care). There is a question whether such reluctance would threaten the health of the principal, because at an earlier proceeding the hospital had "assured petitioner that her mother's treating physicians could gain access to *necessary medical information* by directly contacting the Hospital." N. Y. L. J. Vol. 231, May 19, 2004 (LaMarca J.) (emphasis added)

68. *Cf.* Health Care Agent Misconceptions at 63-65, which argues that no additional HIPAA authorization is needed and including such authorizations in a health care proxy may lead to rejections of otherwise valid health care proxies.

69. 45 C.F.R. § 164.508(b)(5).

70. This would be an issue if the principal is unable to execute an additional HIPAA authorization but still has capacity to make health care decisions. In such case, the agent could not rely upon the health care proxy to obtain any health care information.

71. I deliberately did not use the phrase "protected health information" or "protected health information as defined under HIPAA," which is the subset of the individually identifiable health information accessible under HIPAA. Such phrases seem to be inconsistent with the plain language requirement for HIPAA authorizations and obscure rather than clarify the kind of information to which the principal is giving access. I also prefer to use a narrower phrase than health information to emphasize the privacy concern of the HIPAA authorization.

72. GOL § 5-1501 Def. 2(j). Definition (k) of a principal also excludes arrangements which are not relevant to this article.

73. GOL § 5-1501.1 Definition (k), which defines a principal, also excludes arrangements which are not relevant to this article.

74. GOL § 5-1501C item 11.

75. *Id.*

76. *Id.*

77. GOL § 5-1501B.1(a)-(c).

78. GOL § 5-1513(a) describes the agent's fiduciary responsibilities.

79. GOL §§ 5-1505 describes the agent's ficudiary responsibilities.

80. GOL § 5-1501C item 11.

81. GOL § 5-1513.

82. GOL § 5-1502K.

83. *Id.*

84. GOL § 5-1502O.

85. GOL § 5-1502K item 1. It is advisable, as discussed, *infra*, to delete this language.

86. GOL § 5-1502b.1(d)(1).

87. GOL § 5-1502F.2

88. GOL § 5-1502F.4.

89. GOL § 5-1502J.

90. Although employer health care benefits and insurance health care benefits are both health care plan benefits, their plan representatives often prefer powers of attorney to distinguish the benefits. Thus, many practitioners do so. It should be noted that small employer self-administered employer plans are not subject to HIPAA. 45 C.F.R. § 160.103. Such exempt plans, however, generally respect Title 15 powers of attorney appointments of health care finance agents.

91. Health care finance agents are authorized to make decisions related to health care rather than health care decisions. The final sentence of item 1 of GOL 5-1502K fails to make that distinction.

92. 45 C.F.R. §§ 164.502(g)(1) and (2). There is an exception if the covered entity believes treating the agent as a personal representative would endanger the individual or had previously abused or neglected the individual. 45 C.F.R. § 164.502(g)(5)

93. 45 C.F.R. §§ 164.502(a)(2)(i), (g)(2) and 164.524(a)(1).

94. Sometimes this omission is deliberate by principals who wish to control carefully the health information their agents have access to. Covered entities can more easily keep records of which records were made available to an agent than which information is released orally.

95. There are two common modifications. First, there is a provision that prior powers may be revoked and / or the current power may be revoked only with a specific reference. Second, there is a grant of authority to hire, discharge and pay reasonable fees to professionals, which are necessary and proper for the agent to carry out his or her duties.

96. Attorneys are often quite concerned about leaving no question that health insurance premiums are a health care expense.

97. Health care finance agents are authorized to make decisions related to health care rather than health care decisions. The final sentence of item 1 of GOL 5-1502K fails to make that distinction.

98. 45 C.F.R. §§ 164.502(g)(1), (2). There is an exception if the covered entity believes treating the agent as a personal representative would endanger the individual or had previously abused or neglected the individual. 45 C.F.R. § 164.502(g)(5).

99. 45 C.F.R. §§ 164.502(a)(2)(i), (g)(2) and 164.524(a)(1).

100. 45 C.F.R. § 160.203.

101. 45 C.F.R. § 160.202 Definition of state law.

102. 45 C.F.R. § 160.203(b).

103. HHS FAQ, "How do I know if a State law is more stringent than the HIPAA Privacy Rule?" http: / / www.hhs.gov / ocr / privacy / hipaa / faq / preemption_of_state_law / 403.html. [August 24, 2011].

104. 45 C.F.R. § 160.202.

105. HHS FAQ "Will HHS make determinations as to whether a provision of State law is more stringent than or contrary to a provision of the HIPAA Privacy Rule?" http: / / www.hhs.gov / ocr / privacy / hipaa / faq / preemption_of_state_law / 408.html. [August 24, 2011].

106. http: / / www.health.state.ny.us / nysdoh / hipaa / pdf / hipaa_ preemption_charts.pdf [August 24, 2011].

107. PHL §§ 2782.1-4.

108. 10 NYCRR § 63.5(a). There is an exception for releases by health insurers.

109. PHL § 2782.5(a).

110. PHL § 2782.1(a).

111. PHL §§ 2782.1(a) and .5(a).

112. PHL § 2982.3 gives proxy agents access to health information notwithstanding any other law.

113. PHL § 2782.1(q).

114. PHL § 2782.5(a).

115. HHS FAQ "How do I know if a State law is contrary to the HIPAA Privacy Rule?" http://www.hhs.gov/ocr/privacy/hipaa/faq/preemption_of_state_law/402.html [August 24, 2011].

116. HIPAA has exclusions to this treatment, such as in abuse situations, the agent named as the health care agent is no longer treated as the principal's personal representative. 45 C.F.R. § 164.502(g)(5). None of these exceptions are applicable.

117. HHS FAQ, "How do I know if a State law is more stringent than the HIPAA Privacy Rule?" http://www.hhs.gov/ocr/privacy/hipaa/faq/preemption_of_state_law/403.html. [August 24, 2011].

118. PHL § 2782.5(a) and 10 NYCRR § 63.5(a).

119. PHL § 2783.

120. PHL § 2783.3.

121. 42 U.S.C. §§ 1320d-5 and 6.

122. *Cf.* 45 C.F.R. § 160.202 and PHL §§ 18.2, 18.1(b), 18.1(c), 18.1(d).

123. PHL §§ 18.2 and 18.1(e).

124. PHL § 18.1(g).

125. PHL §§ 18.2 and 18.3.

126. 45 C.F.R. § 160.512(a).

127. PHL § 18.4.

128. PHL § 18.3(f).

129. *Cf.* PHL § 2782.1.

130. PHL § 18.6.

131. NYS Form DOH-2557 (8/05).

132. *See* http://www.lawrevision.state.ny.us/reports/revised_final_commentary_2008.pdf at 11 [August 24, 2011].

133. *Id.*

134. New York L. 2004 ch. 634 introduced this statement in PHL § 18.1(g).

135. PHL § 18.1(g).

136. *Id.*

137. 45 C.F.R. §§ 164.502(a)(2)(i).

138. 45 C.F.R. § 164.502(g)(1).

139. PHL §§ 18.2(a), (d).

140. New York L. 2004 ch. 634 introduced this catchall in PHL § 18.3.(i).

141. *Mougiannis v. North Shore-Long Island Jewish Health Systems*, N. Y. L. J. Vol. 231, May 19, 2004. 2004 N.Y. Misc. LEXIS 3196 (S. Ct. Nassau, May 6, 2004) (LaMarca J.).

142. *Mougiannis v. North Shore-Long Island Jewish Health Systems*, 25 A.D.3d 230 at 236, 806 N.Y.S.2d 623 at 628 (2d Dep't 2005).

143. PHL § 18.1(g) added by L. 2004 ch. 634 effective on the October 26, 2004 date of enactment.

144. GOL § 5-1501C.3. Some attorneys appear to use powers that are not government forms and do not comply with Title 15.

145. Attorneys representing estates had been added in New York L. 1992 ch. 277. Estate fiduciaries are not qualified persons.

146. LEXIS statutory history of PHL § 18 [August 24, 2011]. *See also* "HIPAA…Help."

147. *Id.*

148. OCA-Official Form No. 960.

149. *Striegel v. Tofano*, 399 N.Y.S.2d 584 (N.Y. App. Div. 1977) (a patient has a common-law right of access to dental records regardless of the limitations of CPLR 3102(c), whose relevant sections have not changed).

150. See generally Joy L. Pritts, *Altered States: State Health Privacy Laws and the Impact of the Federal Health Privacy Rule*, 2 YALE J. HEALTH POL'Y L. & ETHICS 325,332-334 (2002).

151. 45 C.F.R. § 160.512(a).

152. *See e.g.*, *Burton v. Matteliano*, 81 A.D.3d 1272, 916 N.Y.S.2d 438 (App Div. 4th Dep't 2011), *Daly v. Metro. Life Ins. Co.*, 4 Misc. 3d 887, 891, 782 N.Y.S.2d 530 (N.Y. Sup. Ct. May 20, 2004), and *Doe v. Community Health Plan—Kaiser Corporation*, 268 A.D.2d 183, 709 N.Y.S.2d 215 (NY App. Div. 3rd Dep't 2000) (dismissal motion denied regarding common law claim that clerk allegedly disclosed confidential medical information—HIPAA not considered).

153. *Medtronic, Inc. v. Lohr* (1996) 518 U.S. 470, 485.

154. *Id.* at 487.

155. *Washington Mutual Bank v. Superior Court*, 75 Cal. App. 773, 782-784 (Ct. Ap. 2d. App. Div. 1999).

156. 45 C.F.R. § 160.203(b).

157. *See e.g.*, Joshua Collins, Comment, *Toothless HIPAA: Searching for a Private Right of Action to Remedy Privacy Rule Violations*, 60 VAND. L. REV. 199, 225-233 (2007) (discusses both breach of privacy actions and breach of confidentiality actions) and Peter A. Winn, *Confidentiality in Cyberspace: The HIPAA Privacy Rules and the Common Law*, 33 RUTGERS L. J. 617, 667-672 (2002).

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Changes to Public Health Law § 2801-d—Private Actions by Residents of Residential Health Care Facilities

By Andrew I. Bart

The United States is currently facing a crisis that has profound economic and societal implications—by 2030, one in five people will be 65 and over.[1] This aging population is reflected in the growing number of residents receiving care in nursing homes and the subsequent expansion in facility size. For example, the number of residents receiving care in nursing homes nationwide, on any given day, increased by 27 percent from 1977 to 1999; during that same period the number of beds per nursing home facility increased by 32 percent.[2] While statistics may be impressive, they do not tell the whole story. As we collectively age as a population, what is our responsibility to our seniors residing in these facilities? What will happen to our loved ones to ensure that they are protected from abuse or mistreatment when they are put into a nursing home? New York health care providers and patient advocates now find themselves on the cutting edge of an issue that must be addressed as we enter the second decade of the 21st Century.

New York State has, accordingly, recently amended subdivisions (1) and (4) of Public Health Law ("PHL") § 2801-d,[3] the statute that governs the right of patients to bring private actions against residential health care facilities[4] when injured as a result of being deprived of any right or benefit established by contract or state or federal statute, code, rule or regulation. The New York State Legislature specifically enacted the amendments to help dismantle the "barriers" that patients experienced "in bringing suits under this section of the law."[5] These amendments truly broaden the scope of the statute. Most significantly, subdivision (1) of the statute was amended to define "injury"—for the first time—to include, but not be limited to, emotional and physical harm, financial loss, and death,[6] and subdivision (4) was amended to specifically include language that the remedies available under the statute were in addition to, among other things, "tort causes of action" and that a violation of subdivision (3) of PHL § 2801-c "is not a prerequisite for a claim."

Interestingly, at a time when there is more interest in looking to ADR than lawsuits as a way of resolving disputes, these recent amendments seem to invite far more litigation. There is an argument, posited when the amendments were being debated, that the scarce resources that should be devoted to the care and treatment of our society's most vulnerable members will now be diverted instead to claimants and their lawyers.

To truly understand these amendments, and what they mean for both patient advocates and for residential care facilities, one must first delve into the legislative history of the statute, the statutory language itself, and the pre-amendment divide in the cases. In light of the floodgate of statutory claims that these amendments may now unleash, I have also addressed the statute from both a patient advocate's and a residential care facility's perspective.

Legislative History and Pre-Amendment Cases

PHL § 2801-d(1) was enacted "following the 1975 massive scandal of fraud and abuse in nursing homes" to "give patients increased powers to enforce their right to adequate treatment and care by providing them the right to sue for damages and other relief."[7] The statute thus provides, in relevant part, that "[a]ny residential health care facility that deprives any patient of any right or benefit…shall be liable to said patient for injuries suffered as a result of said deprivation… [A] 'right or benefit'…shall mean any right or benefit created or established for the well-being of the patient by the terms of any contract, by any state statute, code, rule or regulation or by any applicable federal statute, code, rule or regulation, where noncompliance by said facility with such statute, code, rule or regulation has not been expressly authorized by the appropriate government authority." *See* PHL § 2801-d(1).

The statute, moreover, explicitly provided, *pre-amendment*, that "the remedies provided in this section are in addition to and cumulative with any other remedies available to a patient, at law or in equity or by administrative proceedings." *See* pre-amendment PHL § 2801-d.

A. Split as to Whether Claims Under the Statute Limited Only to the Rights Set Forth in PHL § 2803-c

Despite this seemingly clear language, there was a split among the courts as to whether claims under the statute were limited *only* to those patients' rights specifically set forth in PHL § 2803-c and therefore did not extend to rights not delineated under that sub-section.[8] In *Begandy v. Richardson*, 134 Misc.2d 357, 510 N.Y.S.2d 984 (Sup. Ct., Monroe Co. 1987), for example, the trial court held that a nursing home patient, who fell down a flight of stairs and brought a negligence action against a nursing home, could *not* amend her complaint to include a claim under the statute. The plaintiff alleged that the defendant's violation of several regulations and contract provisions were the proximate cause of her injuries. Specifically, she alleged, among other things, that defendant's failure to lock, label or prevent access to a cellar stairway and to light said cellar stairway violated New York State Building Codes and portions of defendant's admission agreement as well

as 10 NYCRR 416.2 by failing to provide adequate care to prevent her from wandering.

The Court stated that "[t]he various memoranda which accompanied the enactment of section 2801-d indicate that the rights or benefits afforded an individual patient…are expressly set forth in Public Health Law 2803-c." *Begandy* at 360. The Court thus held that "section 2801-d is limited to those instances where the wrong complained of involves a deprivation of a personal right or benefit contemplated by section 2803-c…[s]ince the regulations and contract provisions upon which plaintiff seeks to base her claim under 2801-d pertain not to specific personal rights or benefits but generally to the condition of the building used by the facility, no claim is stated under that section." *Id.* at 362.

By contrast, the Appellate Division, First Department, in *Zeides v. Hebrew Home for the Aged at Riverdale*, 300 A.D.2d 178, 753 N.Y.S.2d 450 (1st Dep't 2002), had a much more expansive view of claims that could be asserted under the statute. The Court found that plaintiff had stated a cognizable cause of action by alleging that the decedent was denied the right "to receive adequate and appropriate medical care" under PHL § 2803-c(3)(e) when defendants violated 10 NYCRR 415.12 by failing to prevent the development of pressure sores and by failing to maintain adequate nutrition. *Zeides* at 178-79. The dissent felt, among other things, that the majority had overreached in its interpretation of "the scope of the cause of action created by Public Health Law Section 2801-d" and stated that the statute was merely "to provide a remedy for the denial of the essentially dignitary rights and benefits enumerated by Public Health Law Sec 2803-c(3)." *Zeides* at 181-82.

B. Split as to Whether Plaintiff Could Assert Both a Common Law Tort Cause of Action and a PHL § 2801-d Claim

A closely related issue also arose, prior to the enactment of the amendments, as to whether a plaintiff could assert both a nursing home claim under PHL § 2801-d and a common law tort cause of action using the same set of facts.

The practical distinction between a common law tort cause of action and a claim under PHL § 2801-d claim was, and remains, an important one to both patient advocates and to health care facilities. As the burdens of proof vary, a plaintiff may succeed in one cause of action and not the other as the common law and statutory claims are *not* duplicative. S*ee Pasqua v. Bon Secours New York Health System, Inc*., 13 Misc.3d 1036, 827 N.Y.S.2d 548 (Sup. Ct, Bronx Co. 2006).

The distinction between a PHL § 2801-d claim and common law negligence claims is set forth in *Sullivan v. Our Lady of Consolation Geriatric Care Center*, 60 A.D.3d 663, 875 N.Y.S.2d 116 (2d Dep't 2009), wherein the plaintiff brought a suit, alleging negligence and asserting a claim under the statute, to recover damages for injuries allegedly suffered by an elderly disabled woman in the care of a residential health care facility. The Appellate Division, Second Department, held that the trial court erred by overturning a jury verdict which found that the nursing facility did not violate certain federal and state regulations and thus did not violate the "right and benefits" that those regulations created for the patient's well-being. Plaintiff, therefore, had not established a viable PHL § 2801-d claim. *Sullivan* at 665.

Differences also exist with regard to the applicable limitations period. A PHL § 2801-d claim—like a claim sounding in negligence—is governed by the three-year statute of limitations set forth in CPLR § 214(2). *Zeides v. Hebrew Home for the Aged at Riverdale, Inc*., 300 A.D.2d 178, 753 N.Y.S.2d 450 (1st Dep't 2002); s*ee also Pasqua* at 1042. By contrast, a medical malpractice claim is governed by the 2½ year statute of limitations as set forth in CPLR § 214-a.

The Appellate Divisions, First and Third Departments, had ruled, prior to the enactment of the amendments, that plaintiffs could assert both a statutory claim and a common law tort cause of action. *Leclaire v. Fort Hudson Nursing Home, Inc*., 52 A.D.3d 1101, 861 N.Y.S.2d 436 (3d Dep't 2008); *Fleming v. Barnwell Nursing Home & Health Facilities*, 309 A.D.2d 1132, 766 N.Y.S.2d 241 (3d Dep't 2003); *Ward v. Eastchester Health Care Ctr., LLC*, 34 A.D.3d 247, 823 N.Y.S.2d 398 (1st Dep't 2006); *Zeides v. Hebrew Home for the Aged at Riverdale, Inc*., 300 A.D.2d 178, 753 N.Y.S.2d 450 (1st Dep't 2002).

The Appellate Division, Fourth Department first addressed this issue in *Goldberg v. Plaza Nursing Home*, 22 A.D.2d 1082, 635 N.Y.S.2d 841 (4th Dep't 1995), a case wherein the plaintiff alleged that the employees of the defendant nursing home ignored the calls of her mother to release her from a restraint vest and that the decedent was either strangled by the vest or suffered cardiac arrest. The Appellate Division, Fourth Department ruled that the trial court should have granted the defendant's motion for summary judgment and concluded that the statute's purpose was "not to create a new personal injury cause of action based on negligence when that remedy already existed." *Goldberg* at 1084. The Court held that, to allow a cause of action to stand on the statute, would "authorize a cause of action under that section for every case based upon negligence and implicating a residential health care facility." *Id.*

In *Doe v. Westfall Health Care Ctr*., 303 A.D.2d 102, 755 N.Y.S.2d 769 (4th Dep't 2002), the Appellate Division, Fourth Department carved out a limited exception to its *Goldberg* decision. In *Doe*, the plaintiff's decedent had been raped by an employee of the defendant nursing home and the plaintiff asserted both traditional tort causes of action and a PHL § 2801-d cause of action. The Court concluded that the plaintiff could assert a cause of

action under the statute based, in part, on the fact that although the common law tort causes of action survived a motion to dismiss, they "ultimately [might] not survive a motion for summary judgment." *Doe* at 112.

It was only in February 2009 that the Appellate Division, Fourth Department, in *Kash v. Jewish Home and Infirmary of Rochester, N.Y., Inc.*, 61 A.D.3d 146, 873 N.Y.S.2d 819 (4th Dep't 2009), held that a patient *could* move to amend her medical malpractice complaint to include a separate cause of action under PHL § 2801-d.

The Appellate Division, Second Department, however, had not, at the time of the amendments, ruled on this question. At least one trial court in the Second Department, however, denied plaintiff's request to amend his complaint, based on negligence and medical malpractice, to include a claim under the statute. *Acevedo v. Augustana Lutheran Home*, 7 Misc.3d 1005(A), 2004 WL 3261175 (Sup. Ct., Kings Co.).

The Legislature Amends § 2801-d to Expand Patient Rights

In 2009, the New York State Legislature dove into this morass with the purpose of "clarify[ing] the grounds for liability claims against nursing homes."[9] The Legislature's rationale for the amendments evidences a visceral reaction against the perceived restrictions that the courts had placed on the rights of plaintiffs to assert claims under PHL § 2801-d. The Legislature stated, in relevant part, that:

> [T]he experience of claimants alleging injury caused by facilities has been varied and uneven. Subdivision 4 of section 2801-d permits a nursing home patient to sue for injuries by the nursing home, and further specifies that "the remedies provided in this section are in addition to and cumulative with any other remedies available to a patient, at law or in equity or by administrative proceedings." *Despite this simple and direct language, patients and their representative [sic] have experienced barriers to bringing suits under this section of law.* Some courts have erroneously said that the section only applies to suing for violations of a specific Public Health Law § 2803-c relating to religion, privacy, consent, physical and chemical restraints and visitors. See, e.g., Begandy v. Richardson, 510 N.Y.S.2d 984. Other courts have been open to additional causes not enumerated in § 2803-c. See, e.g., Zeides v. Hebrew Home for the Aged, 753 N.Y.S.2d 450. *This bill would make it clear that the statute means what it says that the right to sue applies to any injury to the patient by the nursing home. This bill will also establish in plain language that the right to sue extends to injuries against physical and emotional health, financial injury as well as death, and that a violation of section 2803-c is not a prerequisite for claim under section 2801-d. [emphasis added].*

Thus, subdivision (1) of § 2801-d was amended to clarify that "for the purposes of this section, 'injury' shall include, but not be limited to, physical harm to a patient; emotional harm to a patient; death of a patient; and financial loss to a patient." Subdivision (4) § 2801-d, which pre-amendment provided that statutory remedies were "in addition to and cumulative with" other remedies available to a patient at law, in equity, or by administrative proceedings added the following language: "including tort causes of action, and may be granted regardless of whether such other remedies are available or are sought. A violation of subdivision three of section twenty-eight hundred three-c of this article is not a prerequisite for a claim under this section." *See*, PHL § 2801-d.

Effect of Recent Amendments to the Statute

Rather than merely "clarify" the statute, the Legislature actually *broadened* patient access to the statute in that advocates can now: (1) safely assert both common law claims and a PHL § 2801-c claim; and (2) assert a PHL § 2801-d claim that is not limited to the rights set forth in PHL § 2803-c; and (3) assert claims under a broad definition of what constitutes a statutory injury. The amendments took effect June 9, 2009 but as yet have not been the subject of a published opinion.

Yet using the facts in the *Begandy* case as an example, it is plain to see how the landscape has changed. In *Begandy*, the plaintiff sought to amend his personal injury complaint based upon violations of both the New York State Building Code and certain provisions of the defendants' admissions agreement. As set forth earlier in the article, the Court denied the motion for leave to amend as it found that claims under PHL § 2801-d were limited to the violation of the rights set forth in PHL § 2803-c, those rights including, among others, the right not to have one's civil and religious liberties infringed, the right to private communications, the right to manage one's own financial affairs, the right to be fully informed of one's medical condition and treatment, the right to present grievances without reprisal, and the right to be free from mental and physical abuse and from physical and chemical restraints.

Post-amendment, however, it would appear that such a plaintiff can: (1) successfully assert both common law personal injury claims and a PHL § 2801-d claim; and (2) assert his claim that a facility violated the statute by, in part, failing to comply with the New York State Building Code. The theory being that, under the statute, the plaintiff was deprived by the facility of a "right or benefit" according to him under the New York Building Code.

Clearly, a nursing home today is facing a whole new category of claims based upon its alleged failure to comply with relevant building codes and/or provisions of its admissions agreement that obviously do not implicate the rights set forth in PHL § 2803-c.

Where does this liability end? Will nursing homes be liable for any alleged violation of any "contract or state or federal statute, code, rule or regulation"? The statute, as amended, clearly does not require that a plaintiff allege that he was deprived of any of the enumerated rights set forth in PHL § 2803-c in order to pursue a claim under PHL § 2801-d. Nor is there, post-amendment, *any* limitation on the type of injury that may be asserted by the plaintiff.

Pursuing/Defending Claims Under the Statute

A. From a Patient's Perspective

For patients and their advocates, pursuing a claim under the statute is an attractive option. First of all, the statute clearly provides that any damages recovered by a patient "shall be exempt for the purposes of determining initial or continuing eligibility for [Medicaid]." PHL § 2801-d(5). The statute, moreover:

- Requires that compensatory damages awarded by the jury must be "no less than twenty-five percent of the daily patient rate" as permitted by PHL § 2807. If there is no established rate, "the average daily charges per patient at the facility" is used. PHL § 2801-d(2);
- Provides for the assessment of punitive damages when the deprivation of a patient's rights was willful or the facility acted in reckless disregard of patient's rights. PHL § 2801-d(2); and
- Grants the trial court discretion to award attorney's fees to the plaintiff. PHL § 2801-d(6).

A plaintiff, as per the amendments, can now assert both common law claims in negligence and medical malpractice and a claim under the statute. The distinction between asserting a common law tort claim and a statutory claim, in regard to the differing burdens or proof and the statute of limitation periods, is set forth above.

Patient advocates should also be aware that a claim based on PHL § 2801-d can be brought as a class action if the prerequisites to certification are met. *See* PHL § 2801-d (5); *Fleming v. Barnwell Nursing Home and Health Facilities*, 309 A.D.2d 1132, 1133, 766 N.Y.S.2d 241 (3d Dep't 2003).

B. From a Health Care Facility's Perspective

A health care facility, when faced with a PHL § 2801-d claim, has an absolute affirmative defense if it can prove that it "exercised all care reasonably necessary to prevent and limit the deprivation and injury." PHL § 2801-d(1). How does this affirmative defense play out in the real world? Does this mean that even if a facility violated a regulation that benefited a patient but thereafter exercised reasonable care to prevent injury to a patient, that the facility is not liable? What does the term "reasonably necessary" mean?

Although there are no published cases that examine this affirmative defense in any depth, there is a clear analogy between the affirmative defense under PHL § 2801-d and the defenses raised by a health care facility when faced with a ordinary negligence and/or a medical malpractice claim. As set forth below, a health care facility will defend itself against a cause of action differently depending on whether a cause of action sounds in medical malpractice or ordinary negligence. I would thus posit that a facility, when faced with a PHL § 2801-d(1) claim, should prepare a defense strategy based on whether the claim sounds in medical malpractice or ordinary negligence.

Courts have generally held that "[a] hospital or medical facility has a general duty to exercise reasonable care and diligence in safeguarding a patient, based in part on the capacity of the patient to provide for his or her own safety." *D'Elia v. Menorah Home and Hospital for the Aged and Infirm*, 51 A.D.3d 848, 850, 859 N.Y.S.2d 224 (2d Dep't 2008); *White v. Sheehan Memorial Hospital*, 119 A.D.2d 989, 500 N.Y.S.2d 885 (4th Dep't 1986).

There is a distinction between the two types of negligence, however, and it "turns on whether the acts or omissions complained of involve a matter of medical science or art requiring special skills not ordinarily possessed by lay persons or whether the conducts complained of can instead be assessed on the basis of the common everyday experience of the trier of fact." *Miller v. Albany Med. Ctr. Hospital*, 965 A.D.2d 977, 978, 464 N.Y.S.2d 297 (3d Dep't 1983). This distinction is set forth clearly in *D'Elia* which held, in relevant part, that:

> [A] claim will be deemed to sound in medical malpractice when the challenged conduct constitutes medical treatment or bears a substantial relationship to the rendition of medical treatment by a licensed physician…when the complaint challenges the medical facility's performance of functions that are an integral part of the process of rendering medical treatment and diagnosis to a patient, such as taking a medical history and determining the need for restraints, it sounds in medical malpractice…when the gravamen of the action concerns the alleged failure to exercise ordinary and reasonable care to insure that no unnecessary harm befell the patient, the claim sounds in ordinary negligence.

D'Elia at 850-851.

The *D'Elia* case is instructive in the defenses available to a nursing home when facing both ordinary negligence and medical malpractice claims. In *D'Elia*, plaintiff's decedent was 91 years old and suffering from serious medical conditions, including heart failure, when she was admitted to the defendant nursing home. After falling once, she was identified by the home as being at a risk for falls. She nonetheless fell again, at a time when her private caretakers were not present, when trying to reach the bathroom without assistance and, among other things, broke her hip. She died later the same day of heart and renal failure. The plaintiff alleged, among other things, that the nursing home was negligent because it allowed the decedent to remain in bed without restraints to prevent her from falling out of her bed and that the injuries from the fall when she tried to reach the bathroom led to her death.

The Appellate Division, Second Department, found that the first cause of action, based on negligence, encompassed allegations of both medical malpractice and "ordinary" negligence. The Court held that the nursing home had established its *prima facie* entitlement to summary judgment in regard to the medical malpractice allegations as it provided an expert affidavit opining that, because she was "gravely ill" in the days leading up to her death, she was not at "imminent risk" of falling and thus restraints were not medically advised or advised. The plaintiff failed to submit an expert affidavit opining that the nursing home deviated from acceptable medical practice. *D'Elia* at 851.

However, the nursing home was *not* entitled to summary judgment with regard to the "ordinary" negligence allegations that it failed to use any safety devices or tools to protect decedent during the period when her private caretakers were not present. While the nursing home did make a *prima facie* showing that it exercised reasonable care, the plaintiff submitted evidence, including testimony from the supervising nurse, that raised questions of fact as to whether the nursing home negligently failed to implement available precautions to protect the decedent from a foreseeable risk of falling. *D'Elia* at 852; *but see*, *Alexander v. American Medical Response*, 68 A.D.3d 1026, 893 N.Y.S.2d 87 (2d Dep't 2009) (Nursing facilities "demonstrated their prima facie entitlement to judgment as a matter of law by establishing, inter alia, that they satisfied their respective duties to 'exercise reasonable care and diligence in safeguarding' the decedent…[i]n opposition, the plaintiff failed to raise a triable issue of fact…
[t]he affidavit of the plaintiff's expert was not probative of the issue of whether [the facilities] satisfied their respective duties to safeguard the decedent…[f]urthermore, contrary to the plaintiff's contention, her submissions failed to establish, among other things, that [the facilities'] staff failed to abide by [their] internal rules and policies").

A recent decision in Nassau County (May 2010) provides a good illustration of how a nursing home was able to—at least at the trial court level—get a PHL § 2801-d claim dismissed on a summary judgment motion. In *Gold v. Park Avenue Extended Care Center Corp d/b/a Park Avenue Extended Care Center*, No: 10309/07, Sup. Ct., Nassau Co., the plaintiff brought a medical malpractice action, asserting, among other things, a violation of § 2801-d, and common law negligence, claiming that the decedent sustained personal injuries and died as a result of receiving substandard care at the defendant health care facility. Specifically, plaintiff alleged that, as a result of defendant's failure to install side rails upon decedent's bed, and as a result of defendant's failure to provide her with proper supervision, she sustained numerous falls which led her to suffer a stroke, dementia, and, ultimately, an untimely death.

The Court, examining the PHL § 2801-d claim, found that "[i]n order to recover…plaintiff must establish, as in a traditional personal injury case, that there were "injuries suffered as a result of said deprivation." Defendant submitted an opinion from a doctor who was board-certified in internal medicine and cardiovascular disease with a subcertification in geriatric medicine, who, the Court found, established: (1) there were no deficiencies in the degree of supervision given the decedent's health and status during her residency; (2) that the use of a physical restraint would have been inappropriate for the decedent; and (3) that the absence of a physical restraint did not proximately cause any injury to the decedent (none of the falls at issue were from decedent's bed). The only possible injury the decedent sustained from the lack of a physical restraint, according to defendant's expert, was a bruised forehead.

Plaintiff's opposition relied principally upon the affidavit of a registered nurse. In light of defendant's medical expert affidavit, the Court found her assertion "entirely meritless" that 42 CFR[10] § 483.25[11] was violated and that decedent was injured thereby. The Court also found that, although defendant claimed that the "dignity" subsection of 42 CFR § 483.15(a)[12] had been violated, the registered nurse failed to identify any acts that violated this statute or any injuries resulting from any such violation suffered as a result of the statue being violated. The nurse's affidavit, moreover, failed to establish a PHL § 2801-d claim based upon a violation of 42 CFR § 483.20[k][3][I];[13] she failed to establish that the decedent's claims related to fall prevention, stroke prevention (allegedly the nursing home failed to continue the decedent's blood pressure medication), blood pressure medication administration and ulcer prevention and care.

In short, the Court granted defendant's motion for summary judgment as plaintiff failed to raise an issue of fact with respect to his medical malpractice claims.

Conclusion

Both patient advocates and health care facilities should be aware of the changes to PHL §2801-d and the implications of these changes for future lawsuits. The protection of our seniors is imperative in an aging society and yet we must ensure that the facilities that care for our loved ones are able to defend themselves against baseless lawsuits. It will be interesting to see how courts and practitioners balance these competing interests under amended PHL § 2801-d.

Endnotes

1. "Trends in Health Status and Heath Care Use Among Older Men," Mabel Crescioni, Yelena Gorina, Linda Bilheimer, and Richard Gillium, National Health Statistic Reports, No 24, Hyattsville, MD: National Center for Health Statistics, 2010.
2. "Nursing Homes, 1977-99: What Has Changed, What Has Not?," Frederic H. Decker, Hyattsville, MD, National Center for Health Statistics, 2005.
3. The amended statute was signed into law by Gov. David A. Paterson in June 2009.
4. A "residential health care facility" is defined as "nursing home or a facility providing health-related service." A "nursing home," in turn, is defined as "a facility providing therein 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, and in addition thereto, providing nursing care and health-related service, or either of them, to persons who are not occupants of the facility." "Health-related service" means service in a facility or facilities which provide or offer lodging, board and physical care including, but not limited to, the recording of health information, dietary supervision and supervised hygienic services incident to such service." *See* PHL § 2801.
5. *See* A.763 and S.3907.
6. *See* PHL § 2801-d.
7. S.3907 and A.763.
8. PHL § 2803-c (2) provides that "every nursing home and facility providing health care related service" shall "make public a statement of the rights and responsibilities of the patients who are receiving care in such facilities and shall treat patients in accordance with the provisions of such statement." Subdivision (3) of PHL § 2803-c sets forth the patient's rights which include, but are not limited to, the right not to have one's civil and religious liberties infringed, the right to private communications, the right to manage his own financial affairs, the right to be fully informed of his medical condition and treatment, the right to present grievances without reprisal, and the right to be free from mental and physical abuse and from physical and chemical restraints.
9. A.763 and S.3907 memorandum.
10. Code of Federal Regulations.
11. 42 CFR § 483.25 provides that "[e]ach resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care" regarding accident hazards, adequacy of supervision, and assistant devices to prevent accidents.
12. The "dignity" subsection of 42 CFR § 483.15(a) provides, in relevant part, that residential care should be done "in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality."
13. 42 CFR § 483.20 [k][3][I] provides that "services provided or arranged by the facility" must "meet professional standards of quality."

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A Practical Guide to the New York State Physician Profile

David A. Zarett and Joshua A. Boxer

I. Background

After some highly publicized cases involving "bad outcomes" by physicians with prior disciplinary histories which were otherwise unknown to the public, in particular the Lisa Smart matter of 1997, the New York State Legislature passed, and Governor George Pataki signed into law, the New York Patient Health Information and Quality Improvement Act of 2000 (the "Act"), creating what we now know as the New York State Physician Profile ("the Profile").[1]

The Act can be found at New York Public Health Law § 2995 *et seq.* ("the Profile Statute") and its regulations can be found at Title 10 NYCRR 1000 *et seq.* (hereinafter, the "Profile Regulations"). In general the Profile is a publicly available online database which contains a wealth of information about every physician licensed in New York State, including background on a physician's medical education and training, board certification, medical staff privileging, and legal actions taken against the physician such as medical malpractice awards or settlements.[2] In February 2002, some two years after the Act was signed, the Profile went live.[3] The stated purpose of the Profile is to provide patients with information about health care providers and thereby improve the quality of health care in New York State.[4]

II. Data Collected—Initial Data and Updating Requirements

The data collected in the Profile spans from "required data," such as education and board certification, to "optional data" such as publications and a statement by the physician. Significantly, New York Public Health Law § 2995-a (7) states that a physician who provides materially inaccurate information to the Profile is guilty of professional misconduct. One explanation for this particular provision is that the information maintained by the Profile is based on the information reported by the physicians in their initial profile submission upon licensure (10 NYCRR 1000.4) and pursuant to the physician's self-updating requirements (10 NYCRR 1000.5).

The initial Profile information is collected in accordance with 10 NYCRR 1000.4, which states that the Department of Health will send an initial profile survey to every newly licensed physician in the State of New York. This initial profile survey was also sent to all currently licensed physicians when the Act became law in 2000. For many physicians, this initial Profile survey is the only time that they provide information to the Profile, however, the Profile Regulations provide for more frequent updating. Pursuant to 10 NYCRR1000.5, physicians licensed in the State of New York are required to notify the Profile of any change in their "non-optional" information within 30-days. Any change in "optional information" must be reported to the Profile within 365 days.[5] Finally, as a condition of license renewal, physicians are required to update their Profile information within six months prior to the expiration date of their registration period.[6]

Physicians can update their Profile information by contacting the Profile customer service center and obtaining a Physician Survey Form. The Physician Survey Form is a ten-page form which lists all the information a physician will find in his or her Profile and allows for modifications which are then submitted to the Profile for updating.[7] There is also an online updating option which requires that the physician obtain a username and password from New York State.[8]

III. How Is the Profile Utilized?

The Profile is utilized by patients, insurance payors, hospitals and physician rating / review websites (such as healthygrades.com and vitals.com), amongst others. The Profile has vastly increased the amount of data available to the public regarding physicians licensed in the State of New York. While many utilize the Profile, the information on the Profile is primarily based on self-reported data.[9] Failure of physicians to timely self-report to the Profile has an obvious negative effect on the ability of patients to make informed decisions regarding their choice in practitioner and puts into question the accuracy of the information presented by physician ratings websites. It also puts physicians at risk for not following the Profile updating requirements. Attorneys representing physicians would be wise to remind their physician clients to confirm the accuracy of their profiles and to timely update their profiles. But that is easier said than done due to the lack of regulatory guidance about Profile updating.

IV. Practical Guidance

There is confusion about what information needs to be updated to the Profile and when such updating responsibilities are triggered. One such area of confusion which we have encountered in our practice relates to New York Public Health Law § 2995-a(1)(d), the reporting of hospital privileges restrictions. Any restriction or loss of a physician's hospital privileges constitutes non-optional information which requires updating to the Profile within 30-days.[10] Recognizing physicians' due process rights to challenge a disciplinary action taken against their privileges by a hospital, New York Public Health Law §

2995-a(1)(d) states that a physician must submit to the Profile "a statement of any loss or involuntary restriction of hospital privileges or a failure to renew professional privileges at hospitals within the last ten years, for reasons related to the quality of patient care delivered or to be delivered by the physician **where procedural due process has been afforded, exhausted, or waived**, or the resignation from or removal of medical staff membership or restriction of privileges at a hospital taken in lieu of a pending disciplinary case related to the quality of patient care delivered or to be delivered by the physician…" (bold for emphasis).

In our practice we have faced this issue when representing physicians who have their hospital privileges summarily suspended, sought appeal of the suspension via the hospital due process hearing rights, and were successful in reversing the suspension through the intra-hospital hearing process. Upon review of the Profile Statute and Regulations, along with consultation with representatives at the Profile, we advised our clients that an update was not necessary even though they had been suspended from clinical practice at their respective hospitals for an extended period of time during the pendency of the internal due process hearing process. From a tactical standpoint, the ability to delay the updating or potentially avoid the updating of a hospital privileging adverse action can be very beneficial when representing a physician who is facing such a predicament. As a result of the paucity of regulatory guidance on the specifics of Profile updating in nuanced situations such as these, we have found it necessary to request two opinions from the Profile to determine whether a physician-client's Profile updating obligations had been triggered. Requesting an opinion from the Profile on reporting obligations for your physician clients is a worthwhile avenue for attorneys to evaluate a physician's updating obligations, especially when an update would have the potential to damage a practitioner's reputation. We have also found it helpful at times to call the Profile and speak to one of the knowledgeable staff members on specific client related issues.

Finally, on multiple occasions we have assisted physicians who received notice from the Profile of a posting of a malpractice award, with an appeal pursuant to 10 NYCRR 1000.3, requesting reversal of the decision to publish the award.[11] This written appeals process permits the physician to submit factual clinical information to the Department of Health, which reviews the submission under the standard of whether the settlement / award is "relevant to patient decisionmaking."[12] In our practice, we represented a physician who had a substantial money damages verdict against him. Though it was his first settlement / award the Profile sought to post the award pursuant to 10 NYCRR 1000.3(b)(2)(i) as the plaintiff had suffered a permanent injury. We successfully appealed the decision to post the award to the Profile. While the jury found our client liable, the Profile (through the panel set up to review Profile appeals pursuant to 10 NYCRR 1000.3(b)(2)(ii)(a)) agreed that, "…despite the awarding of payment to a complaining party, appropriate provision of patient care was provided."[13] It is important to note the 30-day time limit by which the appeal must be submitted is based on the date of the Profile notice, **not** the date of receipt of the notice.[14]

V. Conclusion

If you are an attorney who represents physicians it is important for you to consider Profile related issues when representing your client in a wide array of matters. From the benign situation of a physician resigning privileges at one hospital in order to take a new position at another institution, to the more serious and career-threatening situation of a physician facing criminal charges, each may trigger a Profile update obligation.

For those attorneys who represent physicians before the Office of Professional Medical Conduct ("OPMC"), one of the first things mentioned at the physician's Interview by the OPMC investigator is the physician's need to update his or her Profile. Ideally as a result of your counsel, your client will be able to inform OPMC that he or she is in full compliance with their Profile updating obligations. Furthermore, as explained, it is also critical that the physician's Profile information be accurate as misleading information to the Profile constitutes professional misconduct.[15] A relatively simple way to verify your clients' accurate reporting to the Profile is to assist them with the completion of their Physician Survey Form. Finally, if your client is faced with the obligation to update a negative change to his or her Profile (such as a criminal conviction) you may want to consider submitting an optional statement in which the physician can explain the conviction and potentially limit the reputational damage that can understandably result from such an update.

Endnotes

1. See Buettner and Sherman, New York Daily News, March 8, 2000, "Fight For Law To Open Malpractice Records."
2. See Public Health Law § 2995-a, which lists the information collected by the New York State Physician Profile.
3. The New York State Profile is located at www.nydoctorprofile.com.
4. New York Public Health Law § 2995(1).
5. The non-optional information that a physician must update to the Profile within thirty days of any such change includes education and certification, board certification, teaching appointments, hospital privileges, participation in state or federal health insurance programs, translation services offered at his or her office, malpractice award payments, license actions, hospital privileging limitations, and criminal convictions. The optional information that a physician must update within 365-days of any such change includes practice office location, publications, professional community service activities, health plan contracts or other affiliations, and the physician's concise statement which is an optional statement a physician can include on their Profile.
6. New York Public Health Law § 2995-a (4).

7. The Profile Customer Service Center can be reached at (888) 338-6999.
8. To obtain e-access for Profile updating online contact the New York State Health Provider Network at (866) 529-1890 to apply for an HPN account.
9. Along with the self-reporting obligations of 10 NYCRR 1000.3, malpractice judgments and / or settlements are separately reported by professional liability carriers pursuant to N.Y. Ins. Law § 315.
10. NYCRR 1000.5(a).
11. A physician is able to appeal a malpractice settlement / award posting to the Profile if he or she has two or fewer awards / settlements within the most recent 10 years. 10 NYCRR 1000.3(b)(1).
12. 10 NYCRR 1000.3(b)(2)(ii)(a).
13. 10 NYCRR 1000.3(b)(2)(ii)(a).
14. 10 NYCRR 1000.3(b)(2)(ii)(b).
15. See New York Public Health Law § 2995-a (7).

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Legislative Report: In Support of the Surrogate Decision-Making Improvement Act*

NYSBA Health Law Section

Bill: **A.7343—**An Act to amend the public health law and the surrogate's court procedure act, in relation to orders not to resuscitate for residents of mental hygiene facilities; making technical, clarifying and coordinating amendments regarding health care agents and proxies, amending provisions relating to health care decisions for people with developmental disabilities; and to repeal article 29-B of the public health law relating to orders not to resuscitate for residents of mental hygiene facilities.

Also known as "The Surrogate Decision-Making Improvement Act (SDMIA)"

Position: **Support**

The NYSBA Health Law Section has long supported changes in New York law that would promote the rights and interests of patients. The Health Law Section was a strong supporter of the Family Health Care Decisions Act (Ch. 8, L. 2010) and is committed to help ensure the successful implementation of the FHCDA, and to identify, advance and support proposals to improve the FHCDA and other statutes that govern decisions on behalf of patients who lack the capacity to decide for themselves.

To facilitate successful implementation of the FHCDA, the Section has undertaken several activities. The Section, its leaders, and members, have:

- created a website, accessible to the public, with extensive information about the FHCDA, including a detailed set of frequently asked questions and answers.[1]
- organized several professional educational programs.[2]
- published a special edition of the NYS Bar Association *Health Law Journal* on "Implementing the Family Health Care Decisions Act," with sixteen articles on the FHCDA by attorneys, physicians, bioethicists and others.[3]
- published other important articles on the FHCDA.[4]

The FHCDA effected sweeping changes in New York law to improve decision-making for incapacitated patients by expanding, and clarifying the authority of family members, domestic partners, and others close to the patient to make health care decisions for patients who lack capacity and did not previously appoint a health care agent, in accord with appropriate standards and safeguards.

At this time, it is clear that the statute should be extended to cover decisions about hospice care and to govern decisions about CPR in facilities licensed or operated by the Office of Mental Health. In addition, provisions of the Health Care Proxy Law, the Surrogate's Court Procedure Act, and the FHCDA also require revision to reconcile language in the three laws to clarify the intent of certain provisions. For this reason, the Health Law Section supports the Surrogate Decision-Making Improvement Act.

Summary and Analysis

The SDMIA, in its more significant provisions, will:

1. Replace PHL Article 29-B, Orders Not to Resuscitate for Mental Hygiene Facilities (SDMIA §1)

PHL Article 29-B ("Orders Not to Resuscitate in Mental Hygiene Facilities") governs DNR orders in OPWDD-operated "schools" (an outdated term) and in OMH-operated and licensed psychiatric hospitals and units. There is no longer a need for this article. DNR decisions in OPWDD-operated developmental centers facilities (the successor to OMRDD "schools") are already governed by SCPA 1750-b. DNR decisions in psychiatric hospitals and units could easily be made subject to the FHCDA, which has principles similar to those in PHL Art. 29-B. This would be particularly helpful for general hospitals, which now have to follow slightly different DNR rules in their medical units from those in their psychiatric units, with no policy rationale for the differences

2. Reconcile the authority of agents and surrogates with respect to decisions about medically provided nutrition and hydration (§4)

When strict clinical criteria are satisfied, the FHCDA allows a surrogate to make a decision to withhold or withdraw life-sustaining treatment, including medically provided nutrition and hydration based on the patient's wishes, if reasonably known, or else the patient's best interests. But the Health Care Proxy Law authorizes an agent to decide to withhold or withdraw medically provided nutrition and hydration based solely on the patient's wishes, if reasonably known—and not the patient's best interests if the patient's wishes are not reasonably known. The SDMIA would amend the Health Care Proxy Law to allow an agent to make a decision about artifi-

cial nutrition and hydration based on the patient's best interests. This is an appropriate amendment—a health care agent, specifically appointed by the patient, should be able to act in furtherance of a principal's best interests when the patient's wishes are not reasonably known. (§4).

3. Conform various provisions in the Health Care Proxy Law and the FHCDA (SDMIA §§5, 13)

The SDMIA eliminates many discrepancies in language between the health care proxy law and the FHCDA, mostly in the provisions about determining incapacity. Those discrepancies, though mostly non-substantive, are a source of confusion and other implementation complications.

4. Require a concurring determination of incapacity, and a determination of incapacity by specially qualified professionals, only for life-sustaining treatment decisions

Currently, both the Health Care Proxy Law and the FHCDA require: (i) that the attending physician determine whether a patient lacks capacity; (ii) that if the decision relates to the withdrawal or witholding of life-sustaining treatment there must be a concurring determination of incapacity; and (iii) that if the basis for that determination is a developmental disability or mental illness, either the attending physician must have special qualifications or must secure a concurring opinion by another person with specified qualifications. Also, the FHCDA requires a concurring opinion of incapacity for all determinations involving nursing home residents. The SDMIA amendment would make the Health Care Proxy Law and FHCDA requirement of a determination by a person with specialized qualifications, and the FHCDA requirement of a concurring opinion in nursing homes, applicable only to cases involving withdrawal or witholding life-sustaining treatment decisions, and not to cases involving consent to treatment. This change ensures that additional safeguards, and the additional time, effort and resources that those safeguards require, are mandated in the cases where they are most important—for decisions to withhold or withdraw life-sustaining treatment—and not where they could impede the delivery of treatment to a patient. (§§5, 13).

5. Clarify that the duties that arise when a surrogate insists upon treatment do not apply when the hospital or physician is carrying out an adult patient's prior decision (§§7, 17)

Currently, both the Health Care Proxy Law and FHCDA state that if a health care agent or surrogate directs the provision of life-sustaining treatment, but the hospital or individual health care provider "does not wish to provide such treatment," the hospital or individual provider nevertheless must either comply with the agent's decision, transfer the patient or seek court review. §§2984.5 and 2994-f.3. The SDMIA would amend this requirement to clarify that it does not apply:

- in the case of a health care agent, when the hospital or individual health care provider is carrying out a prior decision by the patient. (§7), and
- in the case of a surrogate, when the hospital or individual health care provider is carrying out a prior decision by the patient made in accord with the FHCDA provisions.

The obligation to honor the clear prior instructions of an adult patient is firmly supported by the United States and New York State Constitutions, as well as numerous federal and New York State statutes, regulations and case-law. Sections 2984.5 and 2994-f.3 should not be read to override that obligation. Moreover, under the FHCDA, if a provider has adequate prior instructions from a patient, there is no need to seek an agent's or surrogate's consent. See §2994-d.3(ii).

6. Extend the FHCDA to decisions regarding hospice care (§§10, 11, 14, 18, 19, 20, 24)

Currently, the FHCDA applies only to decisions regarding health care provided in hospitals and nursing homes. As a result, if patient is dying, meets hospice eligibility criteria, lacks capacity and is in a hospital or nursing home, the FHCDA empowers a surrogate to elect hospice care for the patient and consent to treatment decisions during the course of the patient's hospice care while in the hospital or nursing home. But if the patient is NOT in a hospital or nursing home, or leaves the hospital or nursing home, the surrogate lacks or loses any authority.

As directed by Chapter 8, L. 2010, the New York State Task Force on Life and the Law studied this issue and recommended that the Legislature extend the FHCDA to cover decisions regarding hospice care regardless of where the patient is located. See http://www.health.state.ny.us/regulations/task_force/reports_publications/. This is an especially valuable and pressing amendment, and will help many dying patients who would benefit from hospice care but cannot legally be admitted to a hospice program unless and until they are hospitalized.

7. Clarify medical futility as a basis for a DNR order (§§15, 19, 33)

The FHCDA establishes that two physicians can consent to a DNR order if the treatment "offers the patient no medical benefit and the patient will die imminently even if treatment is provided, and the provision of treatment would violate accepted medical standards..." The proposed amendment in Section 19 clarifies the meaning of medical futility in the context of a DNR order. The amendments also clarify that physicians can enter a DNR order on the basis of medical futility even if the patient is eligible for decision-making by an article 80 surrogate decision-making committee, since the decision about

futility, as defined in the statute, is strictly a medical determination.

Under the former DNR law (PHL Art 29-B), a surrogate could consent to a DNR order if the patient met any one of four clinical criteria, including a finding by two physicians that resuscitation would be "medically futile," defined to mean that resuscitation "will be unsuccessful in restoring cardiac and respiratory function or that the patient will experience repeated arrest in a short time period before death occurs." The former DNR law also allowed two physicians to write a DNR order on medical futility grounds for a patient who did not have a surrogate.

For decisions by family members and other surrogates, the FHCDA established standards for the withdrawal or withholding of a broader range of life-sustaining treatment, including resuscitation. The FHCDA does not specify medical futility as a basis for a DNR order or for other treatments. However, medical futility would clearly be encompassed by the existing standards for decision-making under the FHCDA.

The Section members have different views on the value of including the medical futility standard as a basis for a surrogate consent for a DNR order. However, we support explicitly clarifying the manner in which the medical futility standard applies as a basis for approval of a DNR order for patient who does not have a surrogate (or for whom a MHL Art 80 surrogate decision-making panel would be the surrogate).

8. Clarify the right of developmentally disabled persons who have capacity to make decisions (§31)

Currently, SCPA §1750-b only authorizes life-sustaining treatment decisions when made by SCPA § 1750-b guardians. This amendment clarifies that if the developmentally disabled person is found to have capacity can make his or her own decisions relating to life-sustaining treatment (§31). It also provides that if the developmentally disabled person created a health care proxy, then such decisions can be made pursuant to the health care proxy law.

9. Modify the roles of Surrogate Decision Making Committees and Mental Hygiene Legal Services with respect to DNR orders (§§35, 36)

Surrogate Decision Making Committees—Under the former DNR law, the MHL Article 80 Surrogate Decision Making Committee (SDMC) had no role in reviewing DNR orders. The FHCDA, by making SCPA § 1750-b applicable to DNR orders for developmentally disabled persons, indirectly required SDMC review of DNR orders for such persons. This bill removes the SDMC's role in the review of DNR orders entered on the basis of medical futility. (§35)

Mental Hygiene Legal Services. Under the former DNR law, for patients in or transferred from a mental hygiene facility, notice of a DNR order had to be given to the facility director, but not to the mental hygiene legal services (MHLS) prior to entry of the order. By making SCPA§1750-b applicable to most such patients, the FHCDA requires notice to MHLS of all decisions to withhold or withdraw life-sustaining treatment, including DNR orders. Moreover, if MHLS objects to the order, it must be stayed.

Notice to MHLS of all DNR orders for developmentally disabled persons in hospitals or nursing homes is not supported by identified problems or poor decisions and delays what may be urgent treatment decisions for these patients Restoring the previous procedure, and eliminating both the notice to MHLS and its authority to object would reduce a burden on hospitals and nursing homes, and prevent unnecessary and sometimes harmful delays in the issuance of appropriate DNR orders while MHLS investigates each case.

The proposed amendments preserve the safeguard of notice to MHLS, but provide that an objection by MHLS will not stay the DNR order unless MHLS provides a basis for its objection, including clinical support. This approach strikes a reasonable balance. (§36).

Conclusion

The Surrogate Decision-Making Improvement Act makes a series of valuable clarifications and adjustments to the FHCDA and related laws. The Health Law Section urges passage of the bill to further realize the intention of New York's laws on treatment decisions.

Endnotes

1. See www.nysba.org/fhcda.
2. E.g., "Health Care Decision Making: Implementation of the Family Health Care Decisions Act, Recent Developments and Ethical Considerations," Albany (May 6, 2011) and NYC (May 13, 2011).
3. NYSBA Health L. J., Spring 2011.
4. See, e.g., Tracy Miller, "New York Adopts Broad Law on Changes to Treatment Decisions," 243 *N.Y.L.J.* 1 (March 21, 2010) and Robert N. Swidler, "New York's Family Health Care Decisions Act: The Legal and Political Background, Key Provisions and Emerging Issues," 82 *N.Y. Bar J.* 18 (June 2010).

***Editor's Note: The so-called Surrogate Decision-Making Improvement Act (A.7343) (Gottfried) (hereinafter "SDMIA") would have made amendments to several New York laws relating to surrogate decision-making, to improve and coordinate those laws. In June 2011, the Legislature passed a small but important part of the SDMIA: the provisions necessary to extend the FHCDA to decisions regarding hospice care. A.7343-A (Gottfried)/S.5259-A(Hannon). It is likely that the remaining provisions of the SDMIA will be introduced again in 2012. Accordingly, the NYSBA Health Law Section's report is still relevant.**

Upcoming Events

- **Self-Disclosure: Practical Tips and Stories.** The Committee on Fraud, Abuse and Compliance will present this webinar on September 22, 2011, from 12:00-1:30 p.m. Catherine Diviney and Jeffrey Sherrin will present; Melissa Zambri of Hiscock & Barclay (Albany) will moderate.
- **Fall Program.** This will be held at the Yale Club in New York City on October 22, and will focus on legal, regulatory and corporate aspects of Forming an Accountable Care Organization in New York.

Recent Events

- **Health Care Decision Making**. A CLE program on "Health Care Decision Making: Implementation of the Family Health Care Decisions Act, Recent Developments and Ethical Considerations" was held in Albany, NYC and Buffalo in May. The program covered the FHCDA, the Health Care Decisions Act for Persons with Mental Retardation, Do-Not-Resuscitate statutes, mental health issues. It also considered special issues in consent, such as consent to organ donation, reproductive procedures and human subject research, and consent for children and older minors. The program was co-chaired by Lawrence Faulkner of the Westchester Association for Retarded Citizens and Tracy Miller of Cadwalader, Wickersham and Taft.
- **Basic Health Law for the Non-Health Lawyer.** The Committee on Fraud, Abuse and Compliance offered webinars on May 3, 2011. Alexander Bateman, Jr. and David Daniels presented, Melissa Zambri of Hiscock & Barclay moderated.

Recent Supraspinatus Topics

- Recent meetings: NY DOH Public Health and Health Planning Council
- State's top Medicaid-fraud cop asked to resign | Crain's New York Business
- Holding: Hospital Not Liable for Errors of Attending Physician
- NYS Medicaid Redesign Team Releases Progress Report
- Why Medical School Should Be Free—NYTimes.com
- Jail Time for HIPAA Violator
- Vermont's Single-Payer Health Care Bill Moves Ahead—NYTimes.com
- NY Mulls Physician "Dress Code Council" Bill
- NACHGR open session meeting (5/11); EuroGentest
- Collaborative Drug Therapy by Pharmacists approved
- Two local health executives nominated to state health planning council | Democrat and Chronicle | democratandchronicle.com
- Nursing Homes Seeking Reprieve From Health Care Law—NYTimes.com

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

Section Committees and Chairs

The Health Law Section encourages members to participate in its programs and to volunteer to serve on the Committees listed below. Please contact the Section Officers (listed on the back page) or Committee Chairs for further information about these Committees.

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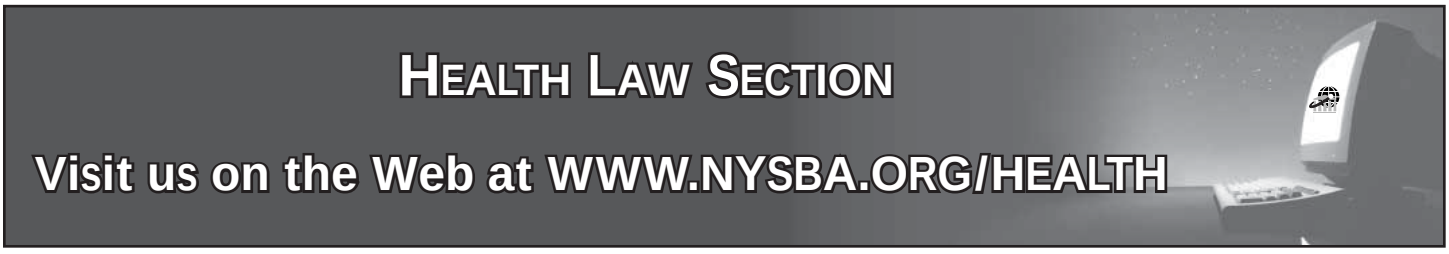

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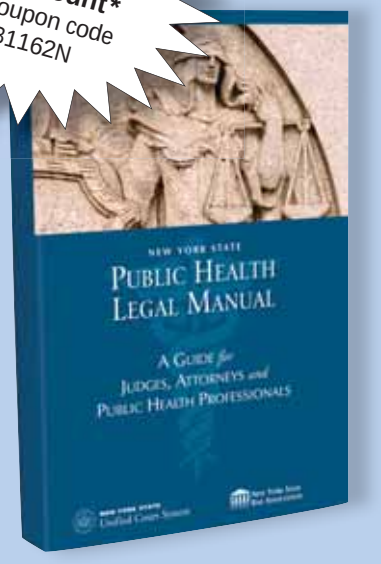

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